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Physician-Assisted Death in Canada: As the Law Changes

Heather Hogan, Mark Handelman, and Madeeha Hashmi

In *Carter v. Canada (Attorney General)*¹ the Supreme Court of Canada (“S.C.C.”) declared that the criminal law prohibition on physician-assisted death will be unconstitutional, effective February 7, 2016. Quebec will be prepared with a statutory framework to govern the provision of physician-assisted death; Quebec’s Bill 52 was assented to on June 10, 2014 and will come into effect in December 2015. No other province has yet tabled legislation.

Some may see these changes as a reflection of the evolution of palliative care and medical science within Canada and abroad. Others may view these changes as slap-dash experiment in physician-assisted death. This article suggests that the truth is somewhere in between the two perspectives. Bill 52 reflects an attempt by Quebec legislators to regulate physician-assisted death. The S.C.C. interpreted only the narrow point put to them, which was whether, in the cases before them, the blanket prohibition on physician-assisted death breached the *Canadian Charter of Rights and Freedoms* [*Charter*].² The S.C.C. did not establish a framework for physician-assisted death across Canada or comment on the Quebec legislation; however, both the legislation and the *Carter* decision raise questions about how physician-assisted death will be implemented in Canada.

Rather than focusing on the arguments for and against physician-assisted death, this article focuses on Canada’s contribution to the global dialogue and considers some of the unanswered questions raised by *Carter* and Bill 52: questions about capacity, subjective suffering, and the potential for medical liability in the provision of physician-assisted death going forward. We suggest that these are the issues that will define the implementation of physician-assisted death in Canada.

The *Charter* and the *Criminal Code* Prohibition of Assisted Suicide

Two statutes are at the heart of the *Carter* decision: The Canadian *Criminal Code* [*Code*]³ and the *Charter*. The *Code* provides that everyone who counsels a person to commit suicide or aids and abets a person to commit suicide is guilty of an indictable offence and liable to imprisonment for a term up to 14 years, regardless of whether or not suicide ensues.⁴ The *Code* also provides that no person is entitled to consent to have death inflicted upon him, and consent in that regard does not mitigate the criminal responsibility.⁵

The *Charter* provides that everyone has the “right to life, liberty and security of the person”.⁶ The *Charter* also provides that every individual has the right to equal protection and equal benefit of the law without discrimination. These rights are guaranteed, subject only to such reasonable limits prescribed by law “in a free and democratic society”.⁷

The *Code* is an Act of Parliament, and must therefore accord with the principles of the *Charter*. If a Canadian citizen is of the view that an Act of Parliament is “unconstitutional”, he or she is entitled to ask the court to declare that statute of no force or effect. He or she may succeed if the court agrees that the impugned legislation infringes upon the rights guaranteed by the *Charter*, and if that infringement cannot be justified. This process of testing the constitutionality of the criminal prohibition of assisted death has been ongoing for over 20 years. In a sense, this illustrates the progress of law and social policy in the areas of health care in general, and in particular, end-of-life care, mental capacity, and autonomy.

Rodriguez v. British Columbia [Rodriguez]⁸

The S.C.C. considered whether the criminal prohibition of assisted suicide was constitutional in 1993 as a result of litigation commenced by Sue Rodriguez. The case began in British Columbia and the S.C.C. held that the *Criminal Code* prohibition was valid across Canada. She suffered from amyotrophic lateral sclerosis (“ALS”). It was her intention to die humanely before the progressive nature of her disease subjected her to undue suffering. However, her disease had already progressed to the point that she was unable to end her life without help. Ms. Rodriguez was cognizant of the fact that anyone who assisted her in dying could be charged with a criminal offence. She believed that her *Charter* right to “life, liberty and security of the person” included her right to die with dignity regardless of whether or not she was physically disabled, and that this right was unjustifiably infringed upon by the criminal prohibition of assisted suicide. Ms. Rodriguez asked the court to find that the *Criminal Code* prohibition was of no force and effect.

The S.C.C. was split in its decision, but the majority upheld the *Criminal Code* provisions. The majority observed that the principles contemplated in s. 7 of the *Charter* require that a fair balance be struck between the interests of the state and those of the individual. The majority was unable to find, on the evidence, that any infringement of Ms. Rodriguez’s s. 7 rights outweighed the protection afforded to vulnerable people by the criminal prohibition of assisted suicide.⁹ The minority disagreed, stating that the right to die with dignity “should be as well protected as is any other aspect of the right to life” contemplated by s. 7 of the *Charter*.¹⁰

The Rodriguez decision represented only a temporary setback for Ms. Rodriguez. She did subsequently avail herself of a form of assisted suicide.

Although the Royal Canadian Mounted Police investigated, no charges were laid.

Carter v. Canada (Attorney General)¹¹

The constitutionality of the criminal prohibition on assisted death was considered again by the S.C.C. in 2015 in *Carter*. However, this issue was far from dormant during the intervening 22 years since the *Rodriguez* case. The House of Commons debated at least six private member’s bills that proposed the decriminalization of physician-assisted death; none was passed. The ongoing debate reached a tipping point with *Carter*. The case was commenced by a group of individuals: Gloria Taylor, Kathleen (by her daughter Lee Carter and Lee’s husband, Hollis Johnson), Dr. William Shoichet, and the British Columbia Civil Liberties Association. Ms. Taylor, like Ms. Rodriguez, suffered from ALS and did not want to die slowly and in pain. Ms. Carter suffered from advanced stages of spinal stenosis. Ms. Carter, like Ms. Rodriguez was cognizant of the criminal liability of any family member or doctor who would assist her with her goal of dying with dignity, so she attended a clinic in Switzerland and died there. Her family pursued the litigation on her behalf.

Justice Lynn Smith heard the application in 2012 and found that the prohibition against physician-assisted death violates the s. 7 rights of competent adults who are suffering intolerably as a result of a grievous and irremediable medical condition.¹² The Government of Canada appealed Smith J.’s decision, and the British Columbia Court of Appeal found that Smith J. erred when she neglected to follow the binding ruling in *Rodriguez*.¹³ Ms. Taylor and her fellow applicants appealed to the S.C.C. The S.C.C. heard the appeal in February 2015.¹⁴ This time, the S.C.C. held that the blanket prohibition on assisted death unjustifiably infringes our *Charter* rights. Notably, the decision of the court was unanimous. Also notably, McLachlin J. (as she was known in 1993 when she wrote in the

minority decision in *Rodriguez*) is now Chief Justice.

The S.C.C. considered the Court of Appeal's view on the principle of *stare decisis* (courts are bound to follow the judgments of their higher courts) and found that it was open to Smith J. to reconsider the settled law in *Rodriguez* because there were new legal issues raised and there was a change in the circumstances or evidence that were before the court in *Rodriguez*, which fundamentally shifted the parameters of the debate.¹⁵

The following table summarizes the new legal issues and the change in circumstances or evidence since 1993:

<i>Rodriguez 1993</i>	<i>Carter 2015</i>
<p>Legal issues:</p> <p>Whether the s. 7 flaw is:</p> <p>Arbitrary (no)</p> <p>Whether prohibition deprives physically disabled adults of the right to equal treatment under s. 15 (presume it does, but saved by s. 1)</p>	<p>Legal issues:</p> <p>Whether the s. 7 flaw is:</p> <p>Arbitrary (no)</p> <p>Overbroad (yes)</p> <p>Grossly disproportionate (not necessary to decide)</p> <p>Whether prohibition deprives physically disabled adults of the right to equal treatment under s. 15 (unnecessary to decide)</p>

<i>Rodriguez 1993</i>	<i>Carter 2015</i>
<p>Social and Legislative Facts:</p> <p>There is a moral (or ethical) distinction between passive and active euthanasia</p> <p>There is no sufficient means to protect the vulnerable, so breach of s. 15 is saved by s. 1</p>	<p>Social and Legislative Facts:</p> <p>No ethical distinction between physician-assisted death and other end-of-life practices whose outcome is likely death</p> <p>Evidence regarding regulatory structures in other jurisdictions; <u>current practices regarding assessment of informed consent in medical decision-making</u></p>

Justice Smith heard a considerable amount of evidence that established two significant changes to the social and legislative facts since 1993. First, in 1993 there was a distinct moral or ethical divide between “passive euthanasia” (which involves the administration of opioids for pain relief or withholding certain treatments, both of which may hasten death), and “active euthanasia” (administering those treatments with the knowledge that they will hasten death; this is sometimes referred to as the “doctrine of double effect”). However, the court heard that this moral or ethical distinction has evolved in the intervening period such that most end-of-life treatments are now understood to expose the patient to a possible hastening of death even if that is not the intent of the treatment, but

this approach to palliative care is no longer considered “active euthanasia”.

The second significant change pertains to the ability of the state to protect people who are vulnerable. In 1993, there were insufficient means to protect vulnerable persons, so the breach of *Charter* rights was justified. The court in *Carter*, by contrast, heard evidence regarding the multitude of regulatory structures in other jurisdictions that allow physician-assisted death without risk to vulnerable individuals. The court in *Carter* also heard evidence to the effect that current medical practices routinely include the assessment of informed consent in medical decision making. Our legislature should therefore be able to carefully draft the provision of medical services within a framework that ensures safeguards for the vulnerable.

For these reasons, the judges held that the court had before it sufficient evidence to establish that the facts had changed since 1993, and in these circumstances, the court was not bound by *Rodriguez*. The S.C.C. declared that ss. 241(b) and 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect as they relate to physician-assisted death.¹⁶ However, the court was very careful to include in their declaration the specific circumstances in which these sections of the *Code* will no longer apply:

Sections 241(b) and 14 unjustifiably infringe s.7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who:

- (i) Clearly consents to the termination of life, and;
- (ii) Has a grievous and irremediable medical condition (including an illness, disease or a disability) that causes enduring suffering that is intolerable to the individual in the circumstance of his or her condition.¹⁷ (emphasis added)

The court suspended the above remedy for 12 months, until February 6, 2016, to give Parliament and the legislatures time to enact laws to govern the procedure.¹⁸ The court also confirmed that no

physician in any circumstances can be forced to cause death if that individual’s conscience or religious belief cannot be reconciled with that service.¹⁹ But, while the Canadian Medical Association’s proposed guidelines on assisted dying stipulate a requirement that a physician who conscientiously objects to assisting death must still provide information to patients including information on how to obtain a referral, without saying how, there are no legislative guidelines. Nor did the S.C.C. offer any guidelines.

Quebec’s Bill No. 52

The Quebec legislature began to hear committee submissions on physician-assisted death in 2013. Those hearings culminated in Bill 52, *An Act Respecting End-of-life Care*, assented to on June 10, 2014. What follows is a very brief overview of the statute.

The purpose of the Quebec Act is two-fold: it is meant to ensure that patients at end-of-life are provided care that is respectful to their dignity and autonomy, and it is meant to recognize the primacy of wishes that are freely and clearly expressed with respect to end-of-life care.²⁰ The Act establishes a regime for end-of-life care and the criteria for accessing and administering it.²¹ It also establishes a Commission to oversee the application of specific requirements pertaining to medical aid in dying.²² Finally, it establishes a framework for a system of advanced medical directives in Quebec.²³

The Act defines two distinct medical treatments that fall within the spectrum of “end-of-life” care: terminal palliative sedation and medical aid in dying. The Act sets out two distinct criteria for accessing and administering these treatments. Terminal palliative sedation is the administration of drugs or substances to a person at the end of his or her life in order to alleviate suffering by keeping him or her unconscious until death, but the Act is careful to stipulate that terminal palliative sedation

not postpone or accelerate death. The Act defines medical aid in dying as a treatment that involves the administration of drugs or substances by a physician to a person for the purpose of alleviating suffering by causing the patient's death.

The Act requires that both forms of end-of-life care must be offered in Quebec by every institution providing healthcare.²⁴ Every institution must also collect and report statistics that include, among other things, the number of requests for, and refusals of, medical aid in dying.²⁵

Terminal palliative sedation can be requested by the patient or by a person authorized to consent on behalf of the patient, provided that the patient or the substitute decision maker has received the prescribed information about the treatment before they consented.²⁶ By contrast, the criteria for requesting and qualifying for medical aid in dying are much more rigorous. In order to receive medical aid in dying, a patient must meet all of the criteria set out in the legislation in s. 26 of the Act. For example, the patient must:

- be an adult and capable of giving consent;
- suffer from incurable serious illness;
- suffer from an advanced state of irreversible decline in capability; and
- suffer from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable.²⁷

In addition to the s. 26 criteria that must be met by requesting patients, the Act also provides criteria that must be met by the physician administering medical aid in dying. The physician must meet the following s. 28 criteria:

- the physician must be of the opinion that the patient meets the s. 26 criteria after, among other things;
 - making sure that the request is being made freely and without external pressure;

- making sure that the request is an informed one;
- verifying the persistence of suffering; and
- verifying that the wish to obtain aid in dying remains unchanged by talking to the patient at reasonably spaced intervals given the progress of the patient's condition;
- discuss the request with the patient's care team;
- discuss the patient's request with close relatives if the patient so wishes.²⁸

The physician must also obtain a second opinion from a physician who must take prescribed steps to ensure that the s. 26 criteria have been met by the requesting patient.²⁹ The criteria for the second opinion are rigorous.

If a requesting patient meets the s. 26 criteria and the physician determines that medical aid in dying may be administered, the physician must administer such aid personally and take care of the requesting patient until death.³⁰ A person's decision to refuse or receive terminal palliative sedation or medical aid in dying may not be invoked as a reason to refuse to pay a benefit or any other sum due under a contract (life insurance, for example).³¹ Nothing in the Act limits the right of health professionals to refuse to take part in end-of-life care in accordance with their code of ethics or conscience.³² The Bill (now an Act)³³ also provides a framework for the format, validity and registration of Advance Medical Directives and, as noted previously, nothing in the Bill provides that medical aid in dying can be requested by way of an advanced medical directive or administered pursuant to an advanced medical directive.

Analysis: Implications for Ontario and Beyond

As of February 7, 2016, unless the S.C.C. grants the federal government an extension, you are entitled to die at a time of your choosing if you are a

competent adult who clearly consents to the termination of life and have a grievous and irremediable medical condition that causes enduring suffering that is intolerable to you in the circumstances of your condition. This is the law in Canada as a result of *Carter*, but the judgment does not define the following words and phrases:

- Competent adult;
- Clearly consents;
- Grievous and irremediable medical condition;
- Enduring suffering;
- That is intolerable...in the circumstances.

And, while the S.C.C. recognized that some physicians will want no part of assisted death, and specifically does not require them to take part, there is no guidance on whether those doctors have an obligation to refer their patient to a doctor willing to take part.

The law in Ontario provides that an adult is capable if they are able to understand information relevant to the decision, and able to appreciate the reasonably foreseeable consequences of making or not making a decision.³⁴ In Ontario, physicians must assess decisional capacity as part of the process of obtaining informed consent to any treatment — an incapable person cannot give informed consent, and in those cases a surrogate, known in Ontario and some other provinces as a “substitute decision-maker”, or “SDM” will make the treatment decision. Most provinces have rules for identifying the SDM and guiding them in making the correct decision.

However, studies have shown that about 80 per cent of physicians do not understand “capacity”, what it means, or how to assess it.³⁵

Ontario’s *Health Care Consent Act*,³⁶ the statute applicable to treatment decisions, contains no age distinctions or limitations, which means that regardless of your age, you are entitled to make your

own treatment decisions if you are “capable”. Do the court’s parameters on the lifting of the prohibition on assisted suicide discriminate against “non-adults”? Age discrimination is expressly prohibited by s. 15 of the *Charter* unless the discrimination is “demonstrably justifiable in a free and democratic society”. One of the issues that may be litigated in the wake of *Carter* is whether *Carter*’s arguably discriminatory common law test for legal physician-assisted death unjustifiably infringes on the *Charter* rights of children.

In Ontario, consent to treatment requires an informed decision that is given by a capable person voluntarily without misrepresentation or fraud.³⁷ How will requests for physician-assisted death be vetted for voluntariness and capability outside of Quebec? It is not difficult to imagine circumstances in which an older adult with a terminal and costly illness does not wish to see his family suffer the emotional and financial drain of his illness. Would a request for physician-assisted death in those circumstances be voluntarily? Are finances something to be contemplated within the concept of “intolerable to the individual in the circumstances of his or her condition”?

It is also not clear how Parliament will ensure that Canadians have consistent access to the right to die across the country. Currently, only Quebec has legislation that makes the provision of “end-of-life” care a mandatory offering for all health care facilities, but even that Act permits conscious objectors to abstain from the provision of medical aid in dying. Health care remains inconsistent across Canada, from urban to rural setting, from province to province. For example, it is still not possible to get a legal abortion in Prince Edward Island.³⁸

Some studies have found that health care professionals do not accurately comprehend the legal status of end-of-life practices in Quebec. For example, 45.8 per cent of physicians and nurses wrongly thought that it was not permitted to withdraw

a potentially life prolonging treatment at the patient's request.³⁹ Only 39.5 per cent believed that, in the event that medical aid in dying was legalized, the use of lethal medication would be permitted at the patient's request; 34.6 per cent believed they would be able to give such medication to an incompetent patient upon a relative's request.⁴⁰ Is there any reason to assume that physicians in other provinces will be better prepared?

Moreover, there is reason to believe that misinformation among health professionals is not limited to Canada. A Belgian study found that, seven years after Belgium legislated euthanasia, many physicians still had difficulty identifying which medical practices constituted euthanasia and must be declared to the appropriate authorities.

What Is Happening—and What Might Happen

The federal government established the “External Panel on Options for a Legislative Response to *Carter v. Canada*”, and issued a mandate to the panel to consult with Canadians and report back in the late fall of 2015.⁴¹ However, since this coincides with the election campaign period, the consultation might not happen. The current government opposed the application in *Carter*. There will presumably be a different perspective if the party in power changes. But, whether or not that happens, it is unlikely any new government will have legislation in place by February 2016. In other words, not much has happened federally.

There is also a pan-provincial panel, with members from across the country, created to advise the provinces.

If there is no federal legislation in place by February, the federal government may ask the S.C.C. for an extension of the deadline. If the court grants the request, the debate will continue with anticipation of legislation. If not, we doubt that provinces other than Quebec will have legislation in place by February.

In the meantime, the Canadian Medical Association has held town hall meetings on the subject across the country and polled its members' views about physician-assisted death. The Association is attempting to formulate guidelines for physicians. At least some provinces are trying to figure out what to do, as are provincial medical regulatory colleges.

But, is the absence of legislation such a bad thing? Following the S.C.C. decision that the ban on abortion was unconstitutional, no legislation was passed anywhere in Canada, and that absence seems to be working reasonably well, except in PEI.

Whether the Supreme Court extends its deadline or not, if it passes and there is no federal legislation, we anticipate a “free for all”: some patients will demand physician-assisted death, leaving doctors to grapple with their own conscience and the risk of prosecution either under the criminal law or before their provincial regulatory colleges. In the latter case, there could be patient complaints when physicians assist in death and when they refuse.

The guidelines the court set out, such as “competent adult”, “enduring suffering that is intolerable to the person in the circumstances”, and “grievous and irremediable medical condition”, are quite subjective and therefore open to interpretation – by individual physicians, ethicists, hospitals, and provinces. We are concerned about inconsistent interpretation and application of the law from province to province and even physician to physician.

What Should Happen?

In a free and democratic society, laws should be applied consistently. Rights available to some should be available to all. If physician-assisted death is, at least in some circumstances, a right, every Canadian should have the same access. Procedures and guidelines should be consistent. That requires federal legislation, consistent provincial legislation, or additional cases to find their way to the Supreme Court (which could take decades) to

establish consistency in law and subsequently in practice. Or, is there another method to achieve consistency?

In another relatively recent case⁴² the S.C.C. commented favourably on the role of Ontario's Consent and Capacity Board in expeditiously adjudicating treatment disputes at end-of-life when physicians and substitute decision-makers disagree on whether or not to withdraw treatment when doing so will likely result in the patient's death. While not a perfect solution to those cases, the Board is statutorily required to convene a hearing within seven days of receiving an application and to release a decision within one day of the end of the hearing. Perhaps a similar federal tribunal is necessary to authorize physician-assisted death?

Alternately for Ontario, if the province wants to "go it alone", relatively minor amendments to the *Health Care Consent Act* could require that physician-assisted death be monitored, approved and reported by the province's Consent and Capacity Board. Other provinces are not really that far behind: each has an equivalent review board, the bulk of whose work remains reviewing the involuntary detention and capacity to make treatment decisions of psychiatric patients.

Who Should Decide, Who Should Approve?

Any attempt by legislatures to set out parameters for the provision of a service as ethically complex and politically charged as physician-assisted death is sure to raise difficult questions about language. Quebec's Bill 52 is no exception. The attempt by the Quebec legislature to draw a statutory distinction between end-of-life care that either does or does not hasten death is one example. First of all, it is not clear how keeping terminally ill patients unconscious cannot be said with any certainty to *not* hasten death, and we wonder if this is purely a theoretical conceit rather than a practical distinction.

This statutory distinction also calls into question the *Carter* finding that the ethical divide between passive and active euthanasia is no longer a practical concern.

Bill 52 provides that the request for medical aid in dying must be made "later in life", but this phrase is not defined. This lack of clarity is but one example of what the courts may yet have to address. Much of the wording in Bill 52's s. 26 criteria is reflected in the *Carter* decision: both require the patient to be capable and to be suffering from an irremediable or incurable illness that is intolerable to him or her in the circumstances. However, neither *Carter* nor Bill 52 define these subjective concepts, if indeed they could have been defined with sufficient precision to anticipate all circumstances.

There are as many concerns about *how to implement* physician-assisted death in Canada as there are about the fact of it. Is it a private conversation between physician and capable patient, or do we need an approval process? If we need an approval process, should it be any second physician, or a hospital/facility committee? Who decides that the patient is capable and meets the S.C.C. or legislative test? Will there be consistent access from facility to facility or province to province, or will patients be compelled to "forum shop"?

There are analogies between approving a physician-assisted death and disputes between the treatment team and the family of an incapable patient over whether or not to discontinue life support, allowing the patient to die. The latter problem has been thoroughly reviewed,⁴³ and Professor Pope speaks favourably of the benefits of an independent quasi-judicial tribunal to resolve treatment disputes at end of life. A similar approach would answer many of the implementation concerns, as well as providing the attending physician with a legal "stamp of approval". Time will tell what the provincial and federal governments decide.

[*Editor's note*: **Heather Hogan, JD**, is a lawyer at Whaley Estate Litigation in Toronto, Ontario.

Mark Handelman, BA, LLB, MHSc (bioethics), is counsel to Whaley Estate Litigation, part time Member of The Human Rights Tribunal of Ontario and former Vice Chair and Senior Lawyer Member of the Ontario Consent and Capacity Board who can be contacted at m.handelman@sympatico.ca.

Madeeha Hashmi is a student at the University of Toronto Faculty of Law.]

¹ *Carter v. Canada (Attorney General)*, [2015] S.C.J. No. 5, 2015 SCC 5, [2015] 1 S.C.R. 331 [*Carter*].
² *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c. 11 [*Charter*].
³ *Criminal Code*, R.S.C. 1985, c. C-46 [*Code*].
⁴ *Code*, s. 241(b).
⁵ *Code*, s. 14.
⁶ *Charter*, s. 7.
⁷ *Charter*, ss. 15(1) and 1.
⁸ [1993] S.C.J. No. 94, [1993] 3 S.C.R. 519, 82 B.C.L.R. (2d) 273.
⁹ *Ibid.*, para. 60.
¹⁰ *Ibid.*, para. 231.
¹¹ *Supra* note 1.
¹² *Carter v. Canada (Attorney General)*, [2012] B.C.J. No. 1196, 2012 BCSC 886, 287 C.C.C. (3d) 1 at para. 1371.
¹³ *Carter v. Canada (Attorney General)*, [2013] B.C.J. No. 2227, 2013 BCCA 435, 302 C.C.C. (3d) 26, para. 316.
¹⁴ Materials available on S.C.C. website.
¹⁵ *Carter*, *supra* note 1, paras. 45-48.
¹⁶ *Carter*, *supra* note 1, para. 147.
¹⁷ *Ibid.*
¹⁸ *Ibid.*
¹⁹ *Ibid.*, at para. 132.
²⁰ An Act Respecting End-of-Life Care, R.S.Q. c. S-32.0001 [the "Act"], s. 1. See also Bill 52, *An Act respecting*

end-of-life care, 1st Sess, 40th Leg, Quebec, 2013, "Explanatory Notes".

²¹ The Act, *ibid.*, ss. 4, 5 and 26–32.

²² *Ibid.*, ss. 38–50.

²³ *Ibid.*, ss. 51–64.

²⁴ *Ibid.*, s. 7.

²⁵ *Ibid.*, s. 8.

²⁶ *Ibid.*, s. 24.

²⁷ *Ibid.*, s. 26.

²⁸ *Ibid.*, s. 29.

²⁹ *Ibid.*, s. 29(3).

³⁰ *Ibid.*, s. 30.

³¹ *Ibid.*, s. 49.

³² *Ibid.*, s. 50.

³³ R.S.Q. c. S-32.0001.

³⁴ *Health Care Consent Act*, S.O. 1996, c. 2, Sch. A, s. 4.

³⁵ See for example *Canadian Family Physician* April 2015, vol. 61 no. 4 e196-e203.

³⁶ S.O. 1996, c. 2, Sch. A.

³⁷ *Ibid.*, s. 11(1).

³⁸ MacQuarrie, Colleen, et al, *Trials and Trails of Accessing Abortion in PEI: Reporting on the Impact of PEI's Abortion Policies on Women*, University of Prince Edward Island, January 2014, accessed online on July 9, 2015: <http://projects.upei.ca/cmacquarrie/files/2014/01/trials_and_trails_final.pdf> citing Kaposy, C. (2010). Improving abortion access in Canada. *Health Care Analysis*, 18(1), 17-34 and Clorey, C. (2007). Votes and vetoes: A discursive history of abortion politics in Prince Edward Island from 1980 - 1996. McMaster University.

³⁹ *Canadian Family Physician* April 2015, vol. 61, no. 4, e196-e203.

⁴⁰ *Ibid.*

⁴¹ <<http://ep-ce.ca>>

⁴² *Cuthbertson v Rasouli*, [2013] S.C.J. No. 53, 2013 SCC 53, [2013] 3 S.C.R. 341.

⁴³ Thaddeus Mason Pope, *Surrogate Selection: An Increasingly Viable, But Limited, Solution to Intractable Futility Disputes*, 2010 Saint Louis University Journal of Health Law & Policy, Vol. 3, p. 183.

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University of London, England

Joseph Jacob, LSE, England

Dr. Alexander McCall Smith, University of Edinburgh, Scotland

Laurence R. Tancredi, New York University, U.S.A.

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