TOPIC PRESENTED: "Palliative & End of Life Care: *Legal Perspective*"

Presentation	Company
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- End of Life;
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- M.A.I.D.;
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- *Carter v Canada (Attorney General)*
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- Informed Consent

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1. The Legalization of Medical Assistance in Dying:

(a) Knowledge is Safety:

Bill C-14 represents a dramatic reversal of the prior state of the law of medically assisted deaths. Prior to 2015, any actions taken by healthcare professionals in facilitating someone's death constituted criminal acts.

Since the Supreme Court of Canada's decision in *Carter v. Canada (Attorney General)*, 2015 SCC 5 (CanLII) ("*Carter v Canada*"), medically assisted deaths are not criminal acts provided that they meet the criteria stipulated by Bill C-14.

However, just because Bill C-14 received Royal Assent on June 17, 2016, this does not mean that the legal issues related to medically assisted deaths are wholly resolved. Bill C-14 represents amendments to the *Criminal Code of Canada*, but it does not speak to regulatory proceedings, civil actions, ethical dilemmas, etc.

Understanding the legal history and context leading up to Bill C-14 is essential knowledge to any healthcare professional involved in a medically assisted death. Such persons are not limited to the doctor or nurse directly engaged in the final steps of a medically assisted death, but would also include, for example:

- the pharmacist who dispensed any drug used to bring about the patient's death;
- the psychologist or therapist who provided counselling to the patient seeking medically assisted death; and
- any other person / professional involved in that patient's decision-making process.

(b) The Current Legal Context.:

In advance of Bill C-14 receiving Royal Assent, Dr. Eric Hoskins stated: "While not required by the Supreme Court, we encourage patients and health care providers to seek further clarity about how the Supreme Court's decision applies to their particular circumstances by bringing an application to the Ontario Superior Court of Justice."

To place this statement in context, Mr. Justice Perell of the Ontario Superior Court of Justice described the legal history of medically assisted deaths in a decision released 9 days after the statements issued by Dr. Hoskins, on June 15, 2016. Mr. Justice Perell's summary is below:

> - "In the **first phase**, physician-assisted death was criminalized. A doctor who assisted a patient in dying committed a serious crime."
> - "In the **second phase**, pursuant to what is known as a constitutional exemption, a physician-assisted death could be authorized by court order."
> - "In the **third phase**, which commenced on June 7, 2016, the legal status of a physician-assisted death is uncertain. The legal status of a physician-assisted death in this third phase is the issue I must determine. The third phase will last until Parliament enacts legislation to govern physician-assisted death."
> - "The **fourth phase** will begin with the enactment of new legislation. That legislation is presently being debated in the House of Commons and in the Senate…"
>
> [*O.P. v. Canada (Attorney General)*, 2016 ONSC 3956, at paras. 28-31, bolded emphasis added]

Mr. Justice Perell observed that "[i]t is likely that the fourth phase will not be the end of the saga and that subsequent phases will be demarcated by litigation and more legislation." (*ibid*., para. 31)

(c) What does Bill C-14 represent?

Bill C-14 became law on June 17, 2016 and represents, in one sense, a bundle of amendments to the *Criminal Code*. These amendments are the legislative response to the Supreme Court of Canada's decision in the 2015 decision of *Carter v Canada*. Prior to that decision, section 241(b) of the *Criminal Code* stipulated that anyone who aids or abets a person in committing suicide will have committed an criminal offence. Section 14 of the *Criminal Code* additionally provides that no person may consent to death being inflicted on them. Taken together, these provisions prohibited the provision of medical assistance in dying in Canada.

Section 14 of the *Criminal Code* continues to stipulate that criminal responsibility will attach to anyone who assists in bringing about the death of another person, regardless of whether that person consents. However, with the amendments to the *Criminal Code* ushered in by Bill C-14, not all such deaths will entail criminal responsibility. More specifically, Bill C-14 permits, in certain circumstances, for specific healthcare professionals to assist in a consenting person's death.

(d) The Supreme Court of Canada's Dramatic Shift:

In 1993, Sue Rodriguez was a 42-year-old mother suffering from amyotrophic lateral sclerosis who made nation-wide news when she unsuccessfully challenged the criminality of medically assisted deaths. After discovering that she would not live more than a year, Ms. Rodriguez brought her challenge to the Supreme Court of Canada, seeking to strike down section 241(b) of the *Criminal Code*. Ms. Rodriguez argued that the criminalization of physician-assisted suicide violated her section 7 rights to life, liberty, and security of the person under the C*harter of Rights and Freedoms* (the "*Charter*").

The Supreme Court of Canada decided against Ms. Rodriguez, reasoning in part:

> "This consensus finds legal expression in our legal system which prohibits capital punishment. This prohibition is supported, in part, on the basis that allowing the state to kill will cheapen the value of human life and thus the state will serve in a sense as a role model for individuals in society. The prohibition against assisted suicide serves a similar purpose. In upholding the respect for life, it may discourage those who consider that life is unbearable at a particular moment, or who perceive themselves to be a burden upon others, from committing suicide. To permit a physician to lawfully participate in taking life would send a signal that there are circumstances in which the state approves of suicide."
>
> [Per Sopinka J. at page 608 in *Rodriguez v. British Columbia (Attorney General)*, 1993 CanLII 75 (SCC)]

22 years later, the Supreme Court of Canada considered another case involving a woman suffering from ALS, but this time its decision was to permit such medically-assisted deaths. That case was *Carter v Canada*.

The parties in *Carter v Canada* included Ms. Taylor, who was also diagnosed with ALS. Ms. Taylor was joined in her efforts by Ms. Carter and Mr. Johnson. Ms. Carter's mother had suffered from degenerative spinal stenosis, and was taken by her daughter and Mr. Johnson to an assisted suicide clinic in Switzerland where she died.

Also joining the litigation were a physician who was willing to participate in physician-assisted dying if it were no longer prohibited, and the British Columbia Civil Liberties Association. The Attorney General of British Columbia participated in the constitutional litigation by way of automatic right.

The Supreme Court of Canada decided in favour of the applicants, and held that sections 241(b) and 14 of the *Criminal Code* unjustifiably infringed section 7 of the *Charter* (the rights to life, liberty, and security of person). The particular provisions of the *Criminal Code* before the Supreme Court were declared of no force or effect *to the extent* that they prohibit:

- Physician-assisted death for a competent adult person who:
    - clearly consents to the termination of life; **and**
    - has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

In arriving at its decision, the Supreme Court stated:

> "It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel."
>
> [The Court at para. 1 of *Carter v. Canada (Attorney General)*, 2015 SCC 5 (CanLII)]

The declaration of invalidity was suspended for 12 months, after which time the newly elected Liberal government was given a 4-month extension in order to consult with appropriate experts and prepare amendments to the current legislation. Bill C-14, which provided the required amendments, was ultimately passed on June 17, 2016.

2. How Did Bill C-14 Change the Criminal Code?

The net effect of Bill C-14 was to introduce amendments to the *Criminal Code* enabling healthcare professionals to no longer be considered "criminally responsible" for their involvement in the death of a consenting patient. The two forms of medical assistance in dying available to Canadians include:

1. **"Voluntary Euthanasia":** When a physician or nurse practitioner directly administers a substance that causes death, such as an injection of a drug; and

2. **"Medically Assisted Suicide":** When a physician or nurse practitioner gives or prescribes a drug that is self-administered to cause death.

While Bill C-14 decriminalizes medically assisted deaths in certain circumstances, it does not, however, speak to professional regulatory processes, civil litigation, or further restrictions at the provincial level. The law in Quebec, for instance, differs from the *Criminal Code* provisions in that the *Criminal Code* allows for both voluntary euthanasia and medically assisted suicide, whereas Quebec's law only permits voluntary euthanasia.

The *Criminal Code* was revised such that the original offence was retained, but medically-assisted exceptions were permitted in specific circumstances. For the purposes of comparison, the offence-creating provisions are set out in the table below:

Section	Prior to Bill C-14	After Bill C-14
14	No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.	No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent.
241(a)-(b)	Everyone who, (*a*) counsels a person to commit suicide, or (*b*) aids or abets a person to commit suicide,	241(1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

Section	Prior to Bill C-14	After Bill C-14
	whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.	(a) counsels a person to die by suicide or abets a person in dying by suicide; or (b) aids a person to die by suicide.
241(2)	N/A	(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2
241(3)	N/A	(3) No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2
241(4)	N/A	(4) No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.
241(5)	N/A	(5) No person commits an offence under paragraph (1)(b) if they do anything, at another person's explicit request, for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assistance in dying in accordance with section 241.2.
241(5.1)	N/A	(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying
241(6)	N/A	(6) For greater certainty, the exemption set out in any of subsections (2) to (5) applies even if the person invoking the exemption has a reasonable but mistaken belief about any fact that is an element of the exemption
241(7)	N/A	

Section	Prior to Bill C-14	After Bill C-14
		(7) In this section, *medical assistance in dying*, *medical practitioner*, *nurse practitioner* and *pharmacist* have the same meanings as in section 241.1

It is important to note that these are not the only amendments introduced to the *Criminal Code*. Additional sections were implemented, and they include the following:

- Section 241.1 (definitions)
- Section 241.2 (eligibility for medical assistance in dying)
- Section 241.3 (failure to comply with safeguards)
- Section 241.4 (forgery)
- Section 241.31 (filing information – medical practitioner or nurse practitioner)

Key amongst these provisions is section 241.2 of the *Criminal Code*, which deals with the eligibility criteria for those seeking medical assistance in dying.

> 241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
>
> (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
>
> (b) they are at least 18 years of age and capable of making decisions with respect to their health;
>
> (c) they have a grievous and irremediable medical condition;
>
> (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
>
> (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Fortunately for medical practitioners who are engaged in providing medical assistance in dying, the highly subjective language used in section 241.2(1) of the *Criminal Code* has already had some degree of judicial comment and insight. Phrases such as "a grievous and irremediable medical condition" and related concepts are discussed below.

3. Who Does Bill C-14 Consider?

As currently structured, the Bill C-14 considers the following stakeholders:

1. People considered eligible for medical assistance in dying;

2. Physicians and/or Nurse Practitioners (who are the only persons specifically permitted under the *Criminal Code* to engage in acts such as "Voluntary Euthanasia" or "Medically Assisted Suicide"); and
3. Pharmacists and any other similar persons who are incidental but necessary for the process of assisted dying.

Section 241(5.1) of the *Criminal Code* also states:

> "For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying."

This basket provision includes various other regulated health professionals beyond those authorized to provide medical assistance in dying.

4. Eligibility Pre-Requisites for Medical Assistance in Dying:

(a) Overall Prerequisites:

The eligibility requirements for medical assistance in dying is critical information not just for those seeking medically assisted death, but also those facilitating it. As at April 18, 2017, the Government of Canada's own understanding of the eligibility criteria are set forth on its website: < https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a1 >

According to www.canada.ca, as noted above:

"In order to be eligible for medical assistance in dying, you must meet **all** of the following conditions. You must:

- be eligible for health services funded by the federal government, or a province or territory
  - generally, visitors to Canada are not eligible for medical assistance in dying
- be at least 18 years old and mentally competent (this means capable of making health care decisions for yourself)
- have a grievous and irremediable medical condition
- make a request for medical assistance in dying which is not the result of outside pressure or influence
- give informed consent to receive medical assistance in dying (this means you have consented to medical assistance in dying after being given all of the information needed to make your decision, including information about:
  - your medical diagnosis
  - available forms of treatment
  - available options to relieve suffering, including palliative care"

(b) What is a "Grievous and Irremediable" Condition?

The www.canada.ca (noted above) goes on to describe what a "grievous and irremediable" condition is. However, the description provided continues to depend on subjective language. The description is below:

> "To be considered as having a grievous and irremediable medical condition, you must meet **all** of the following conditions. You must:
>
> - have a serious illness, disease or disability
> - be in an advanced state of decline that cannot be reversed
> - be suffering unbearably from your illness, disease, disability or state of decline
> - be at a point where your natural death has become reasonably foreseeable, which takes into account all of your medical circumstances
>
> You do **not** need to have a fatal or terminal condition to be eligible for medical assistance in dying."
>
> (emphasis in original)

(c) Mental Illness on its Own Does NOT Qualify:

The Government of Canada website also indicates that **mental illness**, on its own, is insufficient to create eligibility.

> "People with a mental illness are eligible for medical assistance in dying as long as they meet all of the listed conditions.
>
> However, you are not eligible for this service if:
>
> - you are suffering only from a mental illness
> - death is not reasonably foreseeable when considering all the circumstances of your medical condition
> - a mental illness reduces your ability to make medical decisions"

On the issue of mental illness, Simona Chiose of the Globe & Mail reported on April 16, 2017:

> "The suicide of Adam Maier-Clayton, a 27-year-old man who was an advocate for extending the right to a medically assisted death to those suffering from severe psychological distress, is likely to intensify one of the most difficult parts of the debate about assisted death in Canada. Mr. Maier-Clayton suffered from obsessive compulsive disorder, generalized anxiety and somatic symptom disorder and pain from which he could find no relief, he said in a Globe and Mail piece published a year ago."

See: < http://www.theglobeandmail.com/news/national/adam-maier-claytons-death-renews-debate-on-assisted-dying-access-for-those-with-mental-illness/article34718194/ >

(d) Better Guidance is Needed:

The potential criminal ramifications flowing from a legal error involving a medical professional's interpretation of highly subjective legislative language is a frightening prospect. It would also be unsettling for any healthcare provider to be subjected to criminal proceedings, even if acquitted, due to a different understanding of a what constituted a "grievous and irremediable medical condition".

5. The Views, Comments, and Considerations of the Courts:

(a) From *Carter v Canada* until Bill C-14 Received Royal Assent:

On February 6, 2015, the Supreme Court of Canada rendered its decision in *Carter v Canada*. Bill C-14 received Royal Assent on June 17, 2016.

Between February 6, 2015 and June 17, 2016, the only *legal* means by which an eligible person could exercise his or her rights under *Carter v Canada* was by way of court order. This was explained by Mr. Justice Perell of the Ontario Superior Court of Justice in the O.P. case. In *O.P. v Canada (Attorney General)*, 2016 ONSC 3956 (CanLII), Mr. Justice Perell considered the argument of one patient who argued that Court intervention is not required. O.P. had argued that the need for a court order was only a *practical* requirement, designed to reassure the healthcare professionals who were to provide medically assisted deaths.

The Court disagreed, pointing out that, until such time as *Carter v Canada* becomes valid legislation, authorization from the courts was strictly required. Mr. Justice Perell explained that the courts' supervision was necessary to "provide an effective safeguard against potential risks to vulnerable people from an unregulated regime of physician-assisted death" (para. 9).

During the period of time between the release of the Supreme Court of Canada's decision in *Carter v Canada* to the day Bill C-14 received Royal assent, there was a significant number of medically assisted deaths authorized by our country's courts. It appears doubtful that all court decisions dealing with applications for medically assisted deaths were released, as decisions declining medically assisted deaths would raise obvious privacy concerns for the unsuccessful applicant. However, a number of the decisions that *authorized* such applications have been made public. Some of these decisions include:

- *Re HS*, 2016 ABQB 121.
- *A.B. v. Canada (Attorney General)*, 2016 ONSC 1571.
- *A.B. v. Canada (Attorney General)*, 2016 ONSC 1912.
- *A.A. (Re)*, 2016 BCSC 511.
- *A.A. (Re)*, 2016 BCSC 570.
- *Patient v. Attorney General of Canada et al*, 2016 MBQB 63.
- *W.V. v. Attorney General of Canada, Attorney General of Ontario and Dr. C. Doe*, 2016 ONSC 2087.
- *W.V. v. Attorney General of Canada*, 2016 ONSC 2302.
- *A.B. v. Ontario (Attorney General)*, 2016 ONSC 2188.
- *X.Y. v. Canada (Attorney General)*, 2016 ONSC 2371.
- *X.Y. v. Canada (Attorney General)*, 2016 ONSC 2585.
- *C.D. v. Canada (Attorney General)*, 2016 ONSC 2431.
- *W.B.B. (Re)*, 2016 BCSC 1005.
- *Tuckwell, Re*, 2016 ABQB 302.
- *E.F. v. Canada (Attorney General)*, 2016 ONSC 2790.
- *Patient 0518 v. RHA 0518*, 2016 SKQB 175.
- *G.H. v. Attorney General of Canada*, 2016 ONSC 2873.
- *Canada (Attorney General) v. E.F.*, 2016 ABCA 155.
- *M.N. v. Canada (Attorney General)*, 2016 ONSC 3346
- *I.J. v. Canada (Attorney General)*, 2016 ONSC 3380.
- *H.H. (Re)*, 2016 BCSC 971.
- *O.P. v. Canada (Attorney General)*, 2016 ONSC 3956.

These decisions are helpful not only in their interpretation of the *Criminal Code* language, but also insofar as they highlight the key judicial concerns that arise out of Bill C-14.

(b) The Elements of a Court Order Authorizing Medically Assisted Deaths:

Court orders that authorized medically assisted deaths invariably contained the following elements:

Elements of a Court Order Authorizing Medically Assisted Deaths:

(a) A declaration by the Court that the patient met all of the criteria;
(b) A description of the manner of assisted death;
(c) A declaration by the Court that the physician would **not** be violating the *Criminal Code*;
(d) A declaration by the Court that the physician would be acting in compliance with the relevant regulatory policies & guidelines;
(e) A declaration that any assisting nurse practitioners are authorized to assist;
(f) A declaration that any pharmacists involved are authorized to assist by dispensing the relevant drugs; and
(g) A declaration by the Court that *all healthcare professionals involved* were acting in compliance with the law.

(c) Case Studies:

Illustration 1: *A.A. (Re)*, 2016 BCSC 570 (CanLII):

A.A., a woman suffering from Multiple Sclerosis, was successful in her application to the British Columbia Supreme Court in obtaining an order permitting her physician to provide medical assistance in dying. It is important to note the relief granted by the Court, as it included protection for her physician. At para. 43 of the Court's decision, it stated:

> [43] In conclusion, I have determined that A.A. meets the requirements set out in *Carter 2015*, and therefore comes within the class of persons to which the Supreme Court of Canada granted a constitutional exemption from the extension of the suspension of the declaration of invalidity of ss. 14 and 241(b) of the *Criminal Code* in *Carter 2016*. I therefore make the following declarations and orders:
>
> a) A.A. comes within the scope of the constitutional exemption granted by the Supreme Court of Canada in *Carter v. Canada (Attorney General),* 2016 SCC 4 (CanLII).
>
> b) Dr. Ellen Wiebe is authorized to provide A.A. with a physician-assisted death, in the form of voluntary euthanasia by lethal injection, at A.A.'s request and in compliance with the guideline issued by the College of Physicians and Surgeons of British Columbia (approved January 21, 2016 and entitled *Interim Guidance - Physician-assisted Dying*).

c) Either of the two registered nurses who have sworn affidavits in these proceedings is authorized to assist Dr. Wiebe with A.A.'s physician-assisted death.

d) Either of the two registered pharmacists holding practising status with the College of Pharmacists of British Columbia, who have sworn affidavits in these proceedings, is authorized to dispense drugs for A.A. as part of the physician-assisted dying process for A.A.

e) Dr. Wiebe, either of the two registered nurses who have sworn affidavits in these proceedings and either of the two registered pharmacists who have sworn affidavits in these proceedings, in relation to the conduct allowed under this order, are hereby exempt from the suspension of the declaration of invalidity of ss. 14 and 241(b) of the *Criminal Code*, R.S.C. 1985, c. C-46, made by the Supreme Court of Canada in *Carter v. Canada*, 2015 SCC 5 (CanLII), and extended in *Carter v. Canada*, 2016 SCC 4 (CanLII).

As noted above, the Court order included the following elements:

(a) A declaration by the Court that the patient met all of the criteria;
(b) A description of the manner of assisted death;
(c) A declaration by the Court that the physician would **not** be violating the *Criminal Code*;
(d) A declaration by the Court that the physician would be acting in compliance with the relevant regulatory guidelines;
(e) A declaration that the assisting nurse practitioners were authorized to assist;
(f) A declaration that the assisting pharmacists were authorized to assist by dispensing the relevant drugs; and
(g) A declaration by the Court that *all healthcare professionals involved* were acting in compliance with the law.

The Court in the A.A. case described how it perceived its role in deciding the case before it, at para. 13:

> [13] My task is confined to an adjudication or determination respecting whether the petitioner falls within the group of persons to whom the constitutional exemption has already been granted. As described by Madam Justice Martin in *Re H.S.* at paras. 58 – 59, that role is*:*
>
> > [58] … simply to determine whether a particular claimant meets those articulated criteria. The singular question the Supreme Court has directed the superior courts to answer in this type of application is whether the applicant falls within that group. This limited inquiry is individual- and fact-specific. The motions judge must be mindful of the legal framework and overall constitutional context of the inquiry; it is a rights-rich context. However, there is no opportunity or need to re-litigate the various rights and interests fully considered by the Supreme Court's unanimous decision in *Carter 2015.*
> >
> > [59] The question, properly understood after *Carter 2016,* is: does this person fall within the group of persons to whom a constitutional exemption has already been granted?
>
> [underlined emphasis added]

The Court in the A.A. case also cited a decision by Mr. Justice Perell from Ontario, and in doing so endorsed Mr. Justice Perell's interpretation of the words "grievous and irremediable":

> [27] Mr. Justice Perell explained the meaning of a grievous and irremediable medical condition in *A.B.* at para. 25:
>
> > … With respect to the second criterion, a grievous medical condition connotes that the person's medical condition greatly or enormously interferes with the quality of that person's life and is in the range of critical, life-threatening, or terminal. An irremediable medical condition connotes that the medical condition is permanent and irreversible.
>
> [at para. 27, underlined emphasis added]

Illustration 2: *H.H. (Re)*, 2016 BCSC 971 (CanLII):

In the words of the Court, H.H. was "an adult woman who suffers from a constellation of medical difficulties. Her condition is known as mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes, or by the acronym 'MELAS'. … [H.H.] described the onset of the symptoms of her syndrome beginning in 2000, leading to a stroke in December of 2014 and a second stroke in the following month. Her condition has required surgery, affected her memory and manifested itself in aphasia, hemiparesis, myoclonus, hemianopia and hearing loss. She is in pain as a result of her condition and fears experiencing another stroke. She states that her illness is incurable and that her physical and psychological suffering from her condition is intolerable to her." [para. 5, square brackets inserted]

Again, the relief granted by the Court included the following elements, at para. 42:

a) H.H. comes within the scope of the constitutional exemption granted by the Supreme Court of Canada in *Carter v. Canada (Attorney General),* 2016 SCC 4 (CanLII).

b) Dr. Ellen Wiebe is authorized to provide H.H. with a physician-assisted death, in the form of voluntary euthanasia by lethal injection, at H.H.'s request and in compliance with the guideline issued by the College of Physicians and Surgeons of British Columbia (approved January 21, 2016 and entitled *Interim Guidance - Physician-assisted Dying*) up to and including June 5, 2016.

c) Either of the two registered nurses who have sworn affidavits in these proceedings is authorized to assist Dr. Wiebe with H.H.'s physician-assisted death.

d) Either of the two registered pharmacists holding practising status with the College of Pharmacists of British Columbia, who have sworn affidavits in these proceedings, is authorized to dispense drugs for H.H. as part of the physician-assisted dying process for H.H.

e) Dr. Wiebe, either of the two registered nurses who have sworn affidavits in these proceedings and either of the two registered pharmacists who have sworn affidavits in these proceedings, in relation to the conduct allowed under this order, are hereby exempt from the suspension of the declaration of invalidity of ss. 14 and 241(b) of the *Criminal Code*, R.S.C. 1985, c. C-46, made by the Supreme Court of Canada in *Carter*

> *v. Canada*, 2015 SCC 5 (CanLII), and extended in *Carter v. Canada*, 2016 SCC 4 (CanLII), up to and including June 5, 2016.

Illustration 3: CD v Canada (Attorney General), 2016 ONSC 2431 (CanLII):

In the CD case, Mr. Justice Perell concisely summarized the considerations that the Court expected to be addressed in order for a woman who was afflicted with Cancer to receive medical assistance in dying. Beyond the overarching form and approach taken by the Court in its analysis, two important considerations should be noted: (a) informed consent; and (b) the absence of coercion.

> [8] CD's cancer is grievous, terminal, and irremediable. CD's prognosis is that she will die within two to six months. The cancer is causing her to endure excruciating pain and intolerable suffering. The pain is unrelenting. Her suffering cannot be alleviated by any treatment available that she finds acceptable. Indeed, her suffering cannot be alleviated by any treatment at all. Notwithstanding her confident, strong-willed, and resolute personality, multiple pain management medications have been tried without success and the pain remains intolerable. She deposed that her quality of life is non-existent.
>
> [9] I find as a fact that CD is a competent adult person. She has been informed and understands her medical diagnosis, prognosis, and treatment options including palliative care options. Her family doctor, who has known her for almost two decades, and the consulting psychiatrist opined that she has the capacity to make a decision about physician-assisted death.
>
> [10] The psychiatrist, who performed a capacity assessment, added that she is not suffering from any active psychiatric or mood disorder.
>
> [11] CD has been informed of the physician-assisted death process and of the risks involved. There is no evidence of coercion or anyone influencing her decision, and I find that she clearly and freely consents to the termination of her life. She has expressed and understands that the decision to obtain a physician-assisted death is hers alone.
>
> [12] I am also satisfied by the evidence that: (1) CD is a resident of Ontario; (2) she commenced her application after having been fully informed about her medical condition, diagnosis, prognosis, treatment options, and palliative care options; (3) she is aware that her request for an authorization for a physician-assisted death may be withdrawn at any time; (4) she is aware that if the authorization is granted, the decision to use or not use the authorization is entirely hers to make; and (5) she consents without coercion, undue influence, or ambivalence to a physician-assisted death.
>
> [13] I am satisfied that there are physicians willing to assist CD in dying if a physician-assisted death were authorized by court order and that the physicians believe that providing assistance would clearly be consistent with CD's wishes and that they understand that the decision to use or not use the authorization is entirely CD's decision to make.
>
> [14] I, therefore, grant CD a declaration that she satisfies the criteria for the constitutional exemption granted in *Carter v. Canada (Attorney General),* 2016 SCC 4 (CanLII) for a physician-assisted death.

6. Comments on Informed Consent:

A recurring theme in all of the court-authorized medically assisted deaths is the requirement for evidence of *informed consent*. Given its central importance in medically assisted deaths, the issue of *informed consent* is addressed in greater detail below:

(a) The Relationship between Capacity and Consent:

While the notion of "informed consent" appears to present as one unified concept, implicit within it is a 2-step process. In general, obtaining *informed consent* requires the healthcare professional to engage in the following assessment-process, in the following order:

1. Is the patient capable of making a particular treatment-related decision?
2. If so, then has the patient been sufficiently informed about the proposed treatment?

The misconception that underlies informed consent, where a decision about treatment is received directly from the patient, is that it *automatically assumes* that the patient was capable.

However, if the patient is not capable with respect to a particular form of treatment, then the consent given by that patient relating to that treatment-related decision is invalid. The result in such circumstances is that there never was informed consent. These comments must be considered in addition to the particular requirements engaged by Bill C-14 as well as the relevant provincial regulatory policies and guidance.

(b) The First Step – Determining Whether a person is Capable:

A person's capacity is determined by answering the 2 questions below:

Determining Capacity in Medical Practice

1. Does the person understand the relevant information about the proposed treatment?

   ~ AND ~

2. Does the person appreciate the likely consequences of either…?

   a. Consenting to the treatment;
   b. Refusing to consent to the treatment; or
   c. Making no decision about the treatment.

- If the correct answer to **both** questions is "yes", then the person is capable of making the treatment-related decision.

- However, if the answer to **either** question is "no", then the person is not capable of making the treatment-related decision.

The healthcare professional involved in assessing capacity is better-equipped to prepare an appropriate capacity assessment if he or she is able to clearly articulate the factors that went into the assessment. Such factors fall broadly into two categories:

- *Patient-specific*; and
- *Contextual*.

Some suggested considerations in determining capacity, in general, include:

- Communication (including: language; intellectual ability; emotional maturity; cultural factors; etc.)
- Direct observation of the patient;
- Information form family and friends;
- The absence of coercion;
- Events leading up to the capacity assessment (such as mental illness, intoxication, etc.)
- Psychiatric diagnoses;
- The presence of a personality disorder; and
- Any other considerations that the healthcare professional considers relevant.

(c) <u>The Second Step – Obtaining Informed Consent</u>:

Once a capacity assessment is completed, the healthcare professional must then ensure that the decision is an *informed* choice. This requirement has a much more pronounced significance in cases of medically-assisted deaths.

Given the outcome, the highly-specialized considerations made by the courts in the above-noted decisions are of considerable value in understanding whether informed consent has truly been obtained. (For example, in the C.D. case, above, Mr. Justice Perell specifically noted that the patient was "not suffering from any active psychiatric or mood disorder" and had provided consent "without coercion, undue influence, or ambivalence to a physician-assisted death".)

Provided that the decision-making process engaged by all is reasoned, appropriately thorough, and principled, then the "informed" nature of the decision will likely be legal. It is always good practice to get a second opinion given the nature of the decision at issue. In addition, it is essential that all professionals review the relevant regulatory policies and guidelines.

In the circumstances of Bill C-14, the College of Physicians and Surgeons of Ontario, for example, stipulates in Policy 4-16, "Medical Assistance in Dying", the following:

> "The federal legislation does not address how **conscientious objections** of physicians, nurse practitioners, or other healthcare providers are to be managed. … Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must not abandon the patient. **An effective referral must be provided**. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency. The referral must be made in a timely manner to allow the patient to access medical assistance in dying. Patients must not be exposed to adverse clinical outcomes due to delayed referrals." (emphasis added)

The policy stipulation by the CPSO that "an effective referral must be provided" where a physician is conscientiously objecting raises fundamental and contentious human rights issues. This ethical issue is a considerable subject, and outside the scope of this legal analysis.