Essays

Voluntary Euthanasia, Assisted Suicide & Law Reform: A Sketch of the Canadian Experience

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ABSTRACT: This paper outlines the recent Canadian experience of replacing the blanket prohibition of assisted suicide and voluntary euthanasia with a new regulatory regime for "medical assistance in dying". The aim is to illustrate how lawmakers in Canada have pursued the project that the Italian Constitutional Court has urged Italy's parliament to undertake. Thus, the paper traces the arguments behind this law reform and highlighting ongoing disagreements over the manner in which it reconciles the protection of constitutional rights and the pursuit of particular policy objectives. Of course, the constitutional structures, political dynamics, medical cultures, and legal systems of these two countries differ in potentially salient ways. This paper is not a case for substituting Canada's MAID regime for Italy's current end-of-life laws whole cloth. Instead, the goal is to signal ways of thinking about, and responding to, some of the more pressing and difficult challenges to which efforts at law reform in this area may give rise.

KEYWORDS: euthanasia, assisted suicide, law reform, medical assistance in dying

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1. Introduction**

In light of the Corte costituzionale inviting Parliament to reflect on and redress any constitutional imbalance in the present criminal law framework for end of life decision-making, [1] this paper offers a general synopsis of the Canadian experience grappling with the question of how law should govern medical assistance in dying in a constitutional manner.[2] I provide an overview of the legal changes Canada has seen in this area, highlighting features of potential relevance in the Italian context. Canada's Supreme Court and Parliament have played important roles in bringing about these reforms. I highlight tensions over the current state of the law—namely, concerning the criteria for lawful access to medical assistance in dying (the term used in Canadian legislation to designate lawful forms of assisted suicide and voluntary euthanasia.)[3] First, I summarize the reasoning behind the Supreme Court of Canada's invalidation of the blanket prohibition of voluntary euthanasia and assisted suicide. Next, I sketch key features of the new legislative regime regulating access to medical assistance in dying (MAID). Third, I address criticisms of how the present law restricts access to MAID. Fourth, I note the variety of publicly commissioned studies that have contributed to informing the public debate and deliberation on the topic. Lastly, I address the issue of conscientious objection to MAID among health care professionals. Given the distinctive constitutional structures, political dynamics, legal systems, and medical cultures of Canada and Italy, the legislative approaches adopted in these two countries to governing end of life decision-making will necessarily differ. Although this essay does not provide an exhaustive survey, the aim is to flag certain features of the Canadian experience to inform Italian research, reflection, debate, and reform in this area.

2. Shift in the Supreme Court of Canada's Constitutional Interpretation

In 1993, the Supreme Court of Canada (in a 5:4 decision)[4] rejected a constitutional challenge to the blanket prohibition on voluntary euthanasia and assisted suicide.[5] Sue Rodriguez, a 42-year-old

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[1] See "Caso Cappato", ordinanza no. 207, 2018: "Va dunque conclusivamente rilevato che, laddove, come nella specie, la soluzione del quesito di legittimità costituzionale coinvolga l'incrocio di valori di primario rilievo, il cui compiuto bilanciamento presuppone, in via diretta ed immediata, scelte che anzitutto il legislatore è abilitato a compiere, questa Corte reputa doveroso – in uno spirito di leale e dialettica collaborazione istituzionale – consentire, nella specie, al Parlamento ogni opportuna riflessione e iniziativa, così da evitare, per un verso, che, nei termini innanzi illustrati, una disposizione continui a produrre effetti reputati costituzionalmente non compatibili, ma al tempo stesso scongiurare possibili vuoti di tutela di valori, anch'essi pienamente rilevanti sul piano costituzionale."

[2] See T. McMorrow, *MAID in Canada? Debating the Constitutionality of Canada's New Medical Assistance in Dying Law*, in 44:1 *Queen's Law Journal* 69, 2018. See also H. Stewart, *Constitutional Aspects of Canada's New Medically-Assisted Dying Law*, in 85 *SCLR* (2nd) 435, 2018 *Cf.* T. Lemmens, H. Kim, E. Kurz, *Why Canada's Medical Assistance in Dying Legislation Should Be C(h)arter Compliant and What it May Help to Avoid*, in 11:1 *McGill JL & Health* S61, 2018.

[3] See Bill C-14, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*, 1st Sess, 42nd Parl, 2016 (assented to 17 June 2016), SC 2016, c 3 [*Bill C-14*].

[4] *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519, 107 DLR (4th) 342 [*Rodriguez*].

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mother suffering from amyotrophic lateral sclerosis, had argued that criminalizing the act of assisting her to end her life unjustifiably infringed her rights to equality (s 15.1),[6] "life, liberty and security of the person"[7] (s 7) and "freedom from cruel and unusual punishment" (s 12) guaranteed by the *Canadian Charter of Rights and Freedoms*. The majority of the Court did not find a section 7 or section 12 infringement but concluded that, assuming the law did infringe Rodriguez's section 15 equality right, the infringement was nevertheless justified in a free and democratic society.

Twenty-two years later, in 2015, the Supreme Court in *Carter v Canada*[8] reversed its decision in *Rodriguez*. The Supreme Court justified revisiting its decision in *Rodriguez* on the basis of changes in its jurisprudence on section 7 of the *Charter*, as well as differences in the relevant "matrix of legislative and social facts" arising in the over two decades since it had made the ruling. [9] The Court affirmed the trial judge's findings that a moral or ethical distinction between passive and active euthanasia no longer enjoys widespread acceptance; that "halfway measures" between a blanket ban and unfettered access may in fact protect the vulnerable; and that no more is there a "substantial consensus" in Western countries that a blanket ban is the only way to prevent passage down a slippery slope.[10]

In addition, the Court relied on a twenty-year evolution in its own approach to interpreting section 7 of the *Charter* to justify returning to the issues decided in *Rodriguez*.[11] The Court observed that "the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly".[12] Because, in the Court's view, the blanket prohibition on physician-assisted suicide had "the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable", it engaged the right to life.[13] Furthermore, the Court saw the impugned legislation en-

[5] See RSC 1985, c C-46, ss 14, 241(b) as they appeared on 15 October 2014 [*Criminal Code*]. Section 14 stated that "[n]o 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" (*ibid*, s 14). Section 241(b) stated that "everyone who (…) aids or abets a person in committing suicide commits, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years" (*ibid*, s 241(b)).

[6] Section 15 states: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability". Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c 11 [*Charter*].

[7] Section 7 states: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." *Ibid*.

[8] *Carter v. Canada* (Attorney General), 2015 SCC 5 [*Carter*]. See also *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (for the trial judge, Smith J's, lengthy and extensive reasons for judgment). Compare diverging commentary on this ruling in D.L. BESCHLE, *Carter v. Canada (Attorney General): Canadian Courts Revisit the Criminalization of Assisted Suicide*, in 59 *Wayne L Rev* 56, 2013 and J. KEOWN, *A Right to Voluntary Euthanasia? Confusion in Canada in Carter*, in 28 *ND J L Ethics & Pub Pol'y* 1, 2014. In *Carter v. Canada (Attorney General)*, 2013 BCCA 435, the British Colombia Court of Appeal overturned the trial judge's decision but the Supreme Court of Canada reversed this ruling.

[9] *Carter, ibid* at para 47. See the dissenting judgment of McLachlin and L'Hereux-Dube JJ, *Rodriguez*, *supra* note 4 at 616-629, for striking similarities in the reasoning behind the Court's unanimous decision in *Carter*.

[10] *Ibid.*

[11] *Charter*, *supra* note 6, s 7.

[12] *Carter* 2015, *supra* note 8 at para 62.

[13] *Ibid* at para 57.

gaging the rights to liberty and security of the person since the former involves "the right to make fundamental personal choices free from state interference" and the latter concerns "control over one's bodily integrity free from state interference".[14] That is because "[a]n individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy."[15] In the Court's view, the blanket prohibition denied someone in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenched on their liberty.[16] Furthermore, by leaving them to endure intolerable suffering, it infringed their right to security of the person.[17]

According to the Court's section 7 jurisprudence, a law infringing the right to life, liberty or security of the person fails to accord with the principles of fundamental justice when it is arbitrary, overbroad, or has consequences grossly disproportionate to its object.[18] The Court found that the object of the prohibition was not "to preserve life, whatever the circumstances" but to prevent "vulnerable persons from being induced to commit suicide at a time of weakness."[19] In this case, the prohibition was not protecting a vulnerable person; it was limiting the rights of a competent, capable individual; therefore, the ban was overbroad.

The Court acknowledged that Gloria Taylor, the lead plaintiff in *Carter*, would not be able to execute her considered decision to end her life at the point her suffering became unbearable, unless she received physical assistance. The law made it a crime for any physician to actively end her life or aid her in doing so, even though that same physician would be obliged to let her die by withholding or withdrawing life-saving treatment and denying her artificial hydration and nutrition, if she so requested. Furthermore, the Court noted that issues of decisional capacity and vulnerability arise in all end-of-life medical decision-making.[20] Since the law lets injured, ill and disabled patients decide if they wish to refuse (or request withdrawal) of life-sustaining treatment or receive palliative sedation, the Court reasoned that there is no reason to assume those seeking active medical assistance in dying are any more vulnerable or susceptible to biased decision-making.[21] The Court concluded that the law left a person in Gloria Taylor's situation with a "cruel choice": "take her own life prematurely, often by violent or dangerous means, or…suffer until she dies from natural causes."[22]

The question remained, though, whether the section 7 infringement could be saved under section 1, which permits restrictions on *Charter* rights if they are found to be "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".[23] Although acknowledged to

[14] *Ibid* at 64.
[15] *Ibid* at para 66.
[16] See *ibid*.
[17] See *ibid*.
[18] See *ibid* at para 72. See also *Canada (Attorney General) v Bedford*, 2013 SCC 72. See Hamish Stewart, *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms* (Toronto: Irwin Law, 2012) (expanding on section 7 jurisprudence, including other principles of fundamental justice cited therein).
[19] *Carter, ibid* at para 78. See also ibid at paras 70–92.
[20] *Ibid* at para 115.
[21] *Ibid*.
[22] *Ibid.*
[23] *Charter*, *supra* note 6. In full, section 1 states: "The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." *Charter, supra* note 6. See G. HUSCROFT, B.W. MILLER, G. WEBBER

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be prescribed by law, and related to a pressing and substantial objective, the restriction failed the Court's proportionality test.[24] Based on the findings of the trial judge, the Court concluded that the blanket prohibition was not necessary to substantially meet the government's objective, and consequently, was not minimally impairing. The Court wrote:

The inquiry into minimal impairment asks "whether there are less harmful means of achieving the legislative goals"… The burden is on the government to show the absence of less drastic means of achieving the objective "in a real and substantial manner"…The analysis at this stage is meant to ensure that the deprivation of *Charter* rights is confined to what is reasonably necessary to achieve the state's object.[25]

The Court then stated that the case came down to the question of "whether the absolute prohibition on physician-assisted dying, with its heavy impact on the claimants' s. 7 rights to life, liberty and security of the person [was] the least drastic means of achieving the legislative objective".[26] It ultimately affirmed the trial judge's conclusion "that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error".[27]

Therefore, the Court held that the ban infringed section 7 of the *Charter* in a manner that could not be justified under section 1. In light of reaching this conclusion, the Court deemed it unnecessary to consider whether the prohibition also unjustifiably infringed the *Charter*'s section 15 equality guarantee.[28] Had the Court treated *Carter* as foremost an equality case, about "a right of access to disability accommodation,"[29] then the blanket prohibition would have been struck down on the basis that the law barred certain people from ending their lives on account of their physical disability.

Thus, in its remedy, the Court did not make having a physical disability that impairs a person from taking one's own life a prerequisite for accessing lawful physician aid in dying. The Court declared the relevant Criminal Code provisions

void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) 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.[30]

In this way, the Court laid out constitutional parameters for the criminal law. In a move the Italian constitutional court has just cited, the Court suspended its declaration of invalidity[31] from taking ef-

(eds), *Proportionality and the Rule of Law: Rights, Justification, Reasoning*, Cambridge, 2014 (featuring a variety of scholarly contributions on the titular themes).

[24] See *Carter*, *supra* note 8 at paras 94–123.

[25] *Ibid* at para 102 [citations omitted].

[26] *Ibid* at para 103.

[27] *Ibid* at para 105.

[28] *Ibid* at para 93.

[29] D. LEPOKSY, *Carter v. Canada (Attorney General), The Constitutional Attack on Canada's Ban on Assisted Dying: Missing an Obvious Chance to Rule on the Charter's Disability Equality Guarantee*, (2016) 76 *SCLR* (2nd) 89 at 91.

[30] Carter, *supra* note 8 at para 127.

[31] See S. BURNINGHAM, *A Comment on the Court's Decision to Suspend the Declaration of Invalidity in Carter v Canada*, in 78 *Sask L Rev* 201, 2015. See generally B. RYDER, *Suspending the Charter*, in 21 *SCLR* (2nd) 267, 2003;

fect for twelve months.[32] Moreover, as reflected in the Court's adoption of the expression "physician assisted dying"— rather than the terms, "euthanasia" and "assisted suicide" used in *Rodriguez*"— the *Carter* decision inaugurated a marked shift in official Canadian legal and political discourse on the subject.[33] Thus, this landmark court decision had both symbolic, as well as instrumental significance.[34]

3. The New Legislative Framework

In June 2016, Parliament passed amendments to the *Criminal Code*, making it lawful for physicians and nurse practitioners to comply with informed, voluntary requests for MAID from competent adults who suffer from "a grievous and irremediable medical condition".[35] The legislation defines this phrase in the following manner:

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.[36]

Thus, in Canada, the general offences remain;[37] it is just that physicians,[38] nurse practitioners,[39] pharmacists[40] and others[41] who might otherwise run afoul of the law, are exempted from criminal li-

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R. LECKEY, *Bills of Rights in the Common Law*, Cambridge, 2015, at 93-150 (on courts delaying the legal effect of declarations of invalidity).

[32] After the federal election that took place subsequent to the Court's decision, the government succeeded in having the suspension extended for three months. See *Carter v Canada (Attorney General)*, 2016 SCC 4. During this period, however, access to MAID was available in Quebec under the *Loi concernant les soins de fin de vie* RLRQ chap. S-32.0001 and in the rest of Canada through application to the superior court.

[33] Compare the substance and tone of the arguments in these two articles, reflecting Somerville and Downie's previously expressed positions on the subject: B. CHAN, M. SOMERVILLE, *Converting the 'right to life' to the 'right to physician-assisted suicide and euthanasia': An analysis of Carter V Canada (Attorney General), Supreme Court of Canada,* in 24:2 *Medical Law Review* 143, 2016 and J. DOWNIE, *Carter v. Canada: What's next for physicians?*, in 187:7 *CMAJ* 481, 2015. See M. SOMERVILLE, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide*, 2nd ed., Montreal, 2014 *Cf.* J. DOWNIE, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*, Toronto, 2004.

[34] See R. LECKEY, *Families in the Eyes of the Law: Contemporary Challenges and the Grip of the Past*, in 15:8 *IRPP Choices* 1, 2009, online: http://irpp.org/wp-content/uploads/assets/research/family-policy/families-in-the-eyes-of-the-law/vol15no8.pdf, at 3 (on the symbolic versus instrumental distinction in the family law context).

[35] *Bill C-14*, *supra* note 3, s 3. See also R.M. CARTER, B. RODGERSON, *Medical Assistance in Dying: Journey to Medical Self-Determination*, in 55:3 *Alberta Law Review* 777, 2018, at 793-802 (discussing aspects of the legislation).

[36] *Criminal Code* RSC 1985, c C-46, s 241.2(2).

[37] *Ibid*, s 14: "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." Section 241

ability when MAID is provided in accordance with the provisions set out in the *Criminal Code*.[42] MAID comprises both assisted suicide and voluntary euthanasia.

The law requires that the patient to be competent, to be making the decision voluntarily and to be conscious and have decision-making capacity right up to the legal procedure itself. Safeguards include writing, signature and witness requirements for the patient's request.[43] In particular, the medical practitioner or nurse practitioner must not only be of the opinion that the person meets all of the eligibility criteria but be satisfied that the request was signed and dated by the person before two independent witnesses who then also signed and dated the request. MAID providers must also ensure that the patient knows they may, at any time and in any manner, withdraw their request.

A second medical practitioner or nurse practitioner must give a written opinion confirming that the person meets all of the eligibility criteria. The two practitioners must be independent. The MAID provider must ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is given. If however both health care professionals are of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent then the waiting time can be adjusted accordingly. Furthermore, immediately before providing the medical assistance in dying, the physician or nurse practitioner must give the patient an opportunity to withdraw the request and ensure that the person gives express consent to receive medical assistance in dying. The law also specifies that where the patient has difficulty communicating, the doctor or nurse practitioner must take all necessary measures to communicate with the patient, so that they know what is happening and may ex-

(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, (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."

[38] *Ibid*, s. 227 (1) "No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241.2." Also, note the defence of reasonable but mistaken belief included in 227(3): "For greater certainty, the exemption set out in subsection (1) or (2) applies even if the person invoking it has a reasonable but mistaken belief about any fact that is an element of the exemption" as well as s. 241.6.

[39] *Ibid*, s. 241.1: "[N]urse practitioner means a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner — or under an equivalent designation — and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients."

[40] *Ibid*, s. 241(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."

[41] *Ibid*, s. 241 (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." Also, see s. 227(2): "No person is a party to culpable homicide 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." Also, see s. 241(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."

[42] *Ibid*, s 227(4): "Section 14 does not apply with respect to a person who consents to have death inflicted on them by means of medical assistance in dying provided in accordance with section 241.2."

[43] *Ibid*, s 241(3).

press their wishes. The law stipulates sanctions for failure to comply with these safeguards as well as for forgery of any of the relevant records or destruction of documents.[44]

Thus, it remains a crime for a health care professional to satisfy a suffering patient's request to die unless that patient's "natural death has become reasonably foreseeable".[45] According to the new law's preamble, defining MAID eligibility in this way is meant to strike a balance between recognizing the autonomy of persons with grievous and irremediable medical conditions who wish to end their lives, and affirming "the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled".[46] Otherwise healthy individuals with an illness or disability, such as a forty-year-old with chronic back pain or a twenty-year-old accident victim now confined to a wheelchair, are therefore ineligible for MAID.

There is not room to detail the interpretive challenges this provision presents.[47] Sufficed to say, the law ties eligibility for medical assistance in dying to being on a trajectory toward natural death. It does not specify a strict prognosis, of, say, six months—as laws in the US jurisdictions with lawful physician-assisted suicide do.[48] Nor does it require a patient's illness to be terminal. It does mean, though, that a person whose natural death is not deemed reasonably foreseeable will not be eligible for MAID.

There is a lack of clarity and consensus on what such a determination entails. In an ongoing *Charter* to challenge, the government states that "[t]o have become 'reasonably foreseeable,' a natural death must be reasonably anticipated to occur by one of a range of predictable ways, *and* within a period of time that is not too remote."[49] Meanwhile, according to the professional standards of the College of Physicians and Surgeons of Nova Scotia, "natural death will be reasonably foreseeable if a medical or nurse practitioner is of the opinion that a patient's natural death will be sufficiently soon

[44] *Ibid*, s 241.3 (re: non-compliance), 241.4(1)(re: forgery), 241.4(2) (re: destruction of documents).

[45] *Ibid*.

[46] *Bill C-14 Preamble, supra* note 3.

[47] See Department of Justice, *Legislative Background: Medical Assistance in Dying* (Bill C-14), Catalogue No J4-41/2016E (Ottawa: Justice Canada, 2016). Also, see Canadian Association of MAID Assessors and Providers [CAMAP], "The Clinical Interpretation of "Reasonably Foreseeable" (January 2019), online: https://camapcanada.ca/wp-content/uploads/2019/01/cpg1-1.pdf, at 1-2 (providing that "[a]s an aid to clarity, clinicians can consider interpreting 'reasonably foreseeable' as meaning 'reasonably predictable' from the patient's combination of known medical conditions and potential sequelae, whilst taking other factors including age and frailty into account…Clinicians should not employ or support rigid timeframes in their assessments of eligibility for MAID. Bill C-14 contains no requirement for a prognosis having been made as to the length of time the patient has remaining"). CAMAP is a voluntary association made up predominantly of physicians and nurse practitioners whose stated mission is "to support MAiD assessors and providers in their work, educate the public and the health care community about MAiD, and provide leadership on determining standards and guidelines in MAiD provision". See *CAMAP*, online: https://camapcanada.ca/camap-team/.

[48] See California *End of Life Option Act* (2015); *Colorado End-of-Life Options Act* (2016); District of Columbia *Death with Dignity Act of 2016*; Hawaii *Our Care, Our Choice Act* (2018); *Baxter v. Montana* (2009) MT DA 09-0051, 2009 MT 449 [Supreme Court of Montana]; *The Oregon Death With Dignity Act* (1997); Vermont *An Act Relating to Patient Choice and Control at End of Life* (2013); *Washington Death With Dignity Act* (2009).

[49] See *Lamb v Canada* (Attorney General) (27 July 2016), Vancouver, BCSC No S-165851 (Response to Civil Claim at Part 1, para 36), online : www.eol.law.dal.ca/wp-content/uploads/2016/10/2016_07_27_Response_to_Civil_Claim.pdf [Lamb Response] [emphasis added].

or that the patient's cause of natural death has become predictable".[50] In other words, must it simply be possible to predict the manner in which the patient is likely to die or must the patient's death also be projected to occur in the not too distant future? Is that six months, one year, five years or ten years? Should one rely on actuarial tables to make such predictions about lifespan? Some physicians appear to be doing so.

Given the range of interpretations and practices, Trudo Lemmens observes: "it will not be easy to prosecute a physician or nurse under the criminal law, with the requirement that their interpretation is beyond any reasonable doubt wrong".[51] In this way the role of the criminal law is receding vis-à-vis other regulatory forms, such as policies, norms, standards, and guidelines set out by health care institutions and professional associations. Aspects of end-of-life decision-making previously forbidden thereby become subject to clinical judgment and professional ethical responsibility—not to mention questions around billing.[52]

4. Ongoing Disagreement about Who Gets to Access MAID

Currently, under Canadian law, those under 18, those whose medical condition is strictly psychological, those wishing to give advanced directives for MAID (including patients with dementia), those who wish to die but are not suffering from a medical condition, and those whose natural death is not reasonably foreseeable are not eligible to access MAID. Some proponents of a more permissive regime argue that based on either the letter or the spirit of the Supreme Court's ruling in *Carter*, anyone suffering from a medical condition, be it physical or psychiatric in nature, should be eligible for MAID, so long as the individual is competent and making the request voluntarily. In their view, patients at the point of enduring and intolerable suffering should be able to receive MAID regardless of how long they have to live.[53] Furthermore, they argue, it is not only patronizing but discriminatory to

[50] See "Professional Standard Regarding Medical Assistance in Dying" (8 February 2018) at 5, n 9, online: College of Physicians and Surgeons of Nova Scotia, https://cpsns.ns.ca/wp-content/uploads/2016/06/Medical-Assistance-in-Dying-Standard.pdf. For arguments supporting this interpretation of the law, see J. DOWNIE, J.A. CHANDLER, *Interpreting Canada's Medical Assistance in Dying Legislation*, 2018, at 16-19, online: Institute for Research on Public Policy, http://irpp.org/wp-content/uploads/2018/03/Interpreting-Canadas-Medical-Assistance-in-Dying-Legislation-MAiD.pdf; J. DOWNIE, K. SCALLION, *Foreseeably Unclear: The Meaning of the 'Reasonably Foreseeable' Criterion for Access to Medical Assistance in Dying in Canada*, in *Dal LJ* at 30 [forthcoming].

[51] T. LEMMENS, *Charter Scrutiny of Canada's Medical Assistance in Dying Law and the Shifting Landscape of Belgian and Dutch Euthanasia Practice*, in 85 *SCLR* (2nd) 459, 2018, at 462, n. 8.

[52] See N. KHOSHNOOD et al., *Exploring Canadian Physicians' Experiences Providing Medical Assistance in Dying: A Qualitative Study*, 56:2 *Journal of Pain and Symptom Management* 222, 2018, at 225 (noting perception among physicians interviewed in study that the financial compensation for providing MAID was not adequate given the amount of time it required).

[53] See *Lamb v Canada (Attorney General)* (27 June 2016), Vancouver, BCSC No S-165851 *(Notice of Civil Claim, Plaintiffs),* online: https://bccla.org/wp-content/uploads/2016/08/2016-06-27-Notice-of-Civil-Claim.pdf, at 6. Also, see W. ROONEY, U. SCHUKLENK, S. VAN DE VATHORST, *Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying*, in 26:4 *Health Care Analysis* 326, 2018 (where the authors argue that restricting psychiatric patients from accessing MAID is a form of arbitrary, unjustified discrimination also). In light of the mature minors' doctrine at common law, the restriction to adults 18 years or older may be the most vulnerable to a *Charter* challenge. See J. BOND, *A minor is-*

tell a physically disabled person that the criminal law is depriving them of the help they need to carry out their own wishes, even though the same law is silent when it comes to able-bodied people committing suicide by their own hand.[54]

Furthermore, there are those who argue that a person's decision to initiate his or her death is a fundamental right regardless of whether that individual has been diagnosed with a medical condition.[55] In principle, the argument is that when it comes to one's own life— and therefore decisions about death— the individual, not the state, is sovereign. Besides, in practice, a case may be made that allowing medical assistance in dying to all competent persons who voluntarily seek it may in fact help to bring people with undiagnosed or untreated psychological conditions into contact with healthcare professionals. This may not only avert violent, solitary, incomplete (but catastrophically damaging) suicide attempts; it may also prevent some suicides altogether by establishing the necessary treatment and supports.

Obtaining a prescription for drugs with which to end one's life would require a person to demonstrate competence and informed consent. Although for many physicians or nurse practitioners, performing this function would be personally difficult and ethically unsound, there are no doubt some health care professionals whose clinical experience with the intractable suffering of certain patients may make them open to such an approach. That a physician, hypothetically, might feel morally justified to do this in a particular case, does not legitimate the practice or render its prohibition unjustified. After all, the ramifications that lifting this ban might have for the public health issue of suicide, especially within particular demographics, is unknown. Moreover, one may argue that significant ethical distinctions arise (if not absolutely, then depending on the circumstances) between permitting, providing help to, and acting on behalf of an informed, competent adult who has clearly communicated the wish to have their life ended.

For some the most important difference lies between actively terminating a life, and passively letting a person die. Sometimes the ethical distinction may be especially difficult to draw; for example, where withholding nutrition and hydration on the patient's request will result in that person's death but only after a much longer, more agonizing period of time than providing MAID would require. Outside of these clear (last days, weeks or even months) "end of life cases", the irreversible nature of the decision to end one's life coupled with the distinctive ethical challenges "aid in dying" involve caution against a permissive approach to regulating medical assistance in dying. Recognition for individual freedom may also countenance concern for more diffuse and indirect social pressures and expectations to form meaning that for some people, the added option may feel like a burden rather

sue? The shortcomings of the eligibility requirements for medically assisted death in Canada, in 23 *Appeal* 41, 2018, at 52-63.

[54] This is the issue the Court in *Carter* deemed it unnecessary to examine, since it had already concluded that the blanket ban was unconstitutional, supra note 28; see LEPOFSKY, *supra* note 29. See W. ROONEY, U. SCHUKLENK, S. VAN DE VATHORST, *op. cit.*, arguing that restricting psychiatric patients from accessing MAID is a form of arbitrary, unjustified discrimination also.

[55] See M. BATTIN, *Dignity as a Fundamental Human Right Revisited*, in S. MUDERS (ed.), *Human Dignity and Assisted Death*, Oxford, 2017.

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than a welcome choice.[56] Legalization does not just mean permission for, but institutionalization of, a practice.[57] Hence the rules, processes and— most of all— the people who give health care institutions their life-blood are integral to seeing the purposes underpinning autonomy-affirming reforms to the law governing end of life decision making fulfilled.

5. Research and Reports on the Road to Law Reform

A number of government-funded studies and reports have been conducted on this topic in Canada; for instance, the Law Reform Commission of Canada published its *Report on Euthanasia, Aiding Suicide and Cessation of Treatment* in 1983, supporting maintenance of the blanket prohibition on medical assistance in dying.[58] In fact, the Supreme Court cited this report with approval a decade later in the *Rodriguez* case upholding the ban.[59] The Senate of Canada in its 1995 *Special Senate Committee on Euthanasia and Assisted Suicide, Of Life and Death – Final Report* did not recommend reforming the law.[60]

In 2012 a Select Committee on Dying with Dignity of Quebec's legislative assembly published reports endorsing modifications to the criminal law.[61] The Royal Society of Canada Expert Panel on End-of-Life Decision-Making had previously published an extensive report in 2011, examining end-of-life decision-making beyond the topics of voluntary euthanasia and assisted suicide.[62] In fact, the trial judge in *Carter* makes reference to the report of the Royal Society's Expert panel in her judgment.[63] Furthermore, before the Supreme Court of Canada gave its ruling in *Carter*, Quebec passed a provincial statute *La Loi concernant les soins de fin de vie* in 2014, providing for "medical aid in dying".[64] The

[56] Compare J. KEOWN, *A Right to Voluntary Euthanasia?*, *supra* note 8, at 23 and L.W. SUMNER, *Assisted Death: A Study in Ethics and Law*, Oxford, 2011 (whose testimony on this issue Lynn J cited with approval in the *Carter* trial decision, *supra* note 8 at paras 234-237).

[57] See R. STOECKER, *Dignity and the Case in Favor of Assisted Death*, in S. MUDERS (ed.), *op. cit.* (making the case for legalization, while maintaining ethical opposition to individuals choosing an assisted death).

[58] Law Reform Commission of Canada, *Report 20: Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Supply and Services Canada, 1983).

[59] See *Last Right: Assisted Suicide in Canada* (28 October 2013) *The National,* online: CBC, https://www.cbc.ca/player/play/2414731746 (featuring retired Supreme Court justice John Major expressing disappointment with Parliament's failure to modify the law in the years since he and his colleagues handed down their decision in *Rodriguez*).

[60] Senate of Canada, *Of Life and Death: A Report of the Special Senate Committee on Euthanasia and Assisted Suicide* (1995). But see Ontario Law Reform Commission, *Study Paper on Assisted Suicide, Euthanasia and Foregoing Treatment*, by Joan M Gilmour (Toronto: OLRC, 1997).

[61] National Assembly of Quebec, *Select Committee on Dying with Dignity, Dying With Dignity* (March 2012).

[62] U. SCHÜKLENK et al., *End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making*, in 25:S1 *Bioethics* 1, 2011.

[63] *Carter v. Canada (Attorney General)* [trial decision], *supra* note 8.

[64] See *Act Respecting End of Life Care* SQ 2014, c. 2, s. 1. This law came about following an extensive public consultation, framing medical aid in dying among a suite of end of life medical care treatments. But see *Truchon c Procureur général du Canada*, 2018 QCCS 331 (challenging the constitutionality of legislative restrictions barring Jean Truchon and Nicole Gladu from accessing medical assistance in dying). See Commission sur les soins de fin de vie, *Rapport annuel d'activité 1er juillet 2017-31 mars 2018* (December 2018), online http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_141357 (offering an overview of Quebec's Commission on End of Life Care's structure and mandate, reporting among other

law did not enter into force until December 2015, after the Supreme Court had declared the blanket prohibition unconstitutional but before the Court's remedial declaration had taken effect. It is that law which has operated in Quebec, however, ever since the Court's 12 month suspension of its declaration of invalidity expired in February 2016. Interestingly, its reference to the "end of life" means access is likely even more restricted in this province than it is in the rest of the country where access criteria are laid out in the amendments Parliament made to the *Criminal Code* in June 2016.[65]

Significantly, two reports issued prior to the government tabling its legislation in the House of Commons (the 2015 Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying[66] and the House of Commons and Senate, Special Committee on Physician-Assisted Dying, Medical Assistance in Dying: A Patient–Centred Approach, February 2016)[67] recommended less restrictive access criteria than were put forward and ultimately adopted in Parliament. Meanwhile, the new MAID law itself provides for one or more independent reviews to be conducted "relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition."[68] Reports on the state of knowledge pertaining to each matter, completed by a multi-disciplinary expert panel appointed by the Council of Canadian Academies (CCA), were published in December 2018.[69] While offering an overview of existing research, the re-

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things provincial data related to MAID. Created under the Quebec legislation, the Commission does not have any identical parallel body in any of the other provinces. In 2018, pursuant to s 241.31(3) of the *Criminal Code supra* note 36, the Minister of Health introduced *Regulations for the Monitoring of Medical Assistance in Dying*: SOR/2018-166, *Government of Canada*, online: http://www.gazette.gc.ca/rp-pr/p2/2018/2018-08-08/html/sor-dors166-eng.html. For the most recent national government report on MAID, see Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada*, Catalogue No H14-230/3- 2018E (Ottawa: Health Canada, 2018).

[65] See L. SELLER, M-È. BOUTHILLIER, V. FRASER, *Situating Requests for Medical Aid in Dying within the Broader Context of End-of-life Care: Ethical Considerations*, in *J Med Eth* 1, 2018.

[66] Ontario, *Provincial-Territorial Expert Advisory Group on Physician- Assisted Dying: Final Report* (30 November 2015). Compare: Canada, *External Panel on Options for Legislative Response to Carter v Canada, Consultations on Physician-Assisted Dying: Summary of Results and Key Findings: Final Report* (15 December 2015).

[67] House of Commons & Senate, *Medical Assistance in Dying: A Patient-Centered Approach: Report of the Special Joint Committee on Physician-Assisted Dying* (February 2016) (Chairs: Hon Kelvin Kenneth Ogilvie & Robert Oliphant).

[68] *Bill C-14* s. 9.1(1), *supra* note 3.

[69] That is, after the present article was written. See Council of Canadian Academies, *State of Knowledge on Medical Assistance in Dying for Mature Minors, Advance Requests, and Where a Mental Disorder Is the Sole Underlying Medical Condition: Summary of Reports* (2018) *Council of Canadian Academies*, online: https://scienceadvice.ca/wp-content/uploads/2018/12/MAID-Summary-of-Reports.pdf. See Council of Canadian Academies [CCA], *The State of Knowledge on Medical Assistance in Dying for Mature Minors* (Ottawa: The Expert Panel Working Group on MAID for Minors, 2018), online: https://scienceadvice.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf; CCA, *The State of Knowledge on Advance Requests for Medical Assistance in Dying* (Ottawa: The Expert Panel Working Group on Advance Requests for MAID, Council of Canadian Academies, 2018), online: < https://scienceadvice.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf>; *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition* (Ottawa: The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition, 2018), online: https://scienceadvice.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-Where-a-Mental-Disorder-is-the-Sole-Underlying-Medical-Condition.pdf.

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ports do not, as is customary for the CCA, include recommendations. Within five years of the law's enactment, a Parliamentary committee is to review and report on the legislation, and may recommend any changes it deems fit.[70] The history of research, reports and legislative development in Canada demonstrates the importance of identifying and explaining the relationship MAID bears to a number of related, but nevertheless distinct issues, including: passive assistance in dying, such as withdrawal or withholding of life-sustaining treatment and palliative sedation; provision of palliative care treatment; capacity and consent protocols; public health suicide prevention strategies; and advanced directives regimes. Just as the conflation of these issues can stall analysis and discussion, their omission may frustrate a broader, contextual understanding of MAID.

6. Conscientious Objection and Equitable Access to MAID

Canada's MAID law expressly references two potentially competing principles ("the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying" and "the freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms*" of health care professionals) but it does not specify how to strike a balance between them.[71] In *Carter*, the Supreme Court affirmed "that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief".[72] While expressly acknowledging that "the Charter rights of patients and physicians will need to be reconciled", the Court stopped short of spelling out and therefore "pre-empt[ing] the legislative and regulatory response to this judgment."[73] It is medical regulatory bodies who have therefore taken up the task. Thus, the self-governing body for the medical profession in the province of Ontario, the College of Physicians and Surgeons of Ontario's (CPSO) has developed an "effective referral" policy.[74]

The effective referral provisions of the CPSO MAID policy provides as follows:

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.[75]

[70] *Bill C-14* ss. 10(1)-10(2), *supra* note 3.
[71] *Bill C-14 Preamble*, *ibid*.
[72] See *Carter, supra* note 8 at para 132.
[73] *Ibid.*
[74] See the "Effective Referral Fact sheet" (n.d.) College of Physicians and Surgeons of Ontario, online: https://www.cpso.on.ca/cpso/media/documents/policies/policy-items/medical-assistance-in-dying-effective-referral-factsheet.pdf. Compare the Alberta Health Services, "Medical Assistance in Dying Care Coordination Service" (14 July 2016) AHS, online: https://www.albertahealthservices.ca/assets/info/hp/maid/if-hp-maid-coordination-service.pdf.
[75] See Policy Statement #4-16 "Physician-Assisted Death"; the plaintiffs are also challenging another CPSO policy document with similar wording, which applies beyond the context of MAID, to abortion, for example: CPSO – Policy Statement #2-15 "Professional Obligations and Human Rights".

Although a group of physicians and several faith-based medical associations are challenging its constitutionality in the courts,[76] the policy has met with favour among many health care professionals who see it mitigating the risk of incursions onto their freedom of religion and conscience.[77] The primary justification for the effective referral requirement is to ensure "equitable access to health care"[78]. It is to make sure that patients are not abandoned in their pursuit for health care, once their physician has refused, on grounds of religion or conscience, to provide a particular treatment. An effective referral requires the objecting physician to take "positive action", to connect the patient with a physician, another health-care professional or an agency that is "non-objecting, available and accessible". Physicians have multiple options to satisfy the requirement. Many other doctors objecting to providing MAID have managed to reconcile the effective referral requirement with their beliefs. Five physicians and several institutional applicants and interveners claim that the CPSO's policies demand complicity in practices they deem immoral and therefore contravene their freedom of conscience and religion protected by the *Charter*. [79] In January the Superior Court of Justice, (Divisional Court) held that although the CPSO's effective referral requirements did place a non-trivial burden on the plaintiff's freedom of religion and conscience, the infringement was nevertheless justified under section 1 of the *Charter*.[80] As this case winds its way through the appellate process, the policies, practices and strategies that institutions and professional associations have adopted to ensure equitable access to medical assistance in dying are noteworthy beyond the freedom of conscience and religion debate. Depending on the receptivity of the medical community, de-criminalizing a practice by no means will ensure its availability: not just for reasons of conscience, but simply due to habit or convenience also.

[76] See *Christian Medical and Dental Society of Canada et al. v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579.

[77] The matter of faith-based public institutions, like Catholic hospitals and long-term care facilities, refusing to allow poses other questions, as well as a much larger challenge for access to medical assistance in dying for legally eligible patients. Institutions that root their refusal to permit MAID on their premises in the freedom of religion and conscience protection afforded by the Charter do not accord the equivalent level of protection to the individual claims to freedom of conscience and religion by physicians and nurse practitioners wishing to provide MAID to the patients requesting it.

[78] *Christian Medical supra* note 76 at para 212.

[79] See e.g. J. SAVULESCU, U. SCHUKLENK, *Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception*, in 31:3 *Bioethics* 162, 2017 (arguing that doctors who refuse to offer lawful, clinically indicated treatments including medical assistance in dying should not be permitted to practice medicine); D. GILBERT, *Let Thy Conscience Be Thy Guide (but not My Guide): Physicians and the Duty to Refer*, in 10:2 *McGill JL & Health* 47, 2017 (arguing that protecting the conscience of physicians should not interfere with patient access to suitable health care, including abortion and medical assistance in dying); H. YOUNG, *A Proposal for Access to Treatment Contrary to Clinical Judgment*, in 11:2 *McGill JL & Health*, 2017 (examining the relationship between freedom of conscience and the exercise of clinical judgment); J. DOWNIE, F. BAYLIS, *A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms: Regulating and Litigating Conscientious Refusals in Health Care*, in 11:1 *McGill JL & Health* S1, 2017 (outlining a substantive test courts and policy-makers should adopt when interpreting the freedom of conscience guarantee under the Charter.)

[80] See *Christian Medical supra* note 76 at para 212.

7. Conclusion

De-criminalizing a given practice signals an alteration to, not abolition of, law's role in governing human conduct and social interaction.[81] Institutional and regulatory design are always more multifaceted, unpredictable, and interactional than the singular act of repeal. It may be that existing institutions and regulations will already serve to facilitate the purposes behind the repeal or modification of a prohibition. It may be that existing formal structures and informal norms end up frustrating the purpose of the statutory amendment. In either case, reforming the law requires imagining a range of factors to which a constitutional court's decision simply need not attend.

The Supreme Court of Canada concluded that the total prohibition of voluntary euthanasia and assisted suicide could not be justified, given the end-of-life practices that already were lawful. The Court offered a baseline of constitutionality, one that Parliament stretched by defining eligibility in a manner that was ostensibly more strict than the Court envisioned. Establishing a nexus with natural death, the legislation obviates the need to justify exclusion of medical patients with non-physical conditions from accessing MAID. Such an exclusion would have no legal basis if evidence of a medical diagnosis, competence, consent, and intolerable suffering were the only eligibility requirements. Whether this exclusion is justifiable on the level of principle or policy remains a subject of ongoing debate. As one might anticipate, the exclusion of people whose condition is strictly psychological has not attracted the same level of focused, negative attention as the restriction on advance directives. An aging portion of the population—concerned with the consequences of developing dementia and desiring to exercise control over the manner and timing of their death—seek to request MAID through living wills. This is not permitted under the current Canadian legislation, since contemporaneous consent is required as a safeguard to ensure only competent adults who clearly consent receive MAID. Any changes to the present law remain to be seen.

Certainly since *Carter* and the passage of Canada's MAID legislation, the country's legal and political discourse has shifted in salient ways, transforming conversations around the ethics of end of life decision-making. Of course, public support for MAID had already been increasing since *Rodriguez*. In the case, the Canadian Medical Association no longer opposed de-criminalization, albeit stopping short of offering an endorsement. Furthermore, William Shoichet, a physician who said he would be willing to give assistance in dying were it made lawful, was also a party in the *Carter* case. Like *Rodriguez* before it, *Carter* will increasingly become a footnote, as research, reflection and debate continue to inform developments in the law. One contentious area is the current set of MAID eligibility criteria, which raises questions about how to balance values such as legal certainty and objectivity, with flexibility and responsiveness to individual cases. The US states that have decriminalized assisted suicide require the patient to be within six months of death. Neither the BENELUX nor the Swiss model links eligibility to one's trajectory toward death. Meanwhile, the Canadian eligibility regime requires

[81] See R.A. MACDONALD, *Understanding Regulation by Regulations*, in I. BERNIER, A. LAJOIE (eds.), *Regulations, Crown Corporations and Administrative Tribunals*, Toronto, 1985 (on this point specifically); R.A. MACDONALD, *Law Reform for Dummies (3rd Edition)*, in 51:3 *Osgoode Hall Law Journal*, 2014 (where Macdonald emphasizes the importance of engaging the general public in achieving substantive social and legal change). See R. JANDA, D. JUTRAS, R. JUKIER (eds.), *The Unbounded Level of the Mind: Rod Macdonald's Legal Imagination*, Montréal, 2015.

a patient to have experienced an irreversible decline in capability and for their natural death to have become reasonably foreseeable.

Reviewing the Canadian experience reforming law's governance of assisted suicide and voluntary euthanasia, a number of dimensions may be observed: first, the impact a landmark apex court ruling may have, not only in providing the impetus for legislative change, but in transforming the way patients, professionals, and members of the public think and talk about medical assistance in dying. Second, the significance of the details in detailed legislative amendments. Third, the salience of ongoing arguments in academic journals, the press and the courts over eligibility criteria. Fourth, the long-term implications that commissioned studies and reports may have in contributing to public knowledge and debate. Fifth, the complementarity of principled rationales and concrete institutional approaches to accommodating freedom of conscience and religion, as well as ensuring access for eligible patients.

Indeed, lifting the blanket ban recasts a heretofore forbidden practice as a form of medical treatment. Once strictly addressed by the criminal law, medical assistance in dying now becomes also subject to a more flexible array of administrative and professional policies, practices, standards, protocols, and norms. To some extent, battles waged over legalizing MAID continue even after the law is changed—this time in clashes over features of the access regime. As the question of how medical assistance in dying ought to be regulated becomes less polarized, however, it stops serving to the same degree as a proxy for other contentious issues in society in general and end of life health care in particular. Legalization advocacy is all the more persuasive when it does not come at the cost of diminishing the importance of the social determinants of health, the urgent demand for available and accessible palliative care, or the moral claim that elderly, ill and disabled people have to receiving the social, emotional, financial, psychological and medical support they need. Equally, those genuinely concerned with what the content of the criminal law indicates about society's character and values must account for the message that a blanket prohibition on MAID conveys. That is, when the law forces human beings, already on the trajectory toward death, to endure prolonged suffering for the sake of beliefs that they, and those health care practitioners willing to assist them, do not hold.

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