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# *SPECIAL ISSUE*
# *ON*
# THE FUTURE OF HEALTH LAW

## ARTICLES

# EDITOR'S NOTE

## *Kendra Levasseur**

Volume 11 of the McGill Journal of Law and Health both tackles emerging issues in health law and takes a fresh look at longstanding challenges in the field. The articles collected in this volume offer insightful and in-depth consideration of topics relevant to the broader community.

The MJLH is grateful to all the authors and peer reviewers who contributed to this issue. Our appreciation for their work cannot be overstated and we are thankful for everything we learned from them during our time with the MJLH.

As Editor-in-Chief of volume 11, I would also like to thank the entire team of MJLH editors who I had the privilege of working alongside. I am deeply grateful to the dedicated executive team – Alexandra Persaud, Camille Marceau, Chris Laliberte, Lauren Hanon, and Zachary Shefman – and also to the executive team of volume 12 led by Eric Saragosa, who continued their work on volume 11. Thank you also to Professor Alana Klein, the MJLH's Faculty Advisor, and all the members of the MJLH Advisory Board.

*Kendra Levasseur*

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* Editor-in-Chief, *McGill Journal of Law and Health*, Vol. 11.

McGill Journal of Law and Health ~ Revue de droit et santé de McGill

# A Test for Freedom of Conscience under the *Canadian Charter of Rights and Freedoms*: Regulating and Litigating Conscientious Refusals in Health Care

*Jocelyn Downie & Françoise Baylis**

Conscientious refusal to provide insured health care services is a significant point of controversy in Canada, especially in reproductive medicine and end-of-life care. Some provincial and territorial legislatures have developed legislation or regulations, and some professional regulatory bodies have developed policies or guidelines, to better reconcile tensions between health care professionals' conscience and patients' access to health care services. As other groups

L'objection de conscience de fournir des services de soins de santé assurés est un point de controverse important au Canada, surtout en médecine reproductive et en soins de fin de vie. Certains corps législatifs provinciaux et territoriaux ont dévelopé de la législation ou des réglements et certains organismes de réglementation professionnelle ont dévelopé des politiques ou des lignes directrices afin de réconcilier plus facilement les tensions entre la conscience

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attempt to draft standards and as challenges to existing standards head to court, the fact that the meaning of "freedom of conscience" under the *Canadian Charter of Rights and Freedoms* is not yet settled will become ever more problematic. In this paper, we review the case law and legislative history relating to freedom of conscience. Having shown that the nature and scope of the freedom of conscience provision cannot be settled by either review, we turn to philosophy for insights with respect to the contemporary purpose of protecting freedom of conscience. On this basis, we offer a substantive test for freedom of conscience under the *Charter*. We do so for two reasons. First, we seek to assist those responsible for regulating the conduct of health care professionals in designing and implementing laws and policies that protect and promote the health needs and interests of patients without unjustifiably limiting the *Charter* conscience rights of health care professionals. Second, we seek to inform the analysis of future freedom of conscience *Charter* cases in response to the decriminalization of medical assistance in dying and the licensing of the drugs used for medical abortion.

des professionnels de la santé et l'accès des patients aux services de soins de santé. Alors que d'autres groupes tentent de rédiger des standards et alors que les contestations constitutionnelles des standards existants se rendent en cour, le fait que le sens de la « liberté de conscience » sous la *Charte canadienne des droits et libertés* ne soit pas encore déterminé deviendra d'autant plus problématique. Dans cet article, nous révisons la jurisprudence et le contexte législatif relatifs à la liberté de conscience. Ayant montré que la nature et la portée de la liberté de conscience ne peuvent être établies par l'une ou l'autre des révisions, nous nous tournons vers la philosophie pour des renseignements concernant l'objectif contemporain de protéger la liberté de conscience. Sur cette base, nous offrons un test substantif pour la liberté de conscience sous la *Charte*. Nous faisons ceci pour deux raisons. Premièrement, nous cherchons à aider ceux qui sont responsables de réglementer la conduite des professionnels de la santé en concevant et en exécutant des lois et des politiques qui protègent et promeuvent les besoins de santé et les intérêts des patients sans limiter de manière injustifiable les droits de conscience prévus par la *Charte* des professionels de la santé. Deuxièmement, nous cherchons à contribuer aux futurs instances rapportant à la liberté de conscience de la *Charte* en réponse à la récente décriminalisation de l'aide médicale à mourir et à l'autorisation des médicaments utilisés pour l'avortement médical.

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## INTRODUCTION

Conscientious refusal to provide insured health services is a significant point of controversy in Canada, especially in reproductive medicine and end-of-life care. Can a pharmacist legally refuse, on grounds of conscience, to fill a prescription for the birth control pill or emergency contraception? Can a physician, also on grounds of conscience, legally refuse to administer a medical abortion or to provide a surgical abortion? Outside the familiar contexts of contraception and abortion, can a physician legally refuse, on grounds of conscience, to provide artificial insemination to a lesbian woman? Similarly, can a physician legally refuse to provide an elective C-section? Moving to the other end of the life spectrum, can a nurse practitioner legally refuse, on grounds of conscience, to write a prescription for medications to be used for assisted suicide? Can a physician legally refuse, on grounds of conscience, to provide palliative sedation or to participate in euthanasia? Can health care professionals, on grounds of conscience, legally withhold or withdraw potentially life-sustaining treatment against the wishes of a patient's substitute decision maker?[1]

In very general terms, the illustrative questions listed above demonstrate fundamental intrapersonal and interpersonal tensions. As regards intrapersonal tensions, the health care professional may experience tension between her freedom of conscience, her duty to treat, her duty to act in the best interests of her patient, her duty to respect patient autonomy, and her duty to not abandon her patient. As regards interpersonal tensions, tension may exist between the health care professional's freedom of conscience and the patient's freedom of conscience, autonomy, and right to access health

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[1] These and related questions are discussed in a rich literature on conscientious refusals in health care. See e.g. Hilary Young, "A Proposal for Access to Treatment Contrary to Clinical Judgment" 11:2 McGill JL & Health [forthcoming in 2017]; Daphne Gilbert, "Let Thy Conscience Be Thy Guide (but not *My* Guide): Physicians and the Duty to Refer" (2017) 10:2 McGill JL & Health 47; Julian Savulescu & Udo Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception" (2017) 31:3 Bioethics 162; Françoise Baylis, "A Relational View of Conscience and Physician Conscientious Action" (2015) 8:1 Int J Fem Approaches Bioeth 18 [Baylis, "Relational View"]; Jacquelyn Shaw & Jocelyn Downie, "Welcome to the Wild, Wild North: Conscientious Objection Policies Governing Canada's Medical, Nursing, Pharmacy, and Dental Professions" (2014) 28:1 Bioethics 33; Carolyn McLeod & Jocelyn Downie, "Let Conscience Be Their Guide? Conscientious Refusals in Health Care", Editorial, (2014) 28:1 Bioethics ii.

care. The Supreme Court of Canada recognizes some of these tensions in *Carter v Canada (AG)*:

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note – as did Beetz J. in addressing the topic of physician participation in abortion in *Morgentaler* – that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief. In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. *Rather, we underline that the* Charter *rights of patients and physicians will need to be reconciled.*[2]

A recent effort to effectively reconcile these tensions can be found in the March 2015 policy statement "Professional Obligations and Human Rights" of the College of Physicians and Surgeons of Ontario (College).[3] The section on "Conscience or Religious Beliefs" begins with an articulation of fundamental values enshrined in the *Charter* and their relationship to each other:

> The *Canadian Charter of Rights and Freedoms* (the "*Charter*") protects the right to freedom of conscience and religion. Although physicians have this freedom under the *Charter*, the Supreme Court of Canada has determined that no rights are absolute. The right to freedom of conscience and religion can be limited, as necessary, to protect public safety, order, health, morals, or the fundamental rights and freedoms of others.

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[2] 2015 SCC 5 at para 132, [2015] 1 SCR 331 [*Carter*] [emphasis added].

[3] "Policy Statement #2-15: Professional Obligations and Human Rights" (March 2015), online: <www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/Human-Rights.pdf> [College, "Professional Obligations"]. See also College of Physicians and Surgeons of Ontario, "Policy Statement #4-16: Medical Assistance in Dying" (June 2016), online: <www.cpso.on.ca/cpso/media/documents/policies/policy-items/medical-assistance-in-dying.pdf>. We use the College's "Professional Obligations" policy as our example here as it has a more general application.

> Where physicians choose to limit the health services they provide for reasons of conscience or religion, this may impede access to care in a manner that violates patient rights under the *Charter* and *Code*. The courts have determined that there is no hierarchy of rights; all rights are of equal importance.[4]

Having grounded the policy on "Professional Obligations and Human Rights" in the *Canadian Charter of Rights and Freedoms*,[5] the College stipulates that physicians who are unwilling to provide specific medical services for reasons of conscience or religion must: (1) "communicate their objection directly and with sensitivity to existing patients, or those seeking to become patients, and inform them that the objection is due to personal and not clinical reasons;"[6] and (2) provide the patient with "an effective referral to another health-care provider."[7] The policy further stipulates that in an emergency situation where there is the risk of imminent harm, physicians must provide medical care "even where that care conflicts with their conscience or religious beliefs."[8] Notably, this policy is presently subject to a court challenge brought by the Christian Medical and Dental Society of Canada, the Canadian Federation of Catholic Physicians' Societies, the Canadian Physicians for Life, and five individual physicians.[9] These groups and individuals believe that the College has violated physicians' freedom of religion, freedom of conscience, and right to equal treatment and benefit under the law.[10]

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[4] College, "Professional Obligations", *supra* note 3 at 4 (referring to the Ontario *Human Rights Code*, RSO 1990, c H19).

[5] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

[6] College, "Professional Obligations", *supra* note 3 at 5.

[7] *Ibid*.

[8] *Ibid*.

[9] *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, Ottawa, 15-63717 (Ont Sup Ct J) (Amended Notice of Application), online: Canadian Physicians for Life <www.physiciansforlife.ca/wp-content/uploads/2015/07/Amended-Notice-of-Application.pdf>.

[10] *Ibid* at 3. The challenge to the College's policy statement, "Professional Obligations", *supra* note 3, and these arguments have been explored in depth: see Gilbert, *supra* note 1.

As provincial and territorial legislatures and professional regulatory bodies continue to strive to develop policies reconciling interpersonal tensions between health care professionals and patients,[11] and as challenges to legislation and policies head to court, the parties and courts will be confronted with the fact that the meaning of "freedom of conscience" under the *Charter* is not yet settled. Arguably, this lack of clarity, arising in large part due to a lack of attention,[12] is reflected in Peter Hogg's *Constitutional Law of Canada.*[13] In a discussion of the hierarchy of rights under the *Charter*, he references "s. 2 (freedom of religion, expression, assembly and association)"[14] without mentioning "freedom of conscience." His sole discussion of freedom of conscience appears in the chapter entitled "Religion." The discussion is only 16 lines long,[15] and the entry in the index under "Conscience" is "*See* Religion."[16] Further, as we will demonstrate, a thorough review of relevant case law reveals no clear meaning of freedom of conscience. And while a careful review of legislative intent supports the conclusion that freedom of conscience was deliberately included in the *Charter* as a distinct freedom, the relationship between freedom of conscience and freedom of religion remains unclear.

In this paper, we lay out our review of the relevant case law, followed by a review of the legislative history. Having shown that the nature and scope of the freedom of conscience provision cannot be settled by either review,[17]

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[11] For the results of a comprehensive review of conscientious refusal policies for physicians, nurses, pharmacists, and dentists from across Canada, see Shaw & Downie, *supra* note 1.

[12] The lack of attention from the courts is reflected in the literature. See e.g. Richard Moon, *Freedom of Conscience and Religion* (Toronto: Irwin Law, 2014), which includes six chapters of analysis yet (quite understandably) only one chapter on conscience. A literature review revealed that the volume of academic articles on freedom of religion as opposed to freedom of conscience distinct from religion is seriously (again, understandably) skewed.

[13] 5th ed (Toronto: Carswell, 2007) (loose-leaf 2015 supplement) vol 2, ch 36.

[14] *Ibid* at 36-33.

[15] *Ibid* at 42-3 to 42-4.

[16] *Ibid* at I-19.

[17] For prior reviews, see Michael E Manley-Casimir, *The Meaning of 'Freedom of Conscience' in the Canadian Charter of Rights and Freedoms: A*

we turn to philosophy for insights with respect to the contemporary purpose of protecting freedom of conscience.[18] On this basis, we offer a substantive test for freedom of conscience under the *Charter*. We do so for two reasons: first, to assist those responsible for regulating the conduct of health care professionals in designing laws and policies that protect and promote the health needs and interests of patients without unjustifiably limiting the *Charter* conscience rights of health care professionals.[19] Second, to contribute to future freedom of conscience *Charter* cases which are likely to be brought with greater frequency and urgency given the recent decriminalization of medical assistance in dying in Canada[20] and the licensing of the drugs used for medical abortion.[21]

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*Polyvocal Cultural Analysis* (LLM Thesis, University of British Columbia, 2004) [unpublished]; Howard Kislowicz, Richard Haigh & Adrienne Ng, "Calculations of Conscience: The Costs and Benefits of Religious and Conscientious Freedom" (2011) 48:3 Alta L Rev 679.

[18] We focus on the jurisprudential and legislative history (demonstrating there is no satisfactory guidance to be found there). There are, of course, additional tools for statutory interpretation that could be deployed (e.g., textual, consequential, and legal policy). See Ruth Sullivan, *Sullivan on the Construction of Statutes*, 6th ed (Toronto: LexisNexis, 2014). However, having determined that there was no satisfactory guidance to be found in the jurisprudential and legislative history analysis, we recognized that a future case could benefit from a philosophical analysis of the contemporary purpose of protecting freedom of conscience and the section 2(a) test for conscience that might flow from it. We therefore turned to that project and left the other forms of statutory interpretation to others.

[19] This project is premised on the assumption that the *Charter* applies to the College in relation to this policy, following the reasoning in *Eldridge v British Columbia (AG)*, [1997] 3 SCR 624, 151 DLR (4th) 577. It is essential to note that legal arguments about conscientious objection and health care professionals not based on the *Charter* also exist: see e.g. *Cuthbertson v Rasouli*, 2013 SCC 53, [2013] 3 SCR 341. For a discussion of these arguments, see Young, *supra* note 1. These arguments, however, lie outside the scope of this paper.

[20] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, RSC 2016, c 3.

[21] See Health Canada, "Drugs and Health Products: Regulatory Decision Summary: MIFEGYMISO" (29 July 2015), online: <hc-sc.gc.ca/dhp-mps/prodpharma/rds-sdr/drug-med/rds_sdr_mifegymiso_160063-eng.php>.

## I. REVIEW OF THE RELEVANT CASE LAW

There have been a number of Supreme Court of Canada cases involving "freedom of religion," some cases in which "freedom of conscience and religion" have been considered together, but no cases in which freedom of conscience has been considered on its own. Below, we chronicle the key Supreme Court of Canada cases that mention freedom of conscience and freedom of religion with a view to gaining a clearer understanding of the nature and scope of freedom of conscience and how this freedom is the same or different from freedom of religion.[22] Where appropriate, the analysis of individual cases begins with the lower court decisions that led up to Supreme Court of Canada decisions.

### *A.* R v Big M Drug Mart

Not long after the *Charter* was enacted, freedom of conscience was brought before the courts. In *R v Big M Drug Mart*, Big M Drug Mart was charged with violating the *Lord's Day Act*,[23] which prohibited commercial activity on Sundays. Big M Drug Mart challenged the constitutionality of the act in part under section 2(a) of the *Charter*.[24] On appeal, Justice Laycraft stated:

> It is not desirable, in my view, at this stage of *Charter* history to attempt a comprehensive definition of "freedom of religion" or "freedom of conscience". The latter term seems designed to encompass the rights of those whose fundamental principles are not founded on theistic belief.[25]

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[22] We do not review cases that mention freedom of conscience but do not advance our understanding of the Court's view of the relationship between religion and conscience. For example, in *Loyola High School v Quebec (AG)*, 2015 SCC 12, [2015] 1 SCR 613, the word "conscience" is only mentioned when the Court is quoting someone else. A number of other cases mention "conscience" when referring to the wording of the *Charter* section in which "religion" is mentioned, i.e., "freedom of conscience and religion," but, as they are cases claiming only a violation of freedom of religion, they do not advance our understanding of freedom of conscience.

[23] RSC 1970, c L-13, s 4.

[24] *R v Big M Drug Mart Ltd*, [1985] 1 SCR 295 at 300–01, 18 DLR (4th) 321 [*Big M Drug Mart*].

[25] *R v Big M Drug Mart Ltd* (1983), 49 AR 194 at para 42, 9 CCC (3d) 310 (CA).

In this passage, Justice Laycraft suggests that conscience is distinct from religion.

The appeal to the Supreme Court of Canada provided the Court with its first opportunity to consider the meaning of the section 2(a) guarantee of "freedom of conscience and religion." Justice Dickson (as he then was) made the following reference to conscience:

> Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.[26]

This text seems consistent with Justice Laycraft's view of conscience as distinct from religion, since the "beliefs" he refers to are presumably religious beliefs. However, Justice Dickson then suggests that freedom of conscience and freedom of religion are not separable concepts:

> Attempts to compel belief or practice [in post-Reformation Europe] denied the reality of individual conscience and dishonoured the God that had planted it in His creatures. It is from these antecedents that the concepts of freedom of religion and freedom of conscience became associated, to form, as they do in s. 2(a) of our *Charter*, the single integrated concept of "freedom of conscience and religion."[27]

The above text states that conscience and religion are not distinct and that "freedom of conscience and religion" is a "single integrated concept." Justice Dickson (as he then was) then seems to suggest that freedom of religion is a subset of freedom of conscience:

> The values that underlie our political and philosophic traditions demand that every individual be free to hold and to manifest whatever beliefs and opinions his or her conscience dictates, provided *inter alia* only that such manifestations do not injure his or her neighbours or their parallel rights

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[26] *Big M Drug Mart*, *supra* note 24 at 337.

[27] *Ibid* at 345–46.

> to hold and manifest beliefs and opinions of their own. Religious belief and practice are historically prototypical and, in many ways, paradigmatic of conscientiously-held beliefs and manifestations and are therefore protected by the *Charter*. Equally protected, and for the same reasons, are expressions and manifestations of religious non-belief and refusals to participate in religious practice. It may perhaps be that freedom of conscience and religion extends beyond these principles to prohibit other sorts of governmental involvement in matters having to do with religion. For the present case it is sufficient in my opinion to say that whatever else freedom of conscience and religion may mean, it must at the very least mean this: government may not coerce individuals to affirm a specific religious belief or to manifest a specific religious practice for a sectarian purpose.[28]

This text suggests that freedom of religion is "prototypical" and "paradigmatic" of freedom of conscience. In other words, as noted above, freedom of religion is a subset of freedom of conscience.

### *B.* R v Videoflicks Ltd/R v Edwards Books and Art Ltd

Prior to the release of the Supreme Court of Canada's decision in *Big M Drug Mart*, another case involving Sunday shopping was making its way through the courts. In *R v Videoflicks Ltd*,[29] Justice Tarnopolsky delivered what Kislowicz et al refer to as "the first comprehensive analysis of the parameters of conscience as an independent value."[30] In his decision, Justice Tarnopolsky defined freedom of religion and commented on the proper approach to analyzing whether a practice or belief falls within its protection.[31] He then suggested that this same reasoning should be applied to purely conscience-based claims and offered at least a partial definition of freedom of conscience:

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[28] *Ibid* at 346–47.

[29] (1984), 48 OR (2d) 395, 14 DLR (4th) 10 (CA) [*Videoflicks* cited to OR], aff'd *R v Edwards Books and Art Ltd*, [1986] 2 SCR 713, 35 DLR (4th) 1 [*Edwards Books* cited to SCR].

[30] Kislowicz, Haigh & Ng, *supra* note 17 at 708.

[31] *Videoflicks*, *supra* note 29 at 420–422.

> In my view, essentially the same reasoning would apply to the fundamental freedom of conscience, except that freedom of conscience would generally not have the same relationship to the beliefs or creed of an organized or at least collective group of individuals. None the less, and without attempting a complete definition of freedom of conscience, the freedom protected in s. 2(*a*) would not appear to be the mere decision of any individual on any particular occasion to act or not act in a certain way. To warrant constitutional protection, the behaviour or practice in question would have to be based upon a set of beliefs by which one feels bound to conduct most, if not all, of one's voluntary actions. While freedom of conscience necessarily includes the right not to have a religious basis for one's conduct, it does not follow that one can rely upon the Charter protection of freedom of conscience to object to an enforced holiday simply because it happens to coincide with someone else's sabbath. Rather, to make such an objection one would have to demonstrate, based upon genuine beliefs and regular observance, that one holds as a sacrosanct day of rest a day other than Sunday and is thereby forced to close one's business on that day as well as on the enforced holiday. No appellant informed this Court of any such fundamental belief based upon conscience rather than religion.[32]

Justice Tarnopolsky thus considers freedom of conscience and freedom of religion as distinct freedoms.

Unfortunately for our purposes, the Supreme Court of Canada paid very little attention to conscience in its decision on the same matter. Chief Justice Dickson quoted Justice Tarnopolsky: "[F]reedom of conscience necessarily includes the right not to have a religious basis for one's conduct ..."[33] and subsequently noted that "freedom of religion, perhaps unlike freedom of conscience, has both individual and collective aspects."[34]

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[32] *Ibid* at 422.

[33] *Edwards Books*, *supra* note 29 at 761, citing *Videoflicks*, *supra* note 29 at 422.

[34] *Edwards Books*, *supra* note 29 at 781.

## *C.* R v Morgentaler

Two years later, a case arrived at the Supreme Court of Canada which presented an opportunity to consider freedom of conscience separately from freedom of religion. In *R v Morgentaler*,[35] the Court considered the constitutionality of the abortion provision in the *Criminal Code*.[36] The majority held that section 251 of the *Criminal Code* infringed section 7 of the *Charter* and could not be saved under section 1 of the *Charter*.[37] Justice Wilson agreed with the majority in the result, but issued a concurring judgment in which she found that the abortion provisions also violated section 2(a). Justice Wilson acknowledged that in *Big M Drug Mart*, "[t]he Chief Justice [saw] religious belief and practice as the paradigmatic example of conscientiously-held beliefs and manifestations and as such protected by the *Charter*."[38] However, she went on to conclude:

> It seems to me, therefore, that in a free and democratic society "freedom of conscience and religion" should be broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality. Indeed, *as a matter of statutory interpretation, "conscience" and "religion" should not be treated as tautologous if capable of independent, although related, meaning*. Accordingly, for the state to take sides on the issue of abortion, as it does in the impugned legislation by making it a criminal offence for the pregnant woman to exercise one of her options, is not only to endorse but also to enforce, on pain of a further loss of liberty through actual imprisonment, one conscientiously-held view at the expense of another. It is to deny freedom of conscience to some, to treat them as means to an end, to deprive them, as Professor MacCormick puts it, of their "essential humanity".[39]

Justice Wilson clearly rejects the view of freedom of religion as paradigmatic and prototypical of freedom of conscience and an embrace of the view

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[35] [1988] 1 SCR 30, 63 OR (2d) 281 [*Morgentaler* cited to SCR].

[36] RSC 1985, c C-46, s 251.

[37] *Morgentaler*, *supra* note 35 at 79.

[38] *Ibid* at 177–78.

[39] *Ibid* at 179 [emphasis added], citing Neil MacCormick, "Civil Liberties and the Law" in *Legal Right and Social Democracy: Essays in Legal and Political Philosophy* (Oxford: Oxford University Press, 1984) 39 at 41.

of freedom of conscience and freedom of religion as distinct. And while Justice Wilson was speaking only for herself, this opinion is nonetheless notable given the influence it has had on subsequent jurisprudence more generally.[40]

### *D.* B (R) v Children's Aid Society of Metropolitan Toronto

Freedom of conscience surfaced again at the Supreme Court of Canada in *B (R) v Children's Aid Society of Metropolitan Toronto*.[41] In that case, the plaintiffs were Jehovah's Witnesses whose infant daughter had been made a temporary ward of the Children's Aid Society under the Ontario *Child Welfare Act*[42] and given a blood transfusion against her parents' wishes.[43] The plaintiffs claimed that the *Child Welfare Act* contravened section 2(a) of the *Charter* as it infringed their freedom of religion.[44] In their concurring minority opinion, Justices Major and Iacobucci (also writing for Justices Cory and Lamer on this point) found:

> The appellants proceed on the assumption that Sheena is of the same religion as they, and hence cannot submit to a blood transfusion. Yet, Sheena has never expressed any agreement with the Jehovah's Witness faith, nor, for the matter, with any religion, assuming any such agreement would be effective. There is thus an impingement upon Sheena's freedom of conscience which arguably includes the right to live long enough to make one's own reasoned choice about the religion one wishes to follow as well as the right not to hold a religious belief.[45]

This text, albeit a minority opinion, suggests that freedom of religion is subsumed under freedom of conscience.

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[40] See Chris Kaposy & Jocelyn Downie, "Judicial Reasoning about Pregnancy and Choice" (2008) 16 Health LJ 281 at 290–95.

[41] [1995] 1 SCR 315, 122 DLR (4th) 1 [*Children's Aid* cited to SCR].

[42] RSO 1980, c 66.

[43] *Children's Aid*, *supra* note 42 at para 96.

[44] *Ibid* at para 103.

[45] *Ibid* at para 231.

## *E.* Syndicat Northcrest v Amselem

Some years later, the issue was again argued before the Supreme Court of Canada in *Syndicat Northcrest v Amselem*.[46] Here, the appellants were Orthodox Jewish co-owners of units in a condominium. They set up *succahs* (ritual huts) on their balconies for Succot (a Jewish holiday).[47] However, the Syndicat (management of the co-owned property) asked them to remove the *succahs* arguing that "decorations, alterations and constructions on the balconies"[48] were prohibited under the condominium by-laws. The majority in this case noted:

> In order to define religious freedom, we must first ask ourselves what we mean by "religion". While it is perhaps not possible to define religion precisely, some outer definition is useful since only beliefs, convictions and practices rooted in religion, as opposed to those that are secular, socially based or conscientiously held, are protected by the guarantee of freedom of religion.[49]

This text suggests that conscience and religion are distinct concepts.

In contrast, revealing yet again the lack of a unified view on this at the Supreme Court of Canada, Justice Bastarache (in dissent with Justices LeBel and Deschamps) appeared to take a different view:

> Religious precepts constitute a body of objectively identifiable data that permit a distinction to be made between genuine religious beliefs and personal choices or practices that are unrelated to freedom of conscience.[50]
>
> …
>
> La Forest J. explained this as follows in in *Ross v. New Brunswick School District No. 15*:

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[46] 2004 SCC 47, [2004] 2 SCR 551 [*Amselem*].

[47] *Ibid* at paras 2, 4.

[48] *Ibid* at para 9.

[49] *Ibid* at para 39.

[50] *Ibid* at para 135, Bastarache J, dissenting.

> > Indeed, this Court has affirmed that freedom of religion ensures that every individual must be free to hold and to manifest without State interference those beliefs and opinions dictated by one's conscience.[51]
>
> …
>
> Even though religion is, first and foremost, a question of conscience …[52]

These three excerpts imply, respectively, that "genuine religious beliefs" are related to conscience, that beliefs protected by freedom of religion come from conscience, and that religion is subsumed under conscience.

### *F.* Alberta v Hutterian Brethren of Wilson Colony

In *Alberta v Hutterian Brethren of Wilson Colony*, the Supreme Court of Canada considered the constitutionality of a provincial requirement that all persons who hold a driver's licence have their photo taken.[53] Until 2003, the Hutterian Brethren had been exempt from the requirement. Given their religious objection to being photographed, they argued that the new regulation removing the discretionary aspect of the photo requirement violated their section 2(a) rights.[54]

Two of the dissenting opinions in *Hutterian Brethren* offer further illustrations of the varying understanding of freedom of conscience at the Supreme Court of Canada. Whereas Justice LeBel suggested that freedom of religion is not subsumed under other fundamental freedoms (including freedom of conscience), Justice Abella suggested that "freedom of conscience and religion" are a single integrated concept. In his dissenting opinion, Justice LeBel observed:

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[51] *Ibid* at para 136.

[52] *Ibid* at para 140.

[53] 2009 SCC 37 at paras 1–3, [2009] 2 SCR 567.

[54] *Ibid* at paras 3, 28–30.

> Perhaps, courts will never be able to explain in a complete and satisfactory manner the meaning of religion for the purposes of the *Charter*. One might have thought that the guarantee of freedom of opinion, freedom of conscience, freedom of expression and freedom of association could very well have been sufficient to protect freedom of religion. But the framers of the *Charter* thought fit to incorporate into the *Charter* an express guarantee of freedom of religion, which must be given meaning and effect.[55]

Here, Justice LeBel clearly suggests that freedom of religion is not subsumed under the other fundamental freedoms contained in section 2. Justice Abella, on the other hand, analyzing the purpose of the protection of freedom of conscience and religion, notes:

> The European Court of Human Rights espoused a similarly liberal conception of freedom of religion in *Kokkinakis v. Greece*:
>
> > [F]reedom of thought, conscience and religion is one of the foundations of a "democratic society" within the meaning of the Convention. It is, in its religious dimension, one of the most vital elements that go to make up the identity of believers and their conception of life, but it is also a precious asset for atheists, agnostics, sceptics and the unconcerned. The pluralism indissociable from a democratic society, which has been dearly won over the centuries, depends on it.
> >
> > While religious freedom is primarily a matter of individual conscience, it also implies … freedom to "manifest [one's] religion".[56]

Justice Abella's text suggests a return, almost 25 years later, to the conception of freedom of conscience and religion as a single integrated concept.

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[55] *Ibid* at para 180, LeBel J, dissenting.

[56] *Ibid* at para 128, Abella J, dissenting, citing *Kokkinakis v Greece* (1993), 260A ECHR (Ser A) 20 at para 31.

### *G.* Carter v Canada (AG)

In 2015, in *Carter v Canada (AG)*,[57] the Supreme Court of Canada was asked to revisit its earlier decision in *Rodriguez v British Columbia (AG)*.[58] Explicitly referencing Justice Beetz's decision in *R v Morgentaler*, the Court appears to return to the conception of freedom of conscience and freedom of religion as being distinct freedoms:

> [Four of the intervenors (the Catholic Civil Rights League, the Faith and Freedom Alliance, the Protection of Conscience Project, and the Catholic Health Alliance of Canada)] would have the Court direct the legislature to provide robust protection for those who decline to support or participate in physician-assisted dying for reasons of conscience *or* religion.
>
> ...
>
> However, we note – as did Beetz J. in addressing the topic of physician participation in abortion in *Morgentaler* – that a physician's decision to participate in assisted dying is a matter of conscience and, *in some cases*, of religious belief.[59]

### *H. Conclusion*

No clear meaning of freedom of conscience can be taken from the jurisprudence. There is a lack of consistency at best, and confusion at worst.

## II. LEGISLATIVE HISTORY

Given that no authoritative meaning of "freedom of conscience" can be gleaned from the jurisprudence, we now explore whether any insights can be gleaned from the legislative history. A review of legislative history may reveal understandings of key concepts that, upon reflection and in light of other interpretive rules, a court could choose to adopt. So how did the section 2 text as finally expressed come to be in the *Charter* and what were pol-

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[57] *Carter*, *supra* note 2.

[58] [1993] 3 SCR 519, 107 DLR (4th) 342.

[59] *Carter*, *supra* note 2 at paras 130–32, citing *Morgentaler*, *supra* note 35 at 95–96 [emphasis added].

iticians and bureaucrats saying about freedom of conscience as they drafted and debated the text?

In Canada, the phrase "freedom of conscience" first appeared in a provincial bill of rights statute. In 1947, the province of Saskatchewan enacted *The Saskatchewan Bill of Rights Act*.[60] Section 3, entitled "Right to freedom of conscience," provided:

> Every person and every class of persons shall enjoy the right to freedom of conscience, opinion and belief, and freedom of religious association, teaching, practice and worship.[61]

"Freedom of conscience" first appeared in connection with a federal constitutional document in 1968 when Minister of Justice Pierre Trudeau (as he then was) wrote a policy paper entitled *A Canadian Charter of Human Rights*,[62] making the case for a constitutional charter. The proposed *Charter of Human Rights* would guarantee the right to "freedom of conscience and religion." As explained in Trudeau's paper:

> There is some legislative protection now. The Canadian Bill of Rights, section 1, recites "freedom of religion". The Saskatchewan Bill of Rights, section 3, declares the right to "freedom of conscience, opinion, and belief, and freedom of religious association, teaching, practice and worship". The Freedom of Worship Act (applicable in Ontario and Quebec) declares the right to "the free exercise and enjoyment of religious profession and worship". It is arguable, however, that a guarantee of "freedom of religion" does not protect the freedom of the person who chooses to have no religion. To protect such persons, consideration could be given to widening the guarantee to protect, for example, "freedom of conscience".[63]

Two points are worth noting here. The first point concerns the move from the broadest of statements, namely, "freedom of conscience, opinion and

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[60] SS 1947, c 35 [*Bill of Rights*, SK].

[61] *Ibid*, s 3.

[62] Honourable Pierre Elliott Trudeau, *A Canadian Charter of Human Rights* (Ottawa: Queen's Printer, 1968).

[63] *Ibid* at 17–18, citing *Canadian Bill of Rights*, SC 1960, c 44, s 1; *Bill of Rights*, SK, *supra* note 60 at s 3; *Freedom of Worship Act*, RS 1964, c 301, s 1.

belief, and freedom of religious association, teaching, practice and worship" in *The Saskatchewan Bill of Rights Act*, to the closing emphasis in the above paragraph on freedom of conscience, to the final wording of the *Charter*, which joins freedom of conscience and freedom of religion. The second point concerns the stated rationale for adding freedom of conscience to freedom of religion, namely, to protect those who choose to have no religion.

A few years later, the *Victoria Charter* was issued – a product of a constitutional conference held in Victoria, 14–16 June 1971. The *Victoria Charter* included the following article:

> 1. It is hereby recognized and declared that in Canada every person has the following fundamental freedoms:
>
> > freedom of thought, conscience and religion,
> >
> > freedom of opinion and expression, and
> >
> > freedom of peaceful assembly and of association;
>
> and all laws shall be construed and applied so as not to abrogate or abridge any such freedom.[64]

Here, "thought" is introduced into the clause about freedom of conscience and religion.[65]

On 20 June 1978, the *Constitutional Amendment Act, 1978* (Bill C-60)[66] received first reading in the House of Commons. Bill C-60 provided for a

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[64] See Anne F Bayefsky, *Canada's Constitution Act 1982 & Amendments: A Documentary History* (Toronto: McGraw-Hill Ryerson, 1989) vol 1 at 214.

[65] This language is consistent with article 18(1) of the *International Covenant on Civil and Political Rights*:

> Everyone shall have the right to freedom of thought, conscience, and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

(19 December 1966, 999 UNTS 171 (entered into force 23 March 1976, accession by Canada 19 May 1976).

[66] Bill C-60, *An Act to amend the Constitution of Canada with respect to matters coming within the legislative authority of the Parliament of Canada, and to ap-*

*Canadian Charter of Rights and Freedoms*. Under the heading "Political and Legal Rights and Freedoms," the bill reproduced the language of the *Victoria Charter*, declaring that "in Canada, every individual shall enjoy and continue to enjoy the following fundamental rights and freedoms: – freedom of thought, conscience and religion …"[67] The explanatory notes accompanying the text indicate "freedom of 'religion' is expanded from the Bill of Rights to include 'thought and conscience'."[68] Two years later however, on 4 July 1980 when the federal government tabled a discussion draft of the *Charter*, "thought" was no longer one of two concepts expanding "freedom of religion." Instead, "thought" was now clustered with "belief, opinion, and expression." Under the heading "Fundamental Freedoms," section 2 of the discussion draft read:

> Everyone has the following fundamental freedoms:
>
> (a) freedom of conscience and religion;
>
> (b) freedom of thought, opinion, and expression, including freedom in the dissemination of news, opinion, and belief; and
>
> (c) freedom of peaceful assembly and of association.[69]

This revised draft of the fundamental freedoms section narrowed the proposed expansion of "freedom of religion" to "freedom of conscience and religion," thereby offering protection to individuals who choose to have no religion. Given the interpretive principle of *ejusdem generis*, had "thought" remained in the final text of the *Charter*, this could have had significant implications for the meaning of conscience.[70] If conscience were in the same

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*prove and authorize the taking of measures necessary for the amendment of the Constitution with respect to certain other matters*, 3rd Sess, 30th Parl, 1978.

[67] See Bayefsky, vol 1, *supra* note 64 at 347.

[68] See *ibid*, vol 1 at 348.

[69] See *ibid*, vol 2 at 599.

[70] As noted by Manley-Casimir, the implications of the principle of *ejusdem generis* on the placement of conscience within the various subsections of section 2 were noted by the Special Joint Committee of the Senate and the House of Commons on the Constitution of Canada [Special Joint Committee] in their discussions of the *Victoria Charter* (*supra* note 17 at 59).

genus as thought, then conscience could have been considered a narrower concept than if it were considered a distinct genus.

On 6 October 1980, the federal government tabled the *Proposed Resolution for Joint Address to Her Majesty the Queen Respecting the Constitution of Canada*.[71] The resolution asked the Queen to table a bill in the Parliament of the United Kingdom enacting the *Canadian Charter of Rights and Freedoms*, among other constitutional amendments.[72] Despite a suggestion during the process that conscience be removed from section 2(a) of the draft *Charter*,[73] the language of section 2(a) remained unchanged. Thus the category of "freedom of religion" was expanded to "freedom of conscience and religion," and conscience and religion were kept distinct from thought.

Clarity about legislative intent cannot be drawn from the committee hearings or parliamentary debates about the *Charter*. However echoes of the main points of difference in the evolution of the text outlined above can be found in these records, as illustrated below.[74]

Chief Ackroyd of the Metro Toronto Police argued before the Special Joint Committee of the Senate and of the House of Commons on the Constitution of Canada (Special Joint Committee) that the words "of conscience" should be removed or, if not removed, moved to section 2(b) of

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[71] (Ottawa: Supply and Service, 1980).

[72] Bayefsky, *supra* note 64, vol 2 at 744–45.

[73] See e.g. The Right Honourable Jean Chrétien, who recalls:

> Sometimes humour seemed the only thing that kept us going. At one point we got bogged down trying to define freedom of conscience. "So why put it in the charter?" someone asked. It was the end of the day and I was tired, so I said, "Yeah, why? Let's leave it out." Suddenly I felt a hard kick on the back of my chair. It was from Pierre Genest, a hefty and very funny friend who was one of the federal government's best legal advisers. "I guess we leave it in," I said. "Trudeau's spy just kicked me in the ass." He was more effective than my own conscience.

(*Straight from the Heart*, revised ed (Toronto: Key Porter Books, 1994) at 173).

[74] We searched the Special Joint Committee, *Minutes of Proceedings and Evidence*, 32nd Leg, 1st Sess for references to conscience and religion and drew illustrative examples from them.

the *Charter* on freedom of thought, belief, opinion, and expression, including freedom of the press and other media. While not expressed in the language of *ejusdem generis*, Chief Ackroyd's concern seemed to be about the potentially expansive effect of including conscience as a component of the section on religion rather than the section on thought. His focus was on acts, namely moral and drug offences, that he felt might then be protected under the *Charter*.[75]

Professor William Black, a member of the Executive Committee of the British Columbia Civil Liberties Association, argued before the Committee for the retention of freedom of conscience:

> It seems to me that the value of including freedom of conscience as well as freedom of religion is that it makes clear that people can have very deeply held beliefs that they might not call religious beliefs, but which are equally fundamental to them, and using the phrase "freedom of conscience" it gives them rights as well as people who deeply hold religious beliefs.[76]

This resonates with the conception of conscience as distinct from religion (but as equally deserving of protection).

Svend Robinson spoke against the inclusion of God in the preamble to the Constitution. He referred to freedom of conscience, describing it as a freedom that seemed to mean freedom from religion:

> What that means, of course, is that we, as a dualistic society, respect diverse viewpoints; we do not entrench one particular religion; indeed, we do not entrench any religion at all.

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[75] Special Joint Committee, *Minutes of Proceedings and Evidence*, 32nd Leg, 1st Sess, No 14 (27 November 1980) at 13:

> My concern would be that in moral offences, whether one can argue before a court that certain sexual behaviour might be within one's rights of freedom of conscience; certain cults believe in the use of certain drugs as part of their conscience; and can they argue that, because it is part of their cult that the use of certain drugs and chemicals give them a right to argue that they have freedom of conscience? That is a type of concern we are raising.

[76] Special Joint Committee, *Minutes of Proceedings and Evidence*, 32nd Leg, 1st Sess, No 22 (9 December 1980) at 118.

> We leave Canadians free to choose for themselves on the basis of their own conscience.[77]

In sum, a review of legislative intent supports the conclusion that freedom of conscience was deliberately kept as a distinct freedom in the *Charter* and was not considered to be adequately protected through freedom of religion. Indeed, its purpose appears to have been specifically to offer those without religious convictions a freedom analogous to the freedom granted to those with religious convictions. Arguably, this purpose also explains why freedom of conscience was not included in the same section as freedom of thought, belief, or opinion. The intent, it would appear, was for conscience to be considered of the same genus as religion, not the same genus as thought, belief, or opinion. That being said, the relationship of freedom of conscience to freedom of religion, its specific meaning, and the purpose(s) of protecting it remain unsettled.

## III. Contemporary Understanding of the Purpose of Freedom of Conscience

We now look to the purpose of protecting freedom of conscience in contemporary society. While much has been written on this topic in the philosophical literature,[78] what follows relies heavily on a perspective originally developed by one of the authors through a process of deep engagement with that literature.[79]

In our view, the purpose of freedom of conscience is to both nurture and facilitate a dialectical process aimed at improving human ethical practice.[80]

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[77] Special Joint Committee, *Minutes of Proceedings and Evidence*, 32nd Leg, 1st Sess, No 42 (21 January 1981) at 41.

[78] See e.g. Martin Benjamin, "Conscience" in Bruce Jennings, ed, *Bioethics*, 4th ed (Farmington Hills, MI: Gale, 2014) 688; Daniel Brock, "Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?" (2008) 29:3 Theor Med Bioeth 187; James F Childress, "Appeals to Conscience" (1979) 89:4 Ethics 315; Mark R Wicclair, "Conscientious Objection in Medicine" (2000) 14:3 Bioethics 205.

[79] See Baylis, "Relational View", *supra* note 1 (for a full contextualization and defence of this view).

[80] See *ibid* at 30. Note that this approach immediately avoids the epistemological trap for conscience claims described by some authors: see e.g. Bryan Thomas,

Ethical progress depends upon thoughtful deliberations among citizens about right and wrong. Such deliberations cannot meaningfully occur in a political, social, and cultural context that encourages undue deference to "unexamined intuitions, feelings of repugnance, unthinking adherence to internalized social norms or familiar generalizations, past assumptions, previously decided moral categories, preconceived notions of right and wrong, divine commands, professional dictates, or the moral majority."[81] To speak plainly, moral automatons cannot contribute to moral deliberations that enrich our understanding of what it means to live justly and well, which in turn informs our moral norms, as well as our practices, policies, and laws. More generally and importantly, in a secular country like Canada, with citizens who embrace different religions as well as citizens who identify as atheists or humanists, moral deliberations cannot be reduced to religious deliberations.

This perspective on the purpose of freedom of conscience – to nurture and facilitate a dialectical process aimed at improving human ethical practice – informs the view that society has a fourfold interest in: (1) encouraging individuals to engage in thoughtful, reflective inner deliberations about which values, beliefs, and commitments to endorse as their own as part of a shared interest in improving human ethical practice;[82] (2) encouraging individuals to apply these values, beliefs, and commitments in particular circumstances in rendering their best judgment about what is morally prohibited, morally permissible, and morally required; (3) promoting moral integrity understood as both a personal and a social virtue that aims at keeping one in proper relation to oneself and to others; and (4) encouraging individuals to act in ways that manifest principled consistency, value accountability, and model flexible resilience.[83]

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"Secular Law and Inscrutable Faith: Religious Freedom, Freedom of Conscience, and the Law's Epistemology" (2010) [unpublished], online: SSRN <papers.ssrn.com/sol3/papers.cfm?abstract_id=1275351>.

[81] Baylis, "Relational View", *supra* note 1 at 30.

[82] While it is common in the relevant jurisprudence to only make mention of "beliefs," we purposefully refer to "values, beliefs, and commitments" in part because we believe that not all beliefs are conscious or explicit. It follows that we do not consciously recognize all of our own beliefs. For this reason, it is important to try to get at the cluster or framework of values, beliefs, and commitments, some of which will have been absorbed through socialization and are so deeply ingrained that they are not obvious to us as discrete beliefs.

[83] See Baylis, "Relational View", *supra* note 1 at 31–32.

Moreover, the goal of improving human ethical practice requires individuals to commit to both eschewing undue deference and exercising due diligence. This translates into two specific obligations. First, there is the obligation to assess potentially competing moral values, beliefs, and commitments without attributing special weight to those values, beliefs, and commitments that are the tenets of an identifiable religion. Second, there is the obligation to decide what to do in particular circumstances without assuming that the morally right course of action is one that can be grounded in religious or secular dogma.

The overarching commitment to eschew undue deference and to exercise due diligence presupposes that individuals not only care about their own moral development, but also care about the moral development of others. In turn, this caring motivates conscience-based claims, which are in effect claims about right and wrong. On this view, "people are called on to do moral work in developing and orienting their conscience and to be responsible to others in so doing."[84] When an individual makes a conscience-based claim, others are called on to deliberate about whether the claim should be taken seriously (i.e., should be assigned significant moral weight) and, if so, whether it should prevail. These deliberations, whether they are had in the public sphere, in professional organizations, in government, or in the courts, advance both our understanding of what it means to live justly and well, and our ability to do so.

As a society, we have a shared interest in improving human ethical practice, that is to say, in living justly and well. To this end we have a shared interest in nurturing moral agency, not moral automatism. We want citizens to take their moral responsibilities seriously. For this to happen, we need to value freedom of conscience. Valuing freedom of conscience means that we take conscience-based claims seriously.

## IV. A Test for Freedom of Conscience under the *Charter*

In service of the purpose of protecting freedom of conscience as articulated above, we argue that appeals to conscience should be taken seriously when they:

a. evidence a certain thoughtfulness (i.e., morally engaged thinking that involves the exercise of due diligence in

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[84] *Ibid* at 30.

critically reflecting on [1] the particularities of a situation and [2] the values, beliefs, and commitments to endorse as one's own in rendering one's best judgment);

b. are consistent with one's best judgment, taking into consideration a shared interest in living justly and well (i.e., are not characterized by undue deference to self or others);

c. promote moral integrity understood as both a personal and a social virtue (i.e., aim at keeping one in proper relation to oneself and to others); and

d. manifest principled consistency, accountability, and flexible resilience.[85]

Appeals to conscience that should be taken seriously (i.e., given moral weight) may nonetheless be denied protection under the *Charter*. We propose that for such appeals to justify a conclusion that section 2(a) of the *Charter* has been breached, an individual making a section 2(a) conscience claim should have to prove the following to the court:

- his or her conscience claim has a nexus with specific ethical values, beliefs, or commitments that recommend or demand a particular act;
- he or she is sincere in his or her ethical values, beliefs, or commitments;

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[85] *Ibid* at 32. It has been suggested that the juxtaposition of the noun "consistency" and the adjective "flexible" may lead to confusion on a quick reading insofar as the concepts "consistency" and "flexibility" are antithetical to each other. It is important to note, however, that the text does not refer to "flexibility" but rather to "flexible resilience." As per the *Oxford Living Dictionaries*, "resilience" is "the ability of a substance or object to spring back into shape; elasticity" (online: https://en.oxforddictionaries.com/definition/resilience). As such, the reference to "flexible resilience" in the test alludes to the value of reasoned consistency, as contrasted with stubborn consistency. When facts, circumstances, contexts, etc. change or shift, one's best judgment should be re-examined. Upon re-examination, it may all "spring back into shape," or a new understanding or perspective may emerge resulting in a revised best judgment. The core idea here is that one's best judgment should neither be wafting on the wind, nor blinkered and intransigent. See Baylis, "Relational View", *supra* note 1; Françoise Baylis, "Of Courage, Honor, and Integrity" in Lisa A Eckenwiler & Felicia G Cohn, eds, *The Ethics of Bioethics: Mapping the Moral Landscape* (Baltimore: Johns Hopkins University Press, 2007) 193.

- his or her conscience claim is the result of an exercise of ethical judgment that results from:
    - the exercise of due diligence; and
    - the avoidance of undue deference;
- the state action interferes with the freedom to act in accordance with his or her ethical values, beliefs, or commitments; and
- the interference with the act that is grounded in his or her ethical values, beliefs, or commitments is more than trivial or insubstantial.

The elements of the proposed *Charter* test derive from the goal of promoting moral agency in pursuit of the larger goal of improved human ethical practice. Only when the test is satisfied does the appeal to conscience move from "should be given moral weight" to "should be given protection under the *Charter*."

It is important to acknowledge that the *Charter* test outlined above begins by establishing the substantive elements of conscience that are worthy of protection. It then adopts the structure and elements of the Supreme Court of Canada's freedom of religion test insofar as they are consistent with the substantive elements of conscience that are worthy of protection, but it is not identical to the Supreme Court of Canada's freedom of religion test. The freedom of religion test requires the following:

> [T]he first step in successfully advancing a claim that an individual's freedom of religion has been infringed is for a claimant to demonstrate that he or she sincerely believes in a practice or belief that has a nexus with religion. The second step is to then demonstrate that the impugned conduct of a third party interferes with the individual's ability to act in accordance with that practice or belief in a manner that is non-trivial.[86]

The first two elements of our proposed test for freedom of conscience are included in the first step of the Supreme Court of Canada's test for freedom of religion. The fourth and fifth elements of our proposed test for freedom of conscience fall within the Supreme Court's second step of the test for freedom of religion. Notably, there is an additional element in our test for freedom of conscience as compared with the Court's established test for freedom of religion: the required exercise of judgment (the third element).

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[86] *Amselem*, *supra* note 46 at para 65.

Some might object to the proposed *Charter* test for freedom of conscience on the grounds that it is inconsistent with the Supreme Court of Canada's test for freedom of religion. The conscience test requires the exercise of judgment, whereas the religion test does not appear to do so. In response, it can be argued that the two tests are consistent because, although the exercise of judgment is not explicit in the Supreme Court's test for freedom of religion, such a requirement is implicit in that test insofar as the freedom of religion test assumes that the institutionalized religion is doing the judgment work for the individual and the individual's deference to this judgment is not undue. For example, a rabbi might form a judgment grounded in his interpretation of the Torah (potentially supplemented by judgments offered by learned scholars) and his review of the facts, and a member of his congregation might defer to his judgment without such deference being seen as "undue deference." On this reasoning, the proposed test for freedom of conscience would be consistent with the freedom of religion test – it simply makes explicit that which is already implicit for religion.

However, some might object to this reasoning on one of two possible grounds and insist that there is a significant inconsistency between our proposed test for freedom of conscience and the Court's established test for freedom of religion. For example, some might argue that the Court makes no implicit assumptions about the need for judgment within the freedom of religion test. Alternatively, others might grant that while there is an implicit assumption about the need for judgment as outlined above, allowing deference to a religious authority is "undue deference." In either case, inconsistency exists between the test for freedom of religion and the proposed test for freedom of conscience. On this view, the inconsistency makes the test for freedom of conscience more onerous than the test for freedom of religion.

In response, we would concede that the proposed *Charter* test for freedom of conscience is inconsistent with, and *more* onerous than, the current test for "freedom of religion." However, we do not consider this to be a valid criticism of the proposed test insofar as we don't concede that the test is *too* onerous. The purpose of freedom of conscience has been carefully explained and defended, and the test is grounded in that purpose. Having said this, it could be argued that having a more onerous test for freedom of conscience than for freedom of religion means that freedom of conscience is less protected than freedom of religion. What follows from this is not the rejection of our proposed test for freedom of conscience, but rather the provocative question: can the current, less onerous, test for freedom of religion be defended relative to its purpose?[87] That is a question for those who would defend the current freedom of religion test to answer.

## CONCLUSION

Our review of both the jurisprudence and legislative history of the protection of freedom of conscience under section 2(a) of the *Charter* revealed that the meaning of conscience in section 2(a) of the *Charter* is not yet settled and cannot be settled by looking to either of these sources of interpretive guidance. We therefore asked, "What purpose should section 2(a)'s protection of freedom of conscience serve?" Based on our answer to this question, we proposed a substantive test for future freedom of conscience cases under section 2(a) of the *Charter*, particularly in the realm of health care. In doing so, we hope to have provided a tool that can be used to assist those responsible for regulating the conduct of health care professionals as they struggle to design laws and policies that protect and promote the health care needs and interests of patients without unjustifiably limiting the *Charter* conscience rights of health care professionals. We also hope to have made a positive contribution to future freedom of conscience *Charter* cases, especially (but not only) in the area of health care.

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[87] For some discussion of whether freedom of religion and freedom of conscience warrant the same level of scrutiny, see e.g. Thomas, *supra* note 80.

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# REGULATION, PRIVATE HEALTH INSURANCE, AND THE AUSTRALIAN HEALTH SYSTEM

*Fiona McDonald & Stephen Duckett**

In the 40 years since the introduction of universal public health insurance in Australia, there has been an ongoing political debate about the design of the Australian health care system, particularly about the appropriate role of the private sector in the funding and provision of health services. Australian governments have erected a regulatory framework that encourages Australians to purchase private health insurance (PHI). This framework is based on the belief that PHI is an essential element of a balanced two-tier health care system that is funded and provided by public and private actors. This article has three aims: (1) to critically examine the complex regulatory framework that has been created to encourage Australians to purchase PHI, (2) to critically examine some of the impacts of this regulatory framework, and (3) to provide information for other countries about the costs and consequences of government promoting PHI. Reviews have indicated concerns as to whether the framework achieves its stated ends, about acceptability to purchasers, and about whether the system as it currently

Durant les 40 ans depuis l'introduction de l'assurance santé publique universelle en Australie, il y a eu un débat politique continu sur la conception du système de soins de santé australien, particulièrement concernant le rôle approprié du secteur privé dans le financement et la fourniture des services de santé. Les gouvernements australiens ont érigé un cadre réglementaire qui encourage les Australiens à acheter une assurance santé privée (ASP). Ce cadre est fondé sur la croyance que l'ASP est un élément essentiel d'un système de soins de santé à deux niveaux équilibré qui est financé et fourni par des acteurs publiques et privés. Cet article a trois objectifs : (1) d'examiner de façon critique le cadre réglementaire complexe qui a été créé pour encourager les Australiens à acheter une ASP, (2) d'examiner de façon critique quelques-uns des impacts de ce cadre réglementaire, et (3) de fournir de l'information aux autres pays sur les coûts et les conséquences pour les gouvernements de promouvoir l'ASP. Les critiques ont signalé des inquiétudes quant à savoir si le cadre atteint ses fins déclarées,

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stands is sustainable. This analysis indicates some of the issues in respect of the regulation of PHI that will have implications for countries contemplating intervening in PHI markets.

concernant l'acceptabilité aux payeurs et quant à savoir si le système tel qu'établi est durable. Cette analyse indique quelques-uns des problèmes quant à la réglementation de l'ASP qui auront des implications pour des pays contemplant intervenir dans les marchés d'ASP.

## INTRODUCTION

On an international level, arguments continue about whether some, or all, health services should be (1) solely publicly funded and delivered in a public system, (2) funded and delivered by a mix of public and private funders/providers, or (3) privately funded and supported by a public safety net.[1] There are three broad approaches. The first is that public and private funding are complementary: that private funding is only allowed for services not covered by public funding. This is the predominant model in Canada,[2] where private funding is restricted to cosmetic procedures, pharmaceuticals bought outside hospitals, and certain other services. In this model, private funding could be used to pay for additional amenities in publicly funded hospitals or for services not covered by the public sector,[3] such as robotic surgery or certain genetic tests. The European/Bismarckian social insurance model also follows this approach.[4] The underlying principle is that

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[1] See e.g. Carolyn J Tuohy, Colleen M Flood & Mark Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations" (2004) 29:3 J Health Pol Pol'y & L 359 at 360–61 [Tuohy, Flood & Stabile, "Private Finance"]; Colleen M Flood, Mark Stabile & Carolyn Hughes Tuohy, "The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care" (2002) 12:2 Health Matrix 297 at 351–53 [Flood, Stabile & Tuohy, "Borders of Solidarity"]; Jeffrey Simpson, *Chronic Condition: Why Canada's Health-Care System Needs to be Dragged into the 21st Century* (Toronto: Penguin Canada, 2012) at 224–29; Lauren Vogel, "Medicare on Trial", News, (2014) 186:12 CMAJ 901; Colleen Fuller, "Cambie Corp. Goes to Court: The Legal Assault on Universal Health Care" (2015) Canadian Centre for Policy Alternatives at 11–13, online: <www.policyalternatives.ca/publications/reports/cambie-corp-goes-court>.

[2] See e.g. Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 CMAJ 825 at 828–29; Flood, Stabile & Tuohy, "Borders of Solidarity", *supra* note 1 at 300–01; William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: LexisNexis Canada, 2011) 1 at 46; *Canada Health Act*, RSC 1985, c C-6, ss 2, 9.

[3] See Lahey, *supra* note 2 at 39.

[4] See e.g. Colleen Flood, Mark Stabile & Carolyn Tuohy, "Seeking the Grail: Financing for Quality, Accessibility, and Sustainability in the Health Care System" in Colleen M Flood, Mark Stabile & Carolyn Tuohy, eds, *Exploring So-*

all people are entitled to a given level of services that aim to achieve the same outcomes, and that private funding cannot, or should not, be used to obtain better or quicker outcomes.[5] It is possible for privately operated services to function within a complementary model, either under contract to the public funder or by providing services that are not covered by public funding. For example, a privately owned hospital (such as an incorporated religious institution) might contract with a provincial government to provide public hospital services. A critique of this model, which was expressed in *Chaoulli v Québec (AG)*,[6] is that government should not prevent its citizens from purchasing private medical care if the government cannot provide acceptable and timely access through the public system.[7]

The second broad approach is that public and private funding can, and should, overlap – that the core health services can be funded and delivered either publicly or privately as a two-tier system. For example, the Australian health care system has overlapping public and private funding and service provision. There are a number of arguments that are made to support this approach. For instance, it is argued that a private system may allow enhanced consumer "choice"[8] and that private funding will offer speedier access than public service provision.[9] It is sometimes also claimed that private

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*cial Insurance: Can a Dose of Europe Cure Canadian Health Care Finance?* (Montréal: McGill-Queen's University Press, 2008) 1 at 2–3.

[5] See Lahey, *supra* note 2 at 37; Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa: Health Canada, 2002) at 14, 48, online: Government of Canada <www.publications.gc.ca/site/eng/237274/publication.html>.

[6] 2005 SCC 35, [2005] 1 SCR 791 [*Chaoulli*].

[7] *Ibid* at paras 123–24. See also Lahey, *supra* note 2 at 55.

[8] See e.g. Ian McAuley, "Private Health Insurance and Public Policy" (Paper delivered at the 2016 Health Insurance Summit in Sydney, 28 July 2016) at 7 [unpublished], online: <https://cpd.org.au/wp-content/uploads/2016/07/PHI-conference-July-2016.pdf> [McAuley, "Public Policy"]; Aafke Victoor et al, "Determinants of Patient Choice of Healthcare Providers: A Scoping Review" (2012) 12 BMC Health Serv Res 272 at 273; Omar Paccagnella, Vincenzo Rebba & Guglielmo Weber, "Voluntary Private Health Insurance Among the Over 50s in Europe" (2013) 22 Health Econ 289 at 298.

[9] See e.g. Austl, Commonwealth, Department of Health, "Issues for Consideration at Roundtables on Private Health Insurance - November 2015" (13 November 2015), online: <www.health.gov.au/internet/main/publishing.nsf/

hospitals are more efficient than public hospitals, but the evidence for this claim is weak.[10] Some might believe that private funding could substitute for public funding in that an increase in private funding would reduce the need for public funding.[11] A question may then arise as to whether government should (1) tacitly accept a market for the private funding or delivery of health services[12] or (2) actively try and facilitate, or enable, the growth and continuance of a "strong" or "significant" market for private funding and/or private provision of health services.[13] The Australian government has chosen the latter approach. The overlapping model, particularly the variant where government actively intervenes to support a system for private funding and/or service provision, may raise a series of critical questions about fiscal sustainability, such as whether private financing for private service provision reduces demand on the public system or siphons resources from the public system.[14]

The third broad approach is a preference for a private health insurance (PHI) market to fund the access of individuals to health services, depending on the terms and conditions of their policy. This is the approach that has been adopted in the United States. The government's role is to provide a

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Content/healthcare-provider-roundtable> [Department of Health, "Issues for Consideration"].

[10] See e.g. Yauheniya Varabyova & Jonas Schreyögg, "International Comparisons of the Technical Efficiency of the Hospital Sector: Panel Data Analysis of OECD Countries Using Parametric and Non-Parametric Approaches" (2013) 112 Health Policy 70 at 77. See also Sanjay Basu et al, "Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review" (2012) 9:6 PLoS Med at 10.

[11] See e.g. Stephen J Duckett & Terri J Jackson, "The New Health Insurance Rebate: An Inefficient Way of Assisting Public Hospitals" (2000) 172:9 Med J Austr 439; McAuley, "Public Policy" *supra* note 8 at 5–6.

[12] This is the case in New Zealand, where the government has chosen not to regulate the private health sector or provide tax rebates to incentivize the purchase of private health insurance. See Jacqueline Cumming et al, "New Zealand: Health System Review" (2014) 4:2 Health Syst Transit 1 at 80–81.

[13] In the United Kingdom, for example, the National Health Service is increasingly commissioning services to the private sector. See Séan Boyle, "United Kingdom (England): Health System Review" (2011) 13:1 Health Syst Transit at 113.

[14] See Tuohy, Flood & Stabile, "Private Finance", *supra* note 1 at 391.

safety net to support those who cannot afford to access the PHI market, those for whom the market will not or may not provide insurance coverage, or groups for whom the government has a special responsibility, such as indigenous peoples or military veterans.[15] This model has been extensively critiqued on a number of grounds: it has been considered to be inequitable, to be inefficient, and, on the aggregate, to result in poorer health outcomes.[16]

This article focuses on the second approach. Australia has a two-tier public and private health care system. Australia is unique amongst OECD countries in the extent to which successive federal (Commonwealth of Australia) governments have used their legislative powers, pursuant to the Australian *Constitution*, to enact a comprehensive regulatory framework that encourages citizens to purchase PHI.[17] The government has done this by enacting a series of inducements and penalties designed to persuade people to purchase and renew PHI. Purchase is not mandatory. This article examines how Australian federal governments have used their regulatory powers to encourage the take-up of PHI and, through this, to support the continuance of a strong private sector within the larger two-tier system. This article moreover assesses whether the PHI regulatory framework achieves its policy aims, whether the public perceives this framework as legitimate, and whether it is sustainable. A number of other issues also warrant an-

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[15] See Thomas Rice et al, “United States of America: Health System Review” (2013) 15:3 Health Syst Transit 1 at 31, 44.

[16] See e.g. Karen Davis et al, “Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally” (2014) The Commonwealth Fund at 8–9, online: <www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>; Gerard F Anderson & Bianca K Frogner, “Health Spending In OECD Countries: Obtaining Value Per Dollar” (2008) 27:6 Health Aff 1718 at 1725–26; Ellen Nolte & C Martin McKee, “Measuring the Health of Nations: Updating an Earlier Analysis” (2008) 27:1 Health Aff 58 at 69; Cathy Schoen et al, “U.S. Health System Performance: A National Scorecard”, online: (2006) 25:6 Health Aff w457 <content.healthaffairs.org/content/25/6/w457>.

[17] See generally Adrian Kay, “Tense Layering and Synthetic Policy Paradigms: The Politics of Health Insurance in Australia” (2007) 42:4 Australian J Political Science 579 (for an analysis of the reintroduction of financial subsidy to support private health insurance [PHI] in Australia); Jane Hall, Richard de Abreu Lourenco & Rosalie Viney, “Carrots and Sticks: The Fall and Fall of Private Health Insurance in Australia”, Guest Editorial, (1999) 8:8 Health Economics 653 at 655.

alysis, such as equity, but these are not the focus of this article. This analysis can provide valuable lessons for other countries that are considering systemic reforms to the funding, organization, and regulation of their health care systems and/or are considering creating or intervening in their PHI markets.[18]

This article has three aims: (1) to critically examine the complex regulatory framework that has been created to encourage Australians to purchase PHI, (2) to critically examine some of the impacts of this regulatory framework, (3) and to provide information for other countries about the costs and consequences of the government promoting PHI. In the first Part of this article, we provide a brief overview of Australia's two-tier health care system. In the second Part of the article, we discuss the elements of the regulatory framework designed to "encourage" Australians to purchase PHI. In the last Part, we examine some of the impacts of that framework, noting that there are concerns as to whether the framework achieves its stated ends, whether some PHI products are acceptable to purchasers, and whether the system is sustainable. We conclude with an assessment of the implications for other nations who are examining the role of PHI in health care delivery.

## I. THE AUSTRALIAN HEALTH CARE SYSTEM

Strong opposition to the creation and maintenance of a publicly funded universal health care system has long been a feature of the Australian political landscape at the federal level.[19] Traditionally, the conservative (to the

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[18] See generally Flood, Stabile & Tuohy, "Borders of Solidarity", *supra* note 1.

[19] The Australian Medical Association and many members of the medical profession have shared this opposition, as they see their interests as being "best served by a free enterprise, private practice, fee-for-service model" (George Palmer & Stephanie Short, *Health Care and Public Policy: An Australian Analysis*, 5th ed (South Yarra: Palgrave Macmillan, 2014) at 74). Also opposed were, unsurprisingly, the PHI industry and the private hospitals. See e.g. Stephen Duckett & Sharon Willcox, *The Australian Health Care System*, 5th ed (South Melbourne: Oxford University Press, 2015); Fran Collyer, Kirsten Harley & Stephanie Short, "Money and Markets in Australia's Healthcare System" in Gabrielle Meagher & Susan Goodwin, eds, *Markets, Rights and Power in Australian Social Policy* (Sydney: Sydney University Press, 2015) 257 at 260–61; RB Scotton & CR Macdonald, *The Making of Medibank* (Sydney: School of Health Services Management, University of New South Wales, 1993);

right on the political spectrum) Coalition (the Liberal and National political parties) were strongly committed to a United States style model, where the private sector should provide health services funded by individuals through the purchase of PHI and governments should only provide social safety nets.[20] Historically, the Labor party (to the left on the political spectrum) has supported the development of a publicly funded and delivered health care system (where a parallel private system is allowed) based on an equality argument.[21]

In 1943, the federal (Labor) government sought to introduce a program to subsidize pharmaceuticals.[22] A constitutional referendum in 1946 gave the federal government the power to enact legislation about "pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription)"[23] and in 1948 the Labor government implemented a national pharmaceutical benefits scheme for the universal public subsidy of approved medications.[24] From 1949 to 1960, the

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Anne-marie Boxall & James A Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia* (Sydney: NewSouth Publishing, University of New South Wales Press, 2013); Stephen Duckett, "The Continuing Contest of Values in the Australian Health Care System" in AP den Exter, ed, *International Health Law: Solidarity and Justice in Health Care* (Antwerp, Belg: Maklu, 2008) 177 at 190 [Duckett, "Contest"].

[20] See Michael RL Wooldridge, *Health Policy in the Fraser Years: 1975–83* (MBA Thesis, Monash University Faculty of Economics and Politics, 1991) [unpublished] at 5 [Wooldridge, *Health Policy*]; JA Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910–1960* (Cambridge: Cambridge University Press, 1991) at 253–54.

[21] See E Gough Whitlam, "The Alternative Health Programme" (1968) 3:4 Australian J Social Issues 33. See generally Duckett, "Contest", *supra* note 19.

[22] See Fiona McDonald & Deanna Sedgwick, "The Legal Framework of the Australian Health System" in Ben White, Fiona McDonald & Lindy Willmott, eds, *Health Law in Australia*, 2nd ed (Sydney: Thomson, 2014) 69 at 73.

[23] *Commonwealth of Australia Constitution Act 1900* (Cth), s 51(xxiiiA); *Constitution Alteration (Social Services) 1946*, 28 Sept 1946, online: Parliament of Australia <parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22handbook%2Fnewhandbook%2F2014-10-31%2F0049%22>.

[24] See *Pharmaceutical Benefits Act 1947* (Cth), as repealed by *National Health Act 1953* (Cth), ss 7–8. See also Clyde Sloan, *A History of the Pharmaceutical*

Coalition government (the Liberal and National Parties who are in permanent coalition) maintained a modified safety net model that provided free access to selected pharmaceuticals.[25] The model also granted funding for hospitals to provide safety net services to classes of patients who would be otherwise unable to access health care, and subsidized PHI.[26] Kay has argued that PHI subsidies created a vested interest for the Coalition in a multi-payer financing structure.[27] The Coalition government's approach was extensively criticized on a number of grounds, but most critiques focused on equity and complexity.[28]

A federal Labor government was elected in 1972 promising to create a universal, compulsory, national health insurance scheme (Medibank, a publicly funded health care system). After the dissolution of both Houses of Parliament, a federal election, and a joint sitting of both Houses of Parliament,[29] the *Health Insurance Act 1973* (*HI Act*) was enacted.[30] The *HI Act* established a national, government administered, health insurance program for medical services to be funded from taxation revenue on a fee-for-service model. Using its powers under section 96 of the *Constitution* (the making of conditional grants to the states) the federal government, by agreement with the states and territories, also negotiated the provision of public hospital services without direct patient payment (free public hospital care), including outpatient medical care.[31] People could still choose, if they

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*Benefits Scheme: 1947–1992* (Canberra: Commonwealth Department of Human Services and Health, 1995) at 2–3.

[25] See Duckett & Willcox, *supra* note 19 at 304.

[26] See TH Kewley, *Social Security in Australia 1900–72*, 2nd ed (Sydney: Sydney University Press, 1973) at 355–59; Luke B Connelly et al, "Risk Equalisation and Voluntary Health Insurance Markets: The Case of Australia" (2010) 98:1 Health Policy 3 at 4; Collyer, Harley & Short, *supra* note 19 at 261.

[27] *Supra* note 17 at 582–83.

[28] See Duckett & Willcox, *supra* note 19 at 361–64; Kewley, *supra* note 26 at 504.

[29] See Duckett & Willcox, *supra* note 19 at 361–64.

[30] (Cth) [*HI Act*].

[31] This was most recently done through the Council of Australian Governments: Austl, Commonwealth, Council of Australian Governments, *National Healthcare Agreement 2012: Intergovernmental Agreement on Federal Financial*

could afford it, to purchase PHI and/or to be treated privately by specialists or in private hospitals. In 1975, a newly elected Coalition government began to dismantle Medibank, and it ceased being universal in 1981.[32]

The election of a Labor government in 1983 saw the reintroduction of a national insurance scheme (it was renamed Medicare).[33] Medicare is universal, compulsory, and funded by taxpayers through general taxation revenue and a specific tax (a means-tested Medicare levy currently at 2% of taxable income).[34] It is administered by a federal government agency based on a fee-for-service structure for general medical services[35] and, more recently, for services prescribed by midwives or nurse practitioners[36] and

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*Relations* (Canberra: COAG, 2012), online: Council on Federal Financial Relations <www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf> [COAG, *NHA 2012*], as amended by Austl, Commonwealth, Council of Australian Governments, *Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding* (Canberra: COAG, 2016), online: <https://www.coag.gov.au/sites/default/files/agreements/Heads_of_Agreement_between_the_Commonwealth_and_the_States_on_Public_Hospital_Funding-1April2016.pdf> [COAG, *Agreement on Public Hospital Funding*].

[32] See *Health Acts Amendment Act 1981* (Cth), s 8. See also SJ Duckett, "Chopping and Changing Medibank: Part 1 – Implementation of a New Policy" (1979) 14:3 Australian J Social Issues 230 at 235, 237.

[33] See *Health Legislation Amendment Act 1983* (Cth). See also Palmer & Short, *supra* note 19 at 67.

[34] The levy initially began in 1984 at 1% (*Medicare Levy Act 1984* (Cth), s 6(1)). It was increased to 1.25% in 1986 (*Medicare Levy Act 1986* (Cth), s 11(3)(a)), to 1.4% in 1992 (*Medicare Levy Amendment Act No. 2 1992* (Cth), s 3), to 1.5% in 1995 (*Medicare Levy Amendment Act 1995* (Cth), Schedule 2, ss 1, 7), to 1.7% from 1997–1998 to cover the cost of the gun buyback (*Medicare Levy Amendment Act 1996* (Cth), Schedule 1, ss 1, 3), and in July 2014 it rose to 2% to partially offset the cost of the newly introduced *National Disability Insurance Scheme* (*Medicare Levy Amendment [DisabilityCare Australia] Act 2013* (Cth), Schedule 1, ss 1–3).

[35] See *HI Act*, *supra* note 30, s 4.

[36] See *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010* (Cth), amending the *HI Act*, *supra* note 30.

for some mental health services.[37] Public hospitals, and some other services and programs, are provided to the public for free, pursuant to the Medicare program and the *Agreement on Public Hospital Funding*,[38] which were negotiated between the federal government and the states and territories under the federal government's section 96 constitutional powers to make conditional grants to the states.[39] Included in these services are, for example, outpatient specialist clinics run by private hospitals. The Medicare system and the funding agreements for hospitals fund what might be described as "medically necessary services." They do not fund services such as cosmetic surgery, medical examinations for the purpose of obtaining life insurance, and so on. Doctors, or other providers, with a Medicare billing number (including those who are providing for-profit private services) may bulk bill the government directly for the Medicare scheduled fee, or they may bill the patient directly. If they bill the patient, they may charge more than the scheduled fee. The patient then seeks a refund from the government, and the patient either pays the gap fee from their own pocket or, if their policy covers this, their PHI may pay some or all of the difference. In the 2015 financial year (July 2015 to June 2016), 78.2% of all Medicare scheduled services were bulk billed.[40] However, while 85.1% of general practitioner (i.e., family doctor) consultations were bulk-billed, the levels of bulk billing for private specialists, obstetrics, and surgery were lower at 30.2%, 53.1%,

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[37] See generally Ian Hickie & Grace Groom, "Primary Care-Led Mental Health Service Reform: An Outline of the *Better Outcomes in Mental Health Care* Initiative" (2002) 10:4 Australas Psychiatry 376 at 379; Bridget Bassilios et al, "Achievements of the Australian Access to Allied Psychological Services (ATAPS) Program: Summarising (Almost) a Decade of Key Evaluation Data" (2016) 10:61 Int J Ment Health Syst 1 at 2.

[38] COAG, *NHA 2012*, *supra* note 31; COAG, *Agreement on Public Hospital Funding*, *supra* note 31 at 2.

[39] Hospital funding has been subject to a round of reforms, most notably in 2011. See Duckett & Willcox, *supra* note 19 at 124–26; McDonald & Sedgwick, *supra* note 22 at 77–78.

[40] See Austl, Commonwealth, Medicare Australia, "Quarterly Medicare Statistics" (Canberra: MA, 2015) at Table 1.1a, online: Department of Health <www.health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics>.

and 42.2%.[41] If a service was not bulk-billed, patients had an average out-of-pocket cost of AUD$58 per item.[42] Across all components of the fee schedule in 2015, approximately 19% of services were billed above the Medicare schedule fee.[43]

## II. STRUCTURE OF THE PRIVATE HEALTH INSURANCE REGULATORY FRAMEWORK

But what of PHI and private health care? Prior to the introduction of Medicare in 1983, PHI offered two distinct products: insurance against the cost of treatment in public hospitals and, for a higher premium, in private hospitals.[44] With the introduction of Medicare the first product became otiose. Figure 1 shows the significant reduction in those holding basic coverage for public hospital care after the introduction of Medicare in 1983. PHI uptake for private hospital coverage also began to decline (see Figure 1), especially during the early 1990s when Australia was in recession.[45] Between 1983 and 1996 the Labor government passively allowed PHI to decline.[46]

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[41] *Ibid.*

[42] *Ibid.*

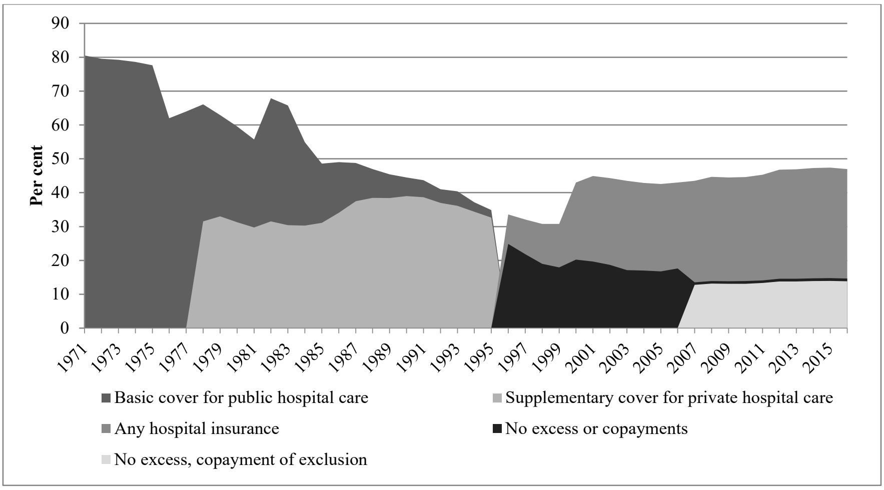
[43] *Ibid.*

[44] There were many offerings, for example single room accommodation in public hospitals. A review of insurance arrangements in 1969 found the offerings "unnecessarily complex and beyond the comprehension of many" (Austl, *Health Insurance: Report of the Commonwealth Committee of Enquiry* by JA Nimmo (Canberra: Commonwealth Government Printing Office, 1969) at 9).

[45] See Sharon Willcox, "Promoting Private Health Insurance in Australia" (2001) 20:3 Health Aff 152 at 155–56; Ian McAuley, "Private Health Insurance: Still Muddling Through" (2005) 12:2 Agenda 159 at 159–60 [McAuley, "Muddling Through"]; Francesca Colombo & Nicole Tapay, "Private Health Insurance in Australia: A Case Study" (2003) OECD Health Working Paper No 8 at para 16; Palmer & Short, *supra* note 19 at 70–71. See also Duckett & Willcox, *supra* note 19 at 80; Collyer, Harley & Short, *supra* note 19 at 263. As to the impact of the recession, see Casey Quinn, "The Pasts and Futures of Private Health Insurance in Australia" (2002) National Centre for Epidemiology and Population Health Working Paper No 47 at 9.

[46] See Duckett & Willcox, *supra* note 19 at 80.

**Figure 1. Percentage of Population with Private Health Insurance, Australia, 1971–2016**[47]



In 1996, the Coalition parties acknowledged the political reality that public support for Medicare was so strong that they needed to support the continuance of a universal national publicly funded health care system.[48] However, the Coalition parties continued to believe that PHI to enable access to private health care is an essential element of a balanced two-tier (public and private) health care system. A two-tier health care system in this view is, and should be, funded and provided by public and private actors.[49]

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[47] Data sourced from Duckett & Willcox, *supra* note 19, Figure 3.14 and updated with data from Austl, Commonwealth, Australian Prudential Regulatory Authority, *Statistics: Private Health Insurance Membership and Benefits* (Sydney: APRA, 2017), online: <www.apra.gov.au/PHI/Publications/Documents/1708-MemBens-20170630.pdf>.

[48] The Coalition is comprised of the National and Liberal parties. The then-Health Minister Wooldridge had studied health policy under the previous Liberal government and had identified the strong public support for Medicare as one reason the Liberals lost elections against Labor in the ensuing period. See Palmer & Short, *supra* note 19. See also Collyer, Harley & Short, *supra* note 19 at 263–64. The current Coalition government, headed by Malcolm Turnbull, has stated that Medicare "is a core Government service" (Jane Norman, "Election 2016: Malcolm Turnbull Says 'Every Element' of Medicare Will Stay in Government Hands", *ABC News* (18 June 2016), online: <www.abc.net.au/news/2016-06-18/medicare-will-never-be-privatised,-turnbull-says/7523242>).

[49] See Willcox, *supra* note 45 at 152.

The former Coalition Prime Minister, Tony Abbott, proudly proclaimed in 2012, while in opposition, that support for PHI was "in the DNA" of the Coalition.[50] Kay argues that the Coalition's platform is in part based on a legacy effect of supporting PHI in preference to what was seen as a socialized health care system supported by Labor. The Coalition traditionally has had deep ties with the PHI industry and the Australian Medical Association (formerly the British Medical Association) (a group deeply opposed to "socialized" medicine and state control over doctors' fees).[51] McAuley also argues that the Coalition is driven by "'private sector primacy' – a belief that if a function *can* be provided in the private sector, even if it could be provided more efficiently in the public sector, then it *should* be provided in the private sector."[52]

In 1996, the newly elected Coalition government focused on the maintenance and support of the PHI industry and, as a consequence, the private hospital sector.[53] The newly appointed Minister of Health, Michael Wooldridge, issued a press statement indicating the importance the government placed on ensuring a public-private balance: "The continuing decline in the number of Australians with PHI is perhaps the single most serious threat to the viability of our entire health care system."[54] This implies that the government considered it vital to the sustainability of the health care system that a strong private health care sector was maintained in parallel to a public one. He subsequently noted, "Australia's very successful universal health care system was predicated on a substantial part of the population having private health coverage."[55] The Minister's speeches on the second reading of the Bills in 1996 and 1998 introducing PHI incentives and sub-

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[50] Michelle Grattan & Mark Metherell, "Abbott Vows to Scrap Health Rebate Means Test", *The Sydney Morning Herald* (16 February 2012), online: <www.smh.com.au/federal-politics/political-news/abbott-vows-to-scrap-health-rebate-means-test-20120215-1t6q0.html>.

[51] See Kay, *supra* note 17 at 585.

[52] McAuley, "Public Policy", *supra* note 8 at 3 [emphasis in the original].

[53] See Colombo & Tapay, *supra* note 45 at para 17.

[54] Michael Wooldridge, Minister for Health and Family Services, Media Release (24 May 1996) [Wooldridge, Media Release], cited in McAuley, "Muddling Through", *supra* note 45 at 160.

[55] John K Iglehart, "An Activist Health Minister in a Conservative Government" (2001) 20:3 Health Aff 146 at 149.

sidies also referred to a belief that PHI would take pressure off public hospitals, preserve consumer choice, restore "balance" between the private and public sectors, and help the private sector (although it is not quite clear why a supposedly free market government would intervene to prop up a private industry).[56]

Between 1996 and 2007 the Coalition government instituted a number of measures to improve the uptake of PHI. These measures, and the current regulatory framework to encourage PHI uptake, are outlined in the following Sections. While income thresholds (see below) were changed by the Labor government (2007–2013), it continued the private health insurance rebate, the Medicare Levy Surcharge, and lifetime cover.[57]

### *A. Insurance*

The federal government has constitutional power under subsection 51(xiv) to regulate insurance.[58] This enables the government to regulate the operations of the private insurance market directly. The PHI market was initially regulated through the *National Health Act 1953*, and is currently directly regulated through the *Private Health Insurance Act 2007* (*PHI Act*).[59] The *PHI Act* "(a) provides incentives to encourage people to have [PHI]; and (b) sets out rules governing [PHI] products."[60] One focus of these rules is to encourage Australians to take out PHI to cover private hospital services in

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[56] Austl, Commonwealth, House of Representatives, *Parliamentary Debates* (13 December 1996) at 8573 [*Debates* 1996], cited in McAuley, "Muddling Through", *supra* note 45 at 166; Austl, Commonwealth, House of Representatives, *Parliamentary Debates* (12 November 1998) at 263 [*Debates* 1998], cited in McAuley, "Muddling Through", *supra* note 45 at 166. See also Duckett & Jackson, *supra* note 11 at 439.

[57] See Duckett & Willcox, *supra* note 19 at 81–82.

[58] Wheelwright has noted that the Commonwealth also has a corporations power under s 51(xx) of the Constitution which could support the regulation of corporations providing PHI or private health services more generally ("Commonwealth and State Powers in Health: A Constitutional Diagnosis" (1995) 21:1 Monash UL Rev 53 at 57, 80).

[59] (Cth) [*PHI Act*].

[60] *Ibid*, ss 3-1(a) to (b).

order to maintain a thriving private hospital sector.[61] Private hospital insurance coverage in Australia may cover all services that are provided by public hospitals in Australia, including accident and emergency care. Some PHI policies allow for certain health services not to be part of the insurance package. For example, a person may choose to purchase PHI that does not cover obstetric services if, because of their gender or age, they may never or no longer need such services. Policies may also cover gaps – for example, for the gap between the Medicare schedule fee (reimbursed by government) and the actual amount charged by the service provider. In order to protect their revenue base by offering policies that might be more attractive to purchasers, PHI plans may also include coverage for extras, such as physiotherapy, chiropractic, optometry, and dental care, and more controversially, unproven natural therapies such as homeopathy. Another policy objective of the reforms was to increase rates of people holding PHI for hospital care so as to reduce pressure on the public system.[62] If a PHI plan providing coverage for both hospitals and extras induced individuals or families to acquire private hospital coverage, it appears that the government was prepared to cross-subsidize the extras in order to achieve this policy objective.[63]

### 1. Community rating

Since 1953, the Coalition government has chosen to intervene in the PHI market to ensure affordable and equal access by requiring PHI companies to offer PHI products to the public on the basis of a

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[61] See *Debates* 1996, *supra* note 56 at 8573, cited in McAuley, "Muddling Through", *supra* note 45 at 166; *Debates* 1998, *supra* note 56 at 263, cited in McAuley, "Muddling Through", *supra* note 45 at 166.

[62] See McAuley, "Muddling Through", *supra* note 45 at 166; *Debates* 1996, *supra* note 56 at 8573, cited in McAuley, "Muddling Through", *supra* note 45 at 166; *Debates* 1998, *supra* note 56 at 263, cited in McAuley, "Muddling Through", *supra* note 45 at 166.

[63] It was only in 2015 that the federal government began to scrutinize whether it should subsidize PHI policies that provide coverage for unproven therapies. See Austl, Commonwealth, Department of Health, *Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance* by Chris Baggoley AO (Canberra: Department of Health, 2015), online: <www.health.gov.au/internet/main/publishing.nsf/content/phi-natural-therapies> [Department of Health, Baggoley Review].

community rating.[64] This means that PHI companies cannot stratify the price of their products on the basis of an individual risk assessment. The *PHI Act* requires that they do not price discriminate on the basis of health status, gender, age (except in relation to the lifetime health cover provisions), and other specified grounds.[65] This is said to act as an inducement for those who are older or have health-related issues to purchase PHI, but it may act as a disincentive for those who are younger as they are in effect subsidizing people with increased health needs.[66]

### 2. Reductions in premiums

In 1998, the federal government began offering incentives for persons to take out PHI hospital coverage in the form of a premium reduction scheme.[67] Individuals or families may be eligible for a premium reduction if they take out approved PHI hospital coverage. The *PHI Act* provides a sliding scale of subsidies currently at 25.93% for those under 65 years of age, 30.26% for those 65–69 years of age, and 34.58% for those 70 years and older.[68] The subsidy rate is adjusted annually[69] in an attempt to moderate the rate of growth of government outlays on PHI.[70] The subsidy is also means-tested. For example, for a single person the subsidy is reduced by about 10% if one earns over AUD$90,000, 20% if one earns over AUD$105,000, and

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[64] See *PHI Act*, *supra* note 59, s 55-1. Early community rating schemes in the *National Health Act 1953*, *supra* note 24, prevented private health insurers from declining coverage but limitations based on risk profile could still be imposed. See also Connelly et al, *supra* note 26 at 4; Willcox, *supra* note 45 at 157.

[65] *PHI Act*, *supra* note 59, ss 55-5(2)(a) to (h).

[66] See McAuley, "Muddling Through", *supra* note 45 at 160, 164.

[67] Initially in the *Private Insurance Incentives Act 1998* (Cth); now in the *PHI Act*, *supra* note 59, s 20-1.

[68] Austl, Commonwealth, Private Health Insurance Ombudsman, "Australian Government Private Health Insurance Rebate" (2017), online: <www.privatehealth.gov.au/healthinsurance/incentivessurcharges/insurancerebate.htm> (subsidy rates applicable from 1 April 2017–31 March 2018).

[69] *PHI Act*, *supra* note 59, ss 22-15(5A) to (5E), 22-30 to 22-45; *Tax Laws Amendment Act (Medicare Levy Surcharge Thresholds) Act (No 2) 2008* (Cth), Schedule 1, ss 2, 7.

[70] See McAuley, "Public Policy" *supra* note 8 at 3.

completely eliminated if one earns more than AUD$140,000.[71] The premium reduction also applies if people take out hospital and extra (ancillary services) coverage. Despite the generosity of the subsidy, it appears to have only had a relatively small upwards impact on PHI coverage.[72]

### 3. Lifetime health cover scheme

A further way in which the federal government, from 2000, has strongly encouraged the uptake of PHI is through the imposition of higher premiums on persons who do not have PHI hospital coverage from an early age[73] thus in effect penalizing those who delay getting private health insurance. This part of the *PHI Act* states that PHI companies must increase the premiums to be paid by individuals if those persons have not taken out PHI hospital coverage by age 30[74] or cease to hold PHI hospital coverage for a period when they are over 30 years of age.[75] This initiative led to a significant

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[71] See *PHI Act*, *supra* note 59, ss 22-15(2) to (4), 22-35; Austl, Commonwealth, Australian Taxation Office, "Income Thresholds and Rates for the Private Health Insurance Rebate" (29 June 2017), online: <www.ato.gov.au/Individuals/Medicare-levy/Private-health-insurance-rebate/Income-thresholds-and-rates-for-the-private-health-insurance-rebate>. For example, the subsidy for a single person aged under 65 with an income less than $90,000 is 25.93% but declines to 17.9% (8.65 percentage points, rounded to 10%) for a person with income in the range $90,001 to $150,000.

[72] See James RG Butler, "Policy Change and Private Health Insurance: Did the Cheapest Policy Do the Trick?" (2002) 25:6 Aust Health Rev 33 at 37. See also Austl, Commonwealth, *Senate Economics Legislation Committee – Inquiry into the Fairer Private Health Insurance Incentives Bills: Submission to Senate Committee* by John Deeble (Canberra: Senate Economics Legislation Committee, 2009) at 3, online: <www.aph.gov.au/~/media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/fairer_private_health_09/submissions/sub06_pdf.ashx>; Hall, Lourenco & Viney, *supra* note 17 at 659; Willcox, *supra* note 45 at 155–56, Rachael Elizabeth Moorin & Cashel D'Arcy J Holman, "Does Federal Health Care Policy Influence Switching Between the Public and Private Sectors in Individuals?" (2006) 79:2 Health Policy 284 at 293.

[73] See *PHI Act*, *supra* note 59, s 31-1.

[74] *Ibid*, s 34-1.

[75] *Ibid*, s 34-5.

increase in coverage from around 30% to around 45% of the population, with most of the increase being in less expensive products with deductibles or exclusions (see Figure 1).[76] This increase following the institution of lifetime cover and the uptake of less expensive policies that did not provide full coverage suggests that consumers acted strategically to avoid the financial impacts of this regulatory change.[77] It does not suggest that consumers wanted or preferred private coverage, as the products themselves did not change.

### *B. Taxation*

The taxation power in subsection 51(ii) of the Constitution supports the imposition of levies and the creation of tax incentives.[78] In addition to the 2% of taxable income levy paid by most Australian taxpayers to fund the Medicare system, since 1997, the government has used its taxation powers to impose an income tested additional levy (up to 1–1.5% of taxable income), the Medicare Surcharge, on individuals who do not have PHI hospital coverage.[79] This penalizes those individuals who choose not to purchase PHI hospital cover. The fact that this penalty exists also creates an incentive for people to purchase PHI to avoid the additional tax, but appears to only have a marginal effect on take-up.[80]

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[76] See also Butler, *supra* note 72 at 36, 38. Policies with exclusions have increased from less than 5% of policies in 2003 to over 30% in 2015. See Austl, Commonwealth, Private Health Insurance Administration Council, *Risk Sharing in the Australian Private Health Insurance Market* (Canberra: PHIAC, 2015) at 11, online: Australian Prudential Regulation Authority <www.apra.gov.au/PHI/PHIAC-Archive/Documents/Risk-Sharing_June-2015.pdf>.

[77] See Duckett & Willcox, *supra* note 19 at 81–82.

[78] *Supra* note 23.

[79] See *Medicare Levy Act 1986*, *supra* note 34, ss 6, 8B–8G.

[80] See Andrew Johnston & Kerrie Sadiq, “Incentivising Private Health Insurance through the Income Tax Regime: Capitalising on Behavioural Models” (2011) 26:4 Australian Tax Forum 633 at 641; Olena Stavrunova & Oleg Yerokhin, “Tax Incentives and the Demand for Private Health Insurance” (2014) 34:1 J Health Econ 121 at 124. The legislation also requires that the insurance coverage does not come with too high an excess, also known as a co-payment. See *Medicare Levy Act 1986*, *supra* note 34, ss 3(5)–(7).

### *C. Medicare*

The federal government has also used subsection 51(xxiiiA) of the Constitution[81] to provide indirect subsidies to the PHI system by subsidizing the medical services to private in-patients. Medicare pays 75% of the Medicare scheduled fee for patients who are hospitalized or who are receiving hospital-substitute treatment,[82] including for those persons with PHI hospital coverage.[83] This means that PHIs are only paying the gap between the cost of the medical consultation or procedure, and the amount that is being reimbursed under the Medicare scheme (less, of course, any excess,[84] coverage cap, or coverage limitation).[85] In short, the government is subsidizing the operating costs of PHI.

## III. IMPACT OF THE PRIVATE HEALTH INSURANCE REGULATORY FRAMEWORK

This section assesses the impact of the PHI in respect of whether it achieved the stated policy objectives, the perceived legitimacy or acceptability of the PHI regulatory framework, and its impact on the sustainability of the health care system.

### *A. Achieving policy objectives*

Did the PHI regulatory framework, outlined in the previous Section, achieve its primary stated purpose to avert the decline in the numbers of Australians with PHI hospital coverage? In short, at first glance, yes it did. Figure 1 illustrates the expected decline in coverage from the introduction of Medicare in 1983. Figure 1 also shows the decline in coverage for private hospital care from the early 1990s. This decline was reversed when the

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[81] *Supra* note 23.

[82] Defined in the *PHI Act* as "general treatment that ... substitutes for an episode of hospital treatment" (*supra* note 59, s 69-10(a)).

[83] See *HI Act*, *supra* note 30, s 10(2).

[84] Some policies are purchased with an excess, also known as a co-payment, e.g., the first AUD$1,000.00 must be paid by the policyholder.

[85] Some policies have a coverage cap or limitation, e.g., policyholders may only claim AUD$25,000 per year for cancer treatment, etc.

PHI regulatory framework was revised in late 1996 with a sharp increase in coverage after the introduction of lifetime health cover in 2000. However, amongst the 11.3 million Australians covered by hospital insurance in September 2015, 4.0 million had products which did not cover certain procedures ("exclusionary policies") and, of the balance, 5.6 million had to pay an excess, or co-payment, if they claimed on their insurance.[86] This means, as Figure 1 illustrates, that only 11% of those with insurance had first-dollar coverage for any hospitalization. This suggests that the combinations of "carrots and sticks," which has been used to characterize Australian health insurance policy,[87] has resulted in many people purchasing cheaper and less comprehensive PHI plans solely to avoid tax or future premium increase penalties, rather than basing purchase decisions on the actual product or their personal need for coverage.[88] PHI arguably does give patients a choice as to their preferred health provider. However, as McAuley notes, people tend to rely on expert opinion in making these choices – in this context, general practitioners refer their patients to a specialist.[89]

One of the policy rationales supporting a strong PHI sector in Australia has been the idea that a strong private health sector can reduce demand on the public system. Did the regulatory framework achieve its goal of reducing public hospital utilization? This is a complex question as many factors impact utilization, including population change and demand-related factors, so what follows is at best indicative. As the public hospital system in Australia is free at point of use, many people with PHI still seek treatment in public hospitals, especially for emergencies and complex care. The big increase in PHI occurred with the introduction of lifetime cover, with the increase largely occurring in exclusionary policies or policies with no payment requirements (or both) (see Figure 1). This probably explains why there was little impact on public hospital utilization associated with the increase in the proportion of the population covered by PHI.[90] After all, there is little

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[86] See Australian Prudential Regulation Authority, *supra* note 47 at 2.

[87] See Hall, Lourenco & Viney, *supra* note 17.

[88] See Duckett & Willcox, *supra* note 19 at 82.

[89] McAuley, "Public Policy", *supra* note 8 at 7.

[90] See Kate Brameld, D'Arcy Holman & Rachael Moorin, "Possession of Health Insurance in Australia: How Does it Affect Hospital Use and Outcomes?" (2006) 11:2 J Health Serv Res Policy 94 at 97; Moorin & Holman, *supra* note 72 at 284; Rachael Elizabeth Moorin & Cashel D'Arcy James Holman, "Modelling Changes in the Determinants of PHI Utilisation in Western Australia

incentive for people with PHI to use private hospitals if they will have to make a significant copayment to supplement their PHI coverage, especially if they can receive the surgery free of cost in a reasonably timely way in the public hospital system.[91] People with PHI have subsidized access to private specialists (generally with minimal wait times) to jump the "hidden" wait list (there is no public data about the length of wait time for these services) for publicly funded outpatient appointments for surgical assessment. There also may be no incentive if the quality of the treatment is as good, or better, than would be received privately.

Another justification was to reduce wait times in the public hospital sector, but this too is difficult to assess due to complex causation. Most countries with public health care systems are confronting issues concerning the management of wait times and there have been legal cases challenging governmental approaches in several countries, including Canada.[92] McAuley argues that the assumption that higher rates of private hospital usage would relieve public hospitals was flawed as it considered only demand side factors.[93] However, supply side factors suggest that resources will go where the

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across Five Health Care Policy Eras between 1981 and 2001" (2007) 81:2 Health Policy 183 at 188; McAuley, "Muddling Through", *supra* note 45 at 167–68; Stephen J Duckett, "Private Care and Public Waiting" (2005) 29:1 Aust Health Rev 87 at 92 [Duckett, "Private Care"].

[91] See McAuley, "Public Policy", *supra* note 8 at 11.

[92] *Chaoulli*, *supra* note 6, challenged Québec's Medicare system by arguing that wait times were unreasonable. Currently, another case is before the Supreme Court of British Columbia, challenging the ban on private insurance by arguing that the ban violates patients' constitutional rights as they must endure long wait times in the public system. See Geordon Omand, "Landmark Private Health Care Lawsuit Heads to Court", *CBC News* (5 September 2016), online: <www.cbc.ca/news/canada/british-columbia/landmark-private-health-care-lawsuit-heads-to-court-1.3749117>. See also Colleen M Flood, "Canada's Approach to the Public/Private Divide and the Perils of Reform via Court Challenge" (2012) 8:2 Public Policy Rev 191 at 196–98. A case was brought before the Court of Justice of the European Communities, for instance, in which the applicant sought reimbursement for the cost of hip replacement surgery received in France. The applicant sought the surgery in France after having been put on a long waiting list in England. See *R (on application of Yvonne Watts) v Bedford Primary Care Trust and Secretary of State for Health*, C-372/04, [2006] ECR I-4376).

[93] McAuley, "Public Policy", *supra* note 8 at 6.

money is.[94] Research indicates that when medical practitioners allocate more hours of work to the private sector, the number of hours they are available to work in the public sector decreases.[95] While PHI may reduce wait times for individuals who hold PHI, McAuley argues that PHI re-assigns queues for services on the basis of ability to purchase a PHI policy rather than on the basis of clinical need.[96] There is no evidence that the increase in the insured population has led to a reduction in public sector waiting times. Research from 2015 indicated that a higher proportion of private admissions to hospital is associated with higher public hospital waiting times, not lower.[97] Despite the PHI regulatory framework being in place since 2000, in 2009, the federal government entered into an agreement to provide the states and territories with additional funding to manage elective surgery wait times in the public system,[98] which implies that wait times continued to be a problem – even nearly ten years later – and may still be a problem.[99] It seems

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[94] See *ibid*.

[95] See e.g. Terence Chai Cheng, Guyonne Kalb & Anthony Scott, "Public, Private or Both? Analysing Factors Influencing the Labour Supply of Medical Specialists" (2013) Melbourne Institute of Applied Economic and Social Research Working Paper No 40/13 at 16, online: <www.melbourneinstitute.com/downloads/working_paper_series/wp2013n40.pdf>; McAuley, "Muddling Through", *supra* note 45 at 168.

[96] McAuley, "Public Policy", *supra* note 8 at 6.

[97] See Duckett, "Private Care", *supra* note 90 at 92.

[98] Austl, Commonwealth, Council of Australian Governments, *National Partnership Agreement on Elective Surgery Waiting List Reduction Plan* (Canberra: COAG, 2009), online: Council on Federal Financial Relations <www.federalfinancialrelations.gov.au/content/npa/health/national-partnership/past/elective-surgery-waiting-lists-NP.pdf>.

[99] See Gary L Freed, Erin Turbitt & Amy Allen, "Public or Private Care: Where do Specialists Spend their Time?" (2017) Aust Health Rev [forthcoming]; Carla Saunders & David J Carter, "Right Care, Right Place, Right Time: Improving the Timeliness of Health Care in New South Wales through a Public–Private Hospital Partnership", Aust Health Rev [forthcoming]; Chris Johnson, "Public Hospitals Report Card Fail Due to Funding", *Australian Medicine* (3 Mar 2017) at 3–4, online: Australian Medical Association <https://www.ama.com.au/ausmed/public-hospitals-report-card-fail-due-funding>; Austl, Commonwealth, Australian Institute of Health and Welfare, *Elective Surgery Waiting Times 2015–2016: Australian Hospital Statistics*, Health Services Series No 73 (Canberra: AIHW, 2016), online: <https://www.aihw.gov.au/reports-statistics>.

clear that there are continuing questions about the impact of PHI on wait times in public hospitals.

### *B. Legitimacy or acceptability*

A key element of health policy evaluation is the perceived "legitimacy"[100] or "acceptability" of the policy to the public.[101] A recent media release by the Coalition acknowledges that many Australians are frustrated with the PHI system for a variety of reasons. One such reason is that despite the tax benefits that accrue, premiums are rising rapidly and policies are becoming less affordable.[102] The Australian Competition and Consumer Commission (ACCC) and the PHI Ombudsman argue that the market failures in the PHI industry are due to the asymmetric and imperfect information provided to purchasers.[103] These asymmetries result in the market for PHI being unduly complex. This may reduce a purchaser's ability to compare policies and make informed choices about their PHI needs. The ACCC also suggested that the current regulatory framework for PHI can change consumers' incentives when purchasing PHI.[104] Rather than purchasing

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[100] See Lester M Salamon, "The New Governance and the Tools of Public Action: An Introduction" in Lester M Salamon, ed, *The Tools of Government: A Guide to the New Governance* (New York: Oxford University Press, 2002) 1 at 24.

[101] See Duckett & Willcox, *supra* note 19 at 368–69.

[102] Liberal Party of Australia, Media Release, "Coalition's Plan to Ensure Private Health Insurance Delivers Value for Money" (12 June 2016), online: <www.liberal.org.au/latest-news/2016/06/12/coalitions-plan-ensure-private-health-insurance-delivers-value-money> [Liberal Party of Australia].

[103] The term asymmetric means that one party will know more than another. In this case, an insurer will know much more about health insurance and consumer law, as well as hidden terms in contracts, than the average purchaser. See Austl, Commonwealth, Australian Competition and Consumer Commission, *Information and Informed Decision-Making: A Report to the Australian Senate on Anti-Competitive and other Practices by Health Insurers and Providers in Relation to Private Health Insurance* (Canberra: ACCC, 2014) at 1, online: <www.accc.gov.au/system/files/981_Private%20Health%20Report_2013-14_web%20FA.pdf> [ACCC]; Austl, Commonwealth, Private Health Insurance Ombudsman, *Private Health Insurance Ombudsman 2013–2014 Annual Report* (Sydney: PHIO, 2014) at 29, online: <www.ombudsman.gov.au/__data/assets/pdf_file/0027/29295/PHIO-Annual-Report-2014.pdf>.

[104] ACCC, *supra* note 103 at 39.

the best product to meet their health needs, consumers may purchase a product primarily to reduce their tax liabilities.[105] Some PHI companies market products by highlighting tax minimization benefits.[106] As a consequence of the complexity associated with PHI plans, purchasers may be unpleasantly surprised by the policy limitations they experience when they make a claim, resulting in them being dissatisfied with the PHI system.[107] This was acknowledged by the federal government when it announced a 2016 review of PHI.[108]

Issues of equity have also been indirectly raised in the context of the PHI review.[109] The Department of Health's paper identifying issues for consultation noted that rural Australians raise questions about the purpose of having PHI when they cannot easily access these services.[110] Putting in place a regulatory framework that strongly "encourages" people to purchase PHI and penalizes those who do not assumes that these policies offer some benefit to all those who hold them. If some people cannot easily access any benefit from their PHI policy this raises equity concerns. That public discontent threatens the ongoing acceptability and legitimacy of the PHI regulatory framework was implicitly acknowledged by the current Coalition government when it announced purchaser focused reforms to: (1) simplify and standardize policies, (2) weed out junk policies by requiring a mandated minimum level of coverage, and (3) address the needs of rural Australians.[111] The lesson seems to be that if a government intends to use regulation to encourage its citizens to purchase a product, it also needs to pay attention to the quality and usability of that product to ensure continuing public acceptance of the regulatory framework.

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[105] See *ibid*.

[106] See *ibid*.

[107] See *ibid* at 2.

[108] Austl, Commonwealth, Department of Health, "Private Health Insurance Consultations: Scope of Consultations" (3 December 2015), online: <www.health.gov.au/internet/main/publishing.nsf/content/phi-consultations-scope> [Department of Health, "PHI Consultations"].

[109] *Ibid*.

[110] Department of Health, "Issues for Consideration", *supra* note 9.

[111] Liberal Party of Australia, *supra* note 102.

### C. Sustainability

Fiscal sustainability is the ability of a government to sustain its current spending and its policies in the long term.[112] It is another criterion against which policy can be assessed. The concept of sustainability drives much discussion about health care system reform in Australia[113] given that it is faced both with rising costs and fiscal constraints. The expectation is that Australian governments will continue to provide high quality, universal, and affordable health care.[114] The entire design of the system is under consideration. While the uptake of PHI is slowly increasing, the cost to the government of the subsidy is also increasing. However, the direct and indirect cost of PHI has not been subject to economic scrutiny of the sort applied in other areas.[115] The federal government subsidy for PHI is expected to grow 7% in real terms over the period 2015–2016 to 2018–2019.[116] When one consid-

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[112] See OECD, "Government at a Glance 2013", (OECD Publishing, 2013) at 50, online: <www.dx.doi.org/10.1787/gov_glance-2013-11-en>.

[113] See e.g. Department of Health, "Issues for Consideration", *supra* note 9; Austl, Commonwealth, Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper: Roles and Responsibilities in Health*, Issues Paper No 3 (Canberra: Commonwealth of Australia, 2014) at 3, online: Analysis & Policy Observatory <apo.org.au/system/files/56123/apo-nid56123-53961.pdf> [Department of the Prime Minister and Cabinet, *Roles and Responsibilities*]; Austl, Tasmania, Department of Health and Human Services, *Delivering Safe and Sustainable Clinical Services: Sustainability and the Tasmanian Health System*, Supplement No 1 (Tasmania: Department of Health and Human Services, 2014) at 3, online: <www.dhhs.tas.gov.au/__data/assets/pdf_file/0007/179053/OHS-OP01-Sustainability_vF_141208.pdf>; "Executive Summary" in Committee for Economic Development of Australia, *Healthcare: Reform or Ration* (Melbourne: CEDA, 2013) 6 at 6, online: <www.ceda.com.au/CEDA/media/ResearchCatalogueDocuments/PDFs/15366-healthcarefinal1.pdf>.

[114] See Department of the Prime Minister and Cabinet, *Roles and Responsibilities*, *supra* note 112 at 3.

[115] See McAuley, "Public Policy", *supra* note 8 at 4.

[116] See Stephen Duckett, "Aged and Confused: Why the Private Health Insurance Industry is Ripe for Reform", *The Conversation* (10 November 2015), online: <https://theconversation.com/aged-and-confused-why-the-private-health-insurance-industry-is-ripe-for-reform-50384> [Duckett, "Aged and Confused"]; Austl, Commonwealth, *Budget 2015–16: Budget Strategy and Outlook*, Budget Paper No 1 (2015) at 5-13, 5-23, online: <www.budget.gov.au/2015-16/content/bp1/download/Budget_Paper_No_1.pdf> [Austl, *Budget 2015-16*].

ers that federal government health spending growth is 3.2% overall, and its spending on public hospitals is expected to grow at 6.7% from the years 2015–2016 to 2018–2019,[117] the rate of the growth in the PHI subsidy gives cause for concern about whether it is an effective use of taxpayers' funds[118] and whether it is sustainable.[119]

Questions have long been raised about whether it is still desirable to have government directly supporting PHI, or if it would be more cost-efficient to directly subsidize private health care providers, especially private hospitals.[120] In 2005, of the AUD$6.8 billion that was paid to the PHI companies, only AUD$3.6 billion went to private hospitals, the rest went to private specialists and providers of ancillary services. This expenditure was supported by AUD$2.3 billion of public expenditure.[121] The administrative costs are also high as the funds pass through an intermediary. About 85 cents in the dollar funds health services compared to around 95 cents when funded through Medicare.[122] Additionally, Duckett has noted that government advisors believe that the efficiencies gained in the publicly funded health care system through the introduction of activity-based funding models could also be achieved in the private sector.[123] This was canvassed by the government in a recent report.[124] However, in order to achieve this, direct

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[117] Duckett, "Aged and Confused", *supra* note 116; Austl, *Budget 2015-16*, *supra* note 116 at 5-23.

[118] See McAuley, "Muddling Though", *supra* note 45.

[119] See Department of Health, "PHI Consultations", *supra* note 108.

[120] See e.g. McAuley, "Muddling Though", *supra* note 45 at 167; Rhema Vaithianathan, "Will Subsidising Private Health Insurance Help the Public Health System?" (2002) 78:242 The Economic Record 277.

[121] McAuley, "Muddling Through", *supra* note 45 at 167.

[122] McAuley, "Public Policy" *supra* note 8 at 5.

[123] Stephan Duckett, "Health in 2016: A Cheat Sheet On Hospitals, Medicare and Private Health Insurance Reform" *The Conversation* (31 January 2016), online: <www.theconversation.com/health-in-2016-a-cheat-sheet-on-hospitals-medicare-and-private-health-insurance-reform-53868>, citing Austl, Commonwealth, *Efficiency in Health: Productivity Commission Research Paper*, (Canberra: Productivity Commission, 2015), online: <www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf>.

[124] Austl, Commonwealth, Department of the Prime Minister and Cabinet, *Reform of the Federation: Discussion Paper 2015* (Canberra: Commonwealth of

subsidies to private hospitals or to private health providers would be required and, presumably, this would require an end to, or at least a curtailing of, subsidies to the PHI industry.

The breadth of the rebate is also of concern. In the 2012–2013 budget, the federal government announced a review of the Australian government rebate on PHI for natural therapies (the Baggoley Review), such as homeopathy and naturopathy, which are covered by some PHI plans.[125] This review was prompted by a concern about the appropriateness of having taxpayers subsidize services where there is no evidence to support their clinical efficacy and no, or minimal, evidence of actually improving health outcomes – rather than funding services that have been demonstrated to be clinically effective. By subsidizing such "therapies," the government could also be implicitly sending a message that these therapies are actually credible which, if there is evidence to the contrary, may be inconsistent with the government's duties to its citizens. The Baggoley Review suggests that rebates will be paid only if the Chief Medical Officer for the Commonwealth of Australia finds clear evidence that the specified natural therapies are clinically effective.[126]

## CONCLUSION

It is clear that for the foreseeable future Australia will retain an overlapping system of public and private provision of health services. The federal Department of Health has noted: "The Government is committed to ensuring consumers can access affordable, quality and timely health services through [PHI] alongside universal access to Medicare."[127] This indicates the government's continuing commitment to a public–private system. The question is therefore whether Australia will continue to actively subsidize and incentivize Australians to purchase PHI. The current PHI regulatory framework was introduced only when the creation of Australia's public health care system in 1983 saw rates of PHI coverage

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Australia, 2015) at 37–38, online: Analysis & Policy Observatory <apo.org.au/node/55457>.

[125] Department of Health, Baggoley Review, *supra* note 63.

[126] *Ibid* at 3.

[127] Department of Health, "PHI Consultations", *supra* note 108.

decline.[128] This implies that the Australian public health care system was so satisfactory that some Australians began to believe that PHI was no longer required. To change that perception the government had to intervene in the market and incrementally develop a series of incentives and penalties embedded in law to encourage people to purchase PHI coverage.

The PHI regulatory framework has been a success, if success is measured only in terms of there being a reversal of the decline in the numbers of persons with PHI. The government claimed that the scheme would increase choice for those who hold PHI, and this is probably so. But claims that the PHI framework would reduce public hospital utilization and reduce workloads are more difficult to assess, because there are many variables at play. It does not appear on the face of the limited evidence that the revised PHI regulatory framework has had a significant impact on either utilization or wait times. The limited evidence also suggests that the cost of direct and indirect subsidization of PHI may be rising, and in an environment where it is claimed that costs need to be contained, subsidization may be fiscally unsustainable. It is also an oddity that in a country that is committed to reducing industry protectionism and supporting free markets, the PHI industry is supported to such an extent by taxpayers. If government wants to sustain a private health sector, it might be more efficient to directly pay hospitals to provide services, as this will reduce the cost of the overhead of corporate actors in the insurance industry. It also appears that the legitimacy or acceptability of the PHI regulatory framework, in the eyes of the Australian public, has come to be increasingly questioned due to affordability concerns, a lack of clarity around policy inclusions, "junk" policies, and questions about the fairness of being encouraged by government to purchase a product that is difficult to use when one lives in some rural areas.

What lessons should be learnt from the Australian experience by other countries who may be contemplating moving to a two-tier system, or within a two-tier system contemplating intervening in PHI markets? If a country does desire to intervene in the PHI market, it needs to consider acceptability/legitimacy, and sustainability. First, it will need to either work with the industry, or regulate to ensure that PHI products provide value for money, are usable, and are affordable, and thus to ensure that the regulatory framework continues to be perceived as acceptable by the public. Second, thought should be given to the scope of services within PHI products that should be subsidized by government. The arguments against subsidizing products that

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[128] See Wooldridge, Media Release, *supra* note 54, cited in McAuley, "Muddling Through", *supra* note 45 at 160.

reimburse policyholders for accessing unproven natural therapies appear to be strong. Indeed, a government has an obligation to use taxpayers' funds wisely, and does not have an obligation to enable its citizens to access any product or service that they desire. Some may argue that if the purpose of the intervention is to reduce public hospital utilization, then only private hospital coverage should be subsidized. Others might argue that a broader extension of coverage to ancillary services (those with a strong evidence base) may prevent people from subsequently accessing hospital services.

There are larger questions about whether government intervention in a PHI market is desirable. Why should government support an industry, such as the PHI industry, if it is no longer viable, or not as profitable, in changed market conditions? The private sector would not disappear if the PHI regulatory framework were removed. Some Australians would presumably continue to purchase PHI. Many services would continue to be provided by the private sector and would continue to be purchased by Australians. Australian state and territory governments have the option to purchase private hospital services (which they currently do through workplace insurance coverage schemes), as does the Commonwealth government (through the Department of Veteran's Affairs). Additionally, there are some obvious concerns about the costs and effectiveness of the PHI regulatory framework. A nation contemplating directly supporting the PHI industry would do well to take the step that Australia has not yet taken: to undertake a full and open inquiry into the direct and indirect costs of a PHI regulatory framework, and the costs of other options, such as direct payment of private hospitals or additional funding to the public health care system, to inform public debate.

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# Why Canada's Medical Assistance in Dying Legislation Should Be *C(h)arter* Compliant and What It May Help to Avoid

*Trudo Lemmens, Heesoo Kim & Elizabeth Kurz**

In 2015, the Supreme Court of Canada in *Carter v Canada (AG)* (*Carter*) invalidated the absolute prohibition on medical assistance in dying (MAID), while nevertheless reaffirming the validity in principle of a more limited criminal law-based prohibition. Federal legislation enacted in 2016 provides access to MAID to competent

En 2015, la Cour sûpreme du Canada dans *Carter c Canada (PG)* (*Carter*) a invalidé la prohibition absolue sur l'aide médicale à mourir (AMM), tout en réaffirmant la validité en principe d'une prohibition criminelle plus limitée. La législation fédérale promulguée en 2016 permet l'accès à l'AMM aux adultes compétents qui ont des problènes

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adults who have a grievous and irremediable medical condition that causes enduring and intolerable suffering, but it balances this access with restrictions aimed at the realization of several broad goals and values: the protection against errors and abuse; the equal value of every person's life and the avoidance of negative perceptions of the quality of life of persons who are elderly, ill, or disabled; the prevention of suicide; and the protection of vulnerable people. Access is therefore restricted to people whose natural death is "reasonably foreseeable" and whose "capabilities" are irreversibly declining. Several commentators have criticized the law for being inconsistent with *Carter* and for violating the *Canadian Charter of Rights and Freedoms* (*Charter*) and the law is already being challenged in court. In this article, we argue that the federal legislation constitutes a proper response to *Carter*, in that it respects *Carter* as well as the *Charter*.

The first Part of the article discusses in detail the largely ignored restrictive, and at times contradictory, nature of the *Carter* trial and Supreme Court decisions, the discussion of the evidence, the subsequent public and parliamentary debates, the introduction of the legislation, and some problematic interpretations that have since been put forward. The second Part of the article looks at serious problems that are increasingly identified in Belgium, which has been hailed by some as a good model for MAID regulation. It highlights how a Belgian-style regime, which provides broad access to MAID outside of the end-of-life context and relies mostly on physician evaluations and post factum reporting as safeguards, risks undermining the legitimate goals and values of the federal legislation. The article concludes with recommendations to keep the current end-of-life restrictions in place, to introduce a meaningful reporting system, and to provide proper guidance for the interpretation of the end-of-life restrictions.

de santé graves et irrémédiables leur causant des souffrances persistantes et intolérables, mais elle balance cet accès avec des restrictions visant la réalisation de plusieurs grands objectifs et valeurs : la protection contre les erreurs et l'abus; la valeur égale de la vie de chaque personne et l'évitement des perceptions négatives de la qualité de vie des personnes qui sont âgées, malades, ou handicapées; la prévention du suicide; et la protection des personnes vulnérables. L'accès est donc limité aux personnes dont la mort naturelle est « raisonnablement prévisible » et dont les « capacités » sont irréversiblement en déclin. Plusieurs commentateurs ont critiqué la loi pour son incohérence par rapport à *Carter* et pour sa violation de la *Charte canadienne des droits et libertés* (*Charte*), et la loi est déjà contestée en cour. Dans cet article, nous soutenons que la législation fédérale constitue une réponse appropriée à *Carter*, en ce qu'il respecte *Carter* ainsi que la *Charte*.

La première Partie de cet article discute en détail la nature restrictive largement ignorée, et parfois contradictoire, des décisions *Carter* en première instance et en Cour sûpreme, la discussion de la preuve, les débats publics et parlementaires subséquents, l'introduction de la législation, et quelques interprétations problématiques qui ont depuis été mises de l'avant. La deuxième Partie de cet article examine les problèmes sérieux qui sont de plus en plus identifiés en Belgique, qui a été louangé comme modèle de la réglementation de l'AMM. Il souligne qu'un régime à la belge, qui permet un large accès à l'AMM en dehors du contexte de fin de vie et repose principalement sur les évaluations du médecin et les rapports post factum comme sauvegardes, risque de saper les buts et valeurs légitimes de la législation fédérale. L'article conclue avec des recommandations pour garder en place les restrictions de fin de vie de actuelles, pour introduire un système de reportage significatif, et pour fournir des directives appropriées pour l'interprétation des restrictions de fin de vie.

## INTRODUCTION

On 6 February 2015, the Supreme Court of Canada ruled in *Carter v Canada (AG)* (*Carter* SCC) that sections 14 and 214(b) of the *Criminal Code* unjustifiably infringe section 7 of the *Canadian Charter of Rights and Freedoms* (*Charter*), to the extent that they prohibit medical assistance in dying (MAID) for

> a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition … that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[1]

Section 214(b) of the *Criminal Code* prohibited a person from aiding or abetting a person's suicide,[2] while section 14 prohibits individuals from consenting to have death inflicted upon them and prevents the use of consent as a defence to criminal charges.[3] As a result of *Carter* SCC, the landscape of end-of-life care in Canada has changed irreversibly. Since the decision is the first under common law to recognize some level of access to euthanasia and assisted suicide as a constitutional right – only the Constitutional Court of Colombia has framed it along the same lines[4] – and has already been commented on in other common law jurisdictions.[5]

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[1] 2015 SCC 5 at para 127, [2015] 1 SCR 331 [*Carter* SCC].

[2] RSC 1985, c C-46, s 241(b) as it appeared on 6 February 2015.

[3] *Ibid*, s 14 as it appeared on 6 February 2015.

[4] See Corte Constitucional de Colombia, Bogotá, 20 May 1997, *Demanda de inconstitucionalidad contra el artículo 326 del decreto 100 de 1980-Código Penal* [*Claim of unconstitutionality against article 326 of decree 100 of the 1980-Penal Code*] (1997), Sentencia No C-239/79 [translated by editors]; Corte Constitucional de Colombia, Bogotá, 15 December 2014, *Acción de tutela instaurada por Julia en contra de Coomeva EPS* [*Tutelage action launched by Julia against Coomeva EPS*], Sentencia No T-970/14 [translated by editors]. With the second cited decision, the Constitutional Court of Colombia imposed an interdisciplinary prior review system and identified the criteria for access, including a restriction to cases of terminal illness.

[5] See e.g. Austl, Victoria, Legal and Social Issues Committee, *Inquiry into End of Life Choices: Final Report* (Parl Paper No 174) (Melbourne: Victorian Government Printer, 2016) at 273–79 (discussion of Canadian developments); *Voluntary Assisted Dying Act 2017* (Vic) (adoption of legislation by the

In June 2016, the Canadian government enacted Bill C-14 (the *MAID Act*)[6] in response to the Supreme Court's call for a regulatory regime. Indeed, the Supreme Court did not immediately invalidate the challenged provisions in 2015 but allowed the government one year,[7] then an extension of four months,[8] to amend the *Criminal Code* in response to its judgment. But it is unlikely that the new legislation, which permits MAID arguably only when people are reasonably close to the end of their natural life,[9] will put an end to the debate. *Carter* SCC appears to have shifted the rhetoric. As we will discuss further, some advocates of an open-ended regulatory regime have argued that *Carter* SCC allowed only minimal access restrictions and have therefore opposed the bill that was approved by Parliament. For them, the access restrictions in the current legislation, such as the exclusion of mature minors, of mental illness as the sole basis for a request for MAID, and of MAID on the basis of advance requests, are not in line with *Carter* SCC. They are already trying to have the remaining restrictions on access to

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Victorian government following the inquiry); *Minister of Justice and Correctional Services v Estate Stransham-Ford*, [2016] ZASCA 197, [2017] 1 All SA 354 at paras 57, 72, rev'g [2015] ZAGPPHC 230, [2015] 3 All SA 109 (the Supreme Court of Appeal of South Africa overturned the High Court's finding of a constitutional right to medical assistance in dying, emphasizing that the complex issues in this context were better dealt with by Parliament. It rejected the immediate relevance of *Carter* SCC to the South African context because of different circumstances and values in South Africa, including, at para 72, a "sense of the need to protect the poor, the weak and the vulnerable and the values attached to such protection"); *Conway v Secretary of State for Justice*, [2017] EWHC 2447 (Admin) at para 123, [2018] 2 WLR 322 (the England and Wales High Court refused to declare that the absolute ban on physician-assisted suicide under UK law was a violation of the European Convention on Human Rights and deemed that the reasoning in *Carter* SCC was irrelevant because the *Canadian Charter of Rights and Freedoms* engages a different analysis and, importantly for the present discussion, because the decision "turned critically on findings by the trial judge … which the Supreme Court held could not be challenged on appeal," while the High Court stated it had been presented with different evidence).

[6] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, SC 2016, c 3 [*MAID Act*].

[7] *Carter* SCC, *supra* note 1 at para 147.

[8] *Carter v Canada (AG)*, 2016 SCC 4 at para 7, [2016] 1 SCR 13 [*Carter* 2016 SCC].

[9] For a discussion of the precise criteria, see below in Sub-Part I(C).

MAID lifted. For instance, cases have already been launched in British Columbia[10] and Québec,[11] with support from the advocacy organization Dying with Dignity, in which access to MAID is requested for people whose death is not "reasonably foreseeable."

In this article,[12] we argue that the new federal legislation, which allows MAID in specific circumstances as an exception to the criminal prohibi-

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[10] See *Julia Lamb and the British Columbia Civil Liberties Association v Attorney General of Canada* (27 June 2016), Vancouver, BCSC S165851 (notice of civil claim), online: BCCLA <https://bccla.org/wp-content/uploads/2016/08/2016-06-27-Notice-of-Civil-Claim.pdf> [*Lamb* Notice of Civil Claim]. This case was launched by the British Columbia Civil Liberties Association and Julia Lamb, a woman with spinal muscular atrophy (see *ibid* at 2), claiming that the "reasonably foreseeable death" criterion of the *MAID Act* is too restrictive because it excludes those who endure intolerable suffering due to non-terminal illnesses (see *ibid* at 12).

[11] See *Jean Truchon et Nicole Gladu c Procureur général du Canada et Procureur général du Québec* (13 June 2017), Montréal, Qc Sup Ct (Civ Div) 500-17-099119-177 (judicial application), online: Vos droits en santé <www.vosdroitsensante.com/documents/file/demande-introductive-d-instance-en-jugement-declaratoire.pdf> [*Truchon et Gladu* Judicial Application]. The plaintiffs in this case both have serious health conditions which in their view cause enduring and intolerable suffering but are arguably not eligible under the new Canadian or Québec laws to receive MAID (see *ibid* at 7, 13). Nicole Gladu, who has lived from a young age with disabilities resulting from polio, has seen her health significantly deteriorate in recent years as a result of post-polio syndrome (see *ibid* at 9, 13). Jean Truchon has cerebral palsy and in 2012 lost the use of his only functioning limb, making it inevitable for him to move to an institution (see *ibid* at 2–4). See also Verity Stevenson, "2 Montrealers with Degenerative Diseases Challenge Medically Assisted Dying Law", *CBC News* (14 June 2017), online: <www.cbc.ca/news/canada/montreal/assisted-dying-quebec-canada-legal-challenged-1.4160016>.

[12] This paper builds on two earlier chapters and contains an expanded discussion of the *Carter v Canada (AG)* litigation and subsequent legal developments. See Trudo Lemmens, "The Conflict between Open-Ended Access to Physician-Assisted Dying and the Protection of the Vulnerable: Lessons from Belgium's Euthanasia Regime in the Post-Carter Era" in Catherine Régis, Lara Khoury & Robert P Kouri, eds, *Les grands conflits en droit de la santé* (Cowansville, Que: Yvon Blais, 2016) 261 [Lemmens, "Conflict"]; Trudo Lemmens & Elizabeth Kurz, "The Future of Medically Hastened Death in Canada: Why and How We Should Avoid the Mortal Flaws of Belgium's Euthanasia Regime" in Mark Henaghan & Jesse Wall, eds, *Law, Ethics, and Medicine: Essays in Honour of Peter Skegg* (Wellington, NZ: Thompson Reuters, 2016) 96.

tion that remains otherwise in place, constitutes a proper response to *Carter* SCC (i.e., that it respects *Carter* SCC as well as the *Charter*) and that it is good public policy. We will thus examine the legal arguments invoked in the discussion about the constitutionality of the *MAID Act*, as well as the justifications for the legislation's restrictions. Both issues are inevitably connected. The justifications for the remaining restrictions on MAID play a defining role in determining the constitutionality of the legislation, which will again be tested in court when arguments are made about the *Charter* compliance of the legislation.[13] One component of evaluating the reasonableness of the MAID legislation will involve determining whether other, less restrictive regulatory options could still adequately achieve the goals of the legislation and whether foreign regulatory regimes reveal problems that a more restrictive regime can reasonably aim to avoid. Notably, Parliament has identified several broad values and goals that the new criminal law regime, with its remaining restrictions on MAID, aims to achieve. The need for balancing potentially conflicting values is clearly recognized by the legislator. On the one hand, the law recognizes the importance of respecting autonomy, but appears to constrain this value by phrasing it as "the autonomy of *persons who have a grievous and irremediable medical condition that causes enduring and intolerable suffering*."[14] This indicates that the *MAID Act* is not just about enabling autonomous choice. The other values are clearly geared towards providing a foundation for limitations of access and protective restrictions: the need for safeguards to protect against "errors and abuse"; the equal value of every person's life and the need to avoid "negative perceptions of the quality of life of persons who are elderly, ill, or disabled"; the protection of vulnerable people from "being induced, in a moment of weakness, to end their lives"; and the need to prevent suicide.[15] When looking at the Belgian developments, as we do below, it is therefore important to consider whether and how a more permissive regulatory regime may compromise the realization of these broad legislative objectives.

To determine whether the absolute ban on MAID was constitutional, the trial judge in *Carter v Canada (AG)* (*Carter* BCSC), Justice Lynne Smith, examined evidence produced at trial from countries that have legalized some forms of MAID. Justice Smith concluded from this evidence that alternatives to an *absolute* ban on MAID can sufficiently minimize the areas of risk identified in the judgment, including the inducement of so-

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[13] See e.g. *Lamb* Notice of Civil Claim, *supra* note 10.

[14] *MAID Act*, *supra* note 6, Preamble [emphasis added].

[15] *Ibid.*

cially vulnerable people to commit suicide.[16] The Supreme Court accepted the trial judge's assessment of the evidence in support of *this particular claim*.[17] Yet, questions remain as to what the evidence from other countries really tells us and how the Supreme Court of British Columbia and the Supreme Court of Canada assessed the evidence in support of their conclusion – a conclusion that, as we will argue, is narrower than proponents of a more open-ended access system may claim it to be. As we will discuss further, it is important to carefully re-examine the evidence when arguing for a system of MAID that goes beyond the current Canadian legislation. Recent Belgian and Dutch experiences will be particularly relevant in this context, notably in relation to access to MAID for suffering associated with mental illness.

In the Canadian debate, scholars, activists, and public commentators appear to accept – in our view, rather uncritically – that there are no substantial problems in the countries that have legalized wider access to assisted dying.[18] In the wake of *Carter* SCC, several official reports and proposals[19]

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[16] *Carter v Canada (AG)*, 2012 BCSC 886 at paras 761, 844–53, 883, 261 CRR (2d) 1 [*Carter* BCSC]. See below for a discussion of how Justice Smith assessed the evidence.

[17] *Carter* SCC, *supra* note 1 at paras 108, 109. Note that here, the Supreme Court refers to the claim that there are alternatives to an absolute ban, not a claim in support of a particular regime.

[18] Some publications refer to the Belgian and Dutch regimes as good models for the regulation of MAID, seemingly accepting the appropriateness of these regimes without acknowledging serious challenges. See e.g. Jocelyn Downie, "*Carter* v. *Canada*: What's Next for Physicians?", Commentary, (2015) 187:7 CMAJ 481 at 482; Udo Schuklenk & Suzanne van de Vathorst, "Treatment-Resistant Major Depressive Disorder and Assisted Dying" (2015) 41:8 J Med Ethics 577 at 579–80. Others explicitly confirm that these regimes work well and do not raise significant concerns, including the influential report of the Royal Society of Canada Expert Panel (Udo 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" (2011) 25:S1 Bioethics 1 at 51–65).

[19] See e.g. Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report* (Toronto: Ministry of Health and Long-Term Care, 2015) [Advisory Group Report]; Parliament, Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* (February 2016) (Chairs: Hon Kelvin Kenneth Ogilvie and Robert Oliphant) [Joint Committee Report]. See below in Sub-Part I(B)(1) for further discussion of these reports.

were clearly inspired by the more permissive regimes in these countries. Some commentators have put forward explicitly that the arguments in relation to potential problems in these countries are settled, because they had been addressed in full by the courts in *Carter* and by various expert committees.[20] This not only reflects an unfortunate unwillingness to consider evidence of problems in those jurisdictions, but it is also misleading for several reasons, some of which we will discuss below. First, the trial judgement in *Carter* dates back to 2012. New relevant evidence has become available. In fact, the Supreme Court explicitly and exceptionally allowed the government to produce what it called "fresh evidence" about developments in Belgium during hearings, though ultimately the Supreme Court did not deem this new evidence relevant. It noted that this evidence dealt with controversial cases that involved patients in a different situation than the plaintiffs and

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[20] Such a claim even formed a substantial part of a complaint to the Public Editor of *The Globe and Mail* by an academic colleague and the co-chair of the Provincial-Territorial Expert Advisory Group. The complaint was aimed at an editorial co-authored by one of the authors (David Baker & Trudo Lemmens, "Assisted Dying Report Goes Beyond Scope, Ignores Evidence", *The Globe and Mail* (27 February 2016, updated 24 March 2017), online: <www.theglobeandmail.com/opinion/assisted-dying-report-goes-beyond-scope-ignores-evidence/article28939386>) and asked for a correction of the authors' portrayal of the Advisory Group's recommendations but also the authors' statement that there were problems in Belgium and the Netherlands and their interpretation of *Carter*. For a discussion of the complaint, see the note under the blog post by Trudo Lemmens, "Joint Parliamentary Committee Assisted Dying Report Goes Beyond Scope, Ignores Evidence" (5 April 2016), *University of Toronto Faculty of Law Blog*, online: <https://www.law.utoronto.ca/blog/faculty/joint-parliamentary-committee-assisted-dying-report-does-beyond-scope-ignores-evidence>. More importantly, the argument that there should be no further inquiry into the evidence of other regulatory regimes is now also made in the context of ongoing litigation. In both the *Truchon et Gladu* Judicial Application, *supra* note 11 at 17, and the *Lamb* Notice of Civil Claim, *supra* note 10 at 9–10, the lawyers for the plaintiffs are arguing that the trial judge in *Carter* conducted a fulsome analysis of the policy and ethical arguments in this debate, in an effort to limit the production of evidence by the government. In an interim decision on this issue, the British Columbia Supreme Court has rejected the plaintiff's argument for a restriction of the production of evidence. See *Lamb v Canada (AG)*, 2017 BCSC 1802 at paras 74, 78, [2018] 3 WWR 150. The Québec Superior Court, however, has limited the number of witnesses the government can use, although seemingly the primary reason is to "ensure proper case management and the observance of the principle of proportionality" [translated by editors]. *Truchon c PG Canada*, 2018 QCCS 317 at para 31, [2018] JQ no 572 (QL).

in a different medico-legal context.[21] Second, as we will reveal, it is simply not the case that Justice Smith and the Supreme Court concluded that there are no problems in these jurisdictions. The Supreme Court explicitly refused to evaluate the fresh evidence in detail because of the narrow focus of its decision – thus clearly not making any firm statement about some aspects of that evidence – while Justice Smith explicitly acknowledged that problems remain in those regulatory regimes.[22]

In our opinion, the claims made by commentators in the Canadian debate largely ignore a growing body of evidence of problematic components of the MAID practice in other countries. While we will mention in passing relevant developments and reports from the Netherlands, we will primarily discuss evidence from Belgium to highlight why a more cautious approach is warranted and, as a result, why the narrower focus of the Canadian *MAID Act* is appropriate. The focus on Belgium is in part pragmatic (one of the authors is of Belgian origin, has conducted extensive research on MAID in Belgium, and has followed the recent developments in detail), but is further justified because of the relevance of the Belgian evidence and the particular influence that Belgian evidence played in *Carter*. We will discuss further how the Supreme Court suggested that the fresh Belgian evidence was not relevant because of the more narrow focus of the *Carter* decision; and how the current pressure to expand the legislation beyond this more narrow focus makes the assessment of this evidence particularly important. Indeed, the Supreme Court hinted that some components of the Belgian regulatory regime could be avoided. It is thus particularly important to look at that system and to understand what aspects should be avoided.

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[21] *Carter* SCC, *supra* note 1 at paras 110–13. The decision to allow new evidence may have been an indirect response to the government's concern with the expedited timeline at the trial level. Justice Smith had rejected the government's opposition to this timeline (*Carter* BCSC, *supra* note 16 at paras 144–46) and the government's subsequent submission regarding the procedural unfairness was rejected by the British Columbia Court of Appeal. *Carter v Canada (AG)*, 2013 BCCA 435 at paras 183–200, 365 DLR (4th) 351 [*Carter* BCCA]. This expedited timeline likely explains the striking discrepancy between the number of expert witnesses for the plaintiffs (39) and those for the Attorneys General of Canada and British Columbia (18) (see *Carter* BCSC, *supra* note 16 at para 160) and between the number of affidavits filed by the plaintiffs (85) and the defendant (21) (see *Carter* BCCA, *supra* note 21 at para 187). This discrepancy also raises questions as to whether the trial court dealt with a balanced evidentiary record.

[22] See below at S81.

This paper will proceed in two Parts. The first Part will cover *Carter* and the legislative response. We will focus on statements by Justice Smith at trial and by the Supreme Court – statements which can be seen as supporting a narrow legislative framework. We will briefly elaborate on Justice Smith's assessment of the argument that there is sufficient evidence from permissive regimes to show that risks of abuse can be mitigated and those vulnerable to undue influence and coercion can be protected. The second Part will concentrate on the Belgian situation. This Part will support the claim that the narrow focus of the *MAID Act* is warranted and aim to debunk the argument that the Belgian and Dutch systems are advisable models on which to base Canadian legislation. These arguments are particularly relevant to the debate about how Canada's legislation should evolve in the coming years. Notably, the *MAID Act* mandates independent reviews on the issues of assisted dying for mental health disorders, the use of advance directives, and access to assisted dying for mature minors.[23] In late 2016, the Council of Canadian Academies accepted to take the lead in studying whether and to what extent MAID should be expanded in these areas and the reports are due to be released in late 2018.[24] Particularly in relation to the first two issues, the experience in Belgium is highly relevant.

Before proceeding, a note on terminology is required. Thus far, we have used the term medical assistance in dying (MAID) simply because this is the terminology of the Canadian federal legislation.[25] In *Carter*, the courts

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[23] *Supra* note 6, s 9.1(1).

[24] "Assessments in Progress: Medical Assistance in Dying", *Science Advice* (blog), online: <www.scienceadvice.ca/en/assessments/in-progress/medical-assistance-dying.aspx>. One of the authors of this paper (TL) is a member of the expert panel and participates in the subcommittee studying the issue of advance requests and MAID.

[25] In an earlier chapter on which this article builds and which was written before the legislation was adopted, we used the term physician-hastened death (Lemmens & Kurz, *supra* note 12). We pointed out that the term "physician-assisted dying," which was used in *Carter*, may have been embraced by those arguing for broader access to MAID because it has a more positive connotation and is not associated with any of the ongoing controversies around the terms euthanasia and assisted suicide. Indeed, it seems hard to be opposed to "assistance" in dying. Our objection extends to the term "medical assistance in dying." Palliative care specialists, in particular, have objected to the use of this terminology, rightly pointing out that palliative care is fundamentally a form of medical assistance in dying which, in their view, should not be confused with MAID. See Canadian Society of Palliative Care Physicians, "Key Messages:

used the term "physician-assisted dying." We will not use this term, unless it is contained in a quote from the judgment. The federal legislation defines MAID as

> (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
>
> (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.[26]

This definition encompasses what is referred to in other jurisdictions as euthanasia and assisted suicide. In Belgium and the Netherlands, the term euthanasia is used in the legislation. Though we will generally use the term MAID, we will use the term euthanasia when we discuss the practice and legal framework in those countries. When referring to American jurisdictions that allow assisted suicide (but not euthanasia), we will use that term to refer to the practice of prescribing a substance that allows a patient to cause their own death by self-administration.

## I. *CARTER* AND CANADA'S LEGISLATIVE RESPONSE

### *A. The* Carter *case*

*Carter* BCSC was brought to the Supreme Court of British Columbia in 2011 by Gloria Taylor, who was later joined by Lee Carter, Hollis Johnson, Dr. William Shoichet, and the British Columbia Civil Liberties Association (BCCLA). Gloria Taylor suffered from amyotrophic lateral sclerosis (ALS) and was becoming increasingly incapacitated.[27] She wanted to receive MAID but was not able to afford to travel to Switzerland.[28]

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Physician-Hastened Death" (October 2015) at 2, online: <www.cspcp.ca/wp-content/uploads/2015/10/CSPCP-Key-Messages-FINAL.pdf>. Yet, since it is the term used in the legislation, it is now the legal term in Canada.

[26] *MAID Act*, *supra* note 6, s 3, amending *Criminal Code*, *supra* note 2, s 241.1.

[27] See *Carter* BCSC, *supra* note 16 at para 47.

[28] See *ibid* at para 53.

As has been discussed elsewhere in more detail,[29] a determinative question in *Carter* was whether courts were still bound to follow the precedent of the 1993 case of *Rodriguez v British Columbia (AG)* (*Rodriguez*),[30] in which the Supreme Court upheld the criminal prohibition on assisted suicide under section 241(b) of the *Criminal Code*. Justice Smith dealt with the *stare decisis* doctrine by pointing out how the Supreme Court had recognized new principles of fundamental justice since *Rodriguez*, in particular the principles of overbreadth and gross disproportionality.[31] This, she argued, changed how the court should determine whether the criminal prohibition's restriction of the section 7 right to life, liberty, and security of the person was in line with the principles of fundamental justice.[32] In addition, Justice Smith pointed out that the parties in the case had produced an "enormous amount of evidence about the experience with legal physician-assisted death in other jurisdictions" and that this evidence with respect to the "efficacy of possible safeguards" did not exist when *Rodriguez* was decided.[33] She also accepted the argument that, since *Rodriguez* had not discussed whether the right to equality was infringed by the prohibition, the court could now address this claim.[34]

With respect to the equality claim, Justice Smith held that the impugned provisions had a more burdensome effect on persons with physical disabil-

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[29] See e.g. Benny Chan & Margaret Somerville, "Converting the 'Right to Life' to the 'Right to Physician-Assisted Suicide and Euthanasia': An Analysis of *Carter v Canada (Attorney General of Canada)*, Supreme Court of Canada" (2016) 24:2 Med L Rev 143; Stephanie Palmer, "'The Choice is Cruel': Assisted Suicide and *Charter* Rights in Canada" (2015) 74:2 Cambridge LJ 191; John Keown, "A Right to Voluntary Euthanasia? Confusion in Canada in *Carter*" (2014) 28:1 Notre Dame JL Ethics & Pub Pol'y 1.

[30] [1993] 3 SCR 519, 107 DLR (4th) 342 [*Rodriguez*].

[31] *Carter* BCSC, *supra* note 16 at paras 974–76. The principle of overbreadth was first identified in *R v Heywood*, [1994] 3 SCR 761 at 790–94, 120 DLR (4th) 348 [*Heywood*]; the principle of gross disproportionality first emerged as a distinct principle of fundamental justice in *R v Malmo-Levine; R v Caine*, 2003 SCC 74 at paras 159–62, [2003] 3 SCR 591 [*Malmo-Levine*].

[32] *Carter* BCSC, *supra* note 16 at paras 959, 983, 985.

[33] *Ibid* at para 1001.

[34] *Ibid* at para 1013 ("Chief Justice Lamer was the only member of the Court in *Rodriguez* to consider the s. 15 claim; the majority assumed a s. 15 infringement but determined that it was justifiable under s. 1").

ities because it denied the choice of suicide to one group while leaving it available to others.[35] She pointed to case reports that in her view confirmed that "people with physical disabilities who are unable to end their lives themselves are forced into the dilemma of either continuing to suffer or exposing other persons to criminal sanctions," which leads some to take their lives "before their illnesses progress to a point where they are no longer able to do so."[36] In our view, these case reports were not strong evidence that this pre-emptive suicide is a frequently occurring event.

The Supreme Court did not address the equality rights argument in its final judgment and a more detailed discussion of this argument exceeds the scope of this paper. Yet, it is worth pointing out here that if the Supreme Court had based its final decision on this equality rights argument, it could arguably have been easier to justify a legislative framework that permits direct interventions by physicians and nurses in administering MAID only where a person is not physically able to do so herself.[37] It could have also helped to set a logical limit to the law: providing an equal opportunity for those who are physically unable to perform a life-ending act themselves.

Justice Smith also analyzed whether the criminal prohibition infringed the right to life, liberty, and security of the person in light of the new principles of fundamental justice the Supreme Court had recognized in more recent cases. She first considered whether the restriction was overbroad, which is determined by the relation between the objective of the legislation and the means used to achieve that objective.[38] In this case, it required that the plaintiffs show that "the blanket prohibition is broader than is necessary to achieve the state's goal of preventing vulnerable persons from being induced, in moments of weakness, to commit suicide."[39] Justice Smith agreed with the plaintiffs that this was the case.

It is interesting to briefly mention what Justice Smith recognized as evidence that could have supported the claim for an absolute prohibition as a

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[35] *Ibid* at para 1076.

[36] *Ibid* at para 1042.

[37] This point was raised by David Schneiderman in a presentation of an earlier version of this paper at the Faculty of Law of the University of Toronto.

[38] *Carter* BCSC, *supra* note 16 at para 1341, citing *Heywood*, *supra* note 31 at 792–93.

[39] *Carter* BCSC, *supra* note 16 at para 1348.

necessary legislative tool to protect the vulnerable. This would have been the case, she argued

> if the evidence showed that physicians are unable reliably to assess competence, voluntariness and non-ambivalence in patients, or that physicians fail to understand or apply the informed consent requirement for medical treatment.[40]

Justice Smith clearly felt, with more discussion of this claim in other sections of her judgment,[41] that properly qualified physicians could reliably assess patients' decision-making capacity and voluntariness as well as undue influence and coercion as a part of the process. She further suggested that there would be no issue of overbreadth "if the evidence from permissive jurisdictions showed abuse of patients, or carelessness or callousness on the part of physicians, or evidence of the reality of a practical slippery slope."[42] She again found there was no such evidence, and that a

> system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death.[43]

Our discussion further in this paper about some of the developments in Belgium, particularly with regards to euthanasia requests based on mental illness, indicates that this "very high degree of certainty" is clearly not realized in the context of the Belgian regime.

Justice Smith did not need to discuss whether the absolute ban was grossly disproportionate, since she had already found that the justification

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[40] *Ibid* at para 1365. Note also her discussion of how physicians are already "experienced" at assessing capacity and informed consent at the end of life (*ibid* at para 1240). In this paper, we will use the term "capacity," but it should be understood that the terms are often used interchangeably. See Louis C Charland, "Decision-Making Capacity" in *The Stanford Encyclopedia of Philosophy*, Fall 2015 ed by Edward N Zalta at §4, online: <https://plato.stanford.edu/entries/decision-capacity/#Ter> (Terminology).

[41] *Carter* BCSC, *supra* note 16 at paras 795–98, 815, 837, 843.

[42] *Ibid* at para 1366.

[43] *Ibid* at para 1367.

was overbroad, but she nevertheless engaged in the analysis. She recognized explicitly that the evidentiary threshold for the plaintiff to support this principle is very high. Referencing the principle of gross disproportionality from *R v Malmo-Levine*,[44] she pointed out that state actions or legislative responses are only *grossly* disproportionate if "they are *per se* disproportionate to any legitimate government interest."[45] And yet, presumably relying on her earlier discussions of the ethics of MAID[46] and the effectiveness of other regulatory regimes,[47] she arrived at the blunt conclusion that

> the effect of the absolute prohibition on the life, liberty and security of the person interests of the plaintiffs is very severe, and is grossly disproportionate to its effect on preventing inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interest in the preservation of human life.[48]

In light of the complexity of assessing the very divergent and confusing evidence in this area, where many different social, cultural, and economic factors interact, and in light of the fact that we are dealing with matters of life and death, it would, in our view, have reflected proper judicial restraint to respect the discretionary powers of legislators in this area. Courts should not conclude too easily that an absolute prohibition – an approach taken by the large majority of legislators around the world on this issue – is *grossly* disproportionate.

Justice Smith further discussed in detail, particularly in relation to her finding that the prohibition violated the right to equality, whether the broader section 1 justification applied and thus whether the restrictions on the *Charter* rights could be justified as a reasonable restriction demonstrably justified in a free and democratic society. A section 1 analysis requires an evaluation of (1) the purpose of the legislation and (2) the proportionality of the restrictions of the rights to the importance of the legitimate purpose

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[44] *Ibid* at para 1374, citing *Malmo-Levine*, *supra* note 31 at paras 142–43.

[45] *Carter* BCSC, *supra* note 16 at para 1376.

[46] *Ibid* at paras 232–53.

[47] *Ibid* at paras 389–620.

[48] *Ibid* at para 1378.

of the legislation.[49] At this stage of the analysis, the onus is on the government to provide evidence that justifies the restriction.[50] The federal government had put forward that, in addition to the narrower purpose of preventing vulnerable people from committing suicide at a moment of weakness, the criminal prohibition's objective was broadly associated with the state's interest in the preservation of life and in ensuring that life is not depreciated by allowing one person to take the life of another.[51] In its submissions, it had also associated the prohibition with the goal of preventing damage to doctor-patient relationships, preventing a negative impact on palliative care, and preventing negative messages regarding the value of life, in particular the life of people with disabilities.[52] Even though Justice Smith recognized that the prohibition was associated with an underlying broad state interest in preserving life, she ruled that the specific purpose of the legislation was to protect vulnerable persons from being induced to commit suicide at a time of weakness.[53] Importantly, this narrow formulation of the legislative objective influenced the evaluation of the proportionality of the legislative restriction by making it easier for Justice Smith to conclude that an absolute prohibition was not minimally impairing on the protected *Charter* rights. Based on her analysis of the evidence of other regulatory regimes and of the analogy between existing end-of-life practices such as withholding and withdrawing treatment, she concluded:

> A less drastic means of achieving the objective of preventing vulnerable persons from being induced to commit suicide at times of weakness would be to keep the general prohibition in place but allow for a stringently limited, carefully monitored system of exceptions. Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards, could achieve that objective in a real and substantial way.[54]

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[49] See *R v Oakes*, [1986] 1 SCR 103 at 138–39, 53 OR (2d) 719.

[50] See *ibid* at 136–37.

[51] See *Carter* BCSC, *supra* note 16 at para 1185.

[52] See *ibid* at para 1187.

[53] *Ibid* at para 1190.

[54] *Ibid* at para 1243.

The most substantial discussion in Justice Smith's judgment can be found, interestingly, prior to her *Charter* rights analysis. It is this prior discussion that she relied upon in her assessment of the proportionality of the criminal law restrictions. She provided, in the first part of her judgment, an analysis of the ethical and policy arguments for allowing health care providers to provide direct support with life-ending measures outside the context of withdrawal and halting of treatment. She acknowledged that

> there is a strong consensus that if it is ever ethical in an individual case for a physician to assist in death, it would be *only in limited and exceptional circumstances*, where it is clearly consistent with the patient's wishes and best interests, and in order to relieve suffering. The concern about imposing stringent limits stems from the consensus that *unlimited physician-assisted death would pose serious risks*.[55]

A very detailed discussion of Justice Smith's ethical and policy analysis exceeds the scope of this paper but certain elements are worth noting. First, she advanced that there is no ethical difference between the ending of a person's life on the one hand and withdrawal of life support and refusal of treatment on the other. She noted that the

> preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death

and then went on to single out three ethicists (one in fact a medical doctor) whose arguments she found persuasive.[56] This claim is remarkable for two reasons. First, it is remarkable for its treatment of arguments in medical ethics (as opposed to concrete ethics guidelines) as some form of "evidence" that can be factually established like other factual claims, rather than as a form of argumentation influenced by underlying philosophical foundations. Second, the claim is remarkable for how it ignores that many scholars[57]

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[55] *Ibid* at para 342 [emphasis added].

[56] *Ibid* at para 335.

[57] See generally US, New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York State Department of Health, 1997), online: <https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/> at 111–13, nn

and ethics documents emanating from medical organizations[58] continue to distinguish these practices while, around the world, most legal systems continue to treat the intentional and active ending of someone's life as categorically different from treatment withdrawal or respecting treatment refusal.[59] Therefore, it seems difficult to argue that there is ethical clarity on this issue. It is unclear how opinions expressed by a small number of ethics experts in a court proceeding can support the conclusion that there is a "preponderance of evidence" that there exists no distinction.

This is connected to another important "finding" of Justice Smith. She pointed out that physicians already assess capacity and obtain informed consent in the context of end of life and that these tools are considered sufficient to protect patients against premature death.[60] If this is already being done in the context of other life-ending procedures and if these procedures are not categorically different, there is accordingly no reason, so it would seem, why they could not be relied on for MAID. Yet, as one of us has argued in recent co-authored publications, there is significant evidence of

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120–26. As the report states, "the distinction between killing and letting die, in general and in the context of medical decisions, is widely accepted and supported" (*ibid* at 111). For more recent discussions, see e.g. Molly L Olsen, Keith M Swetz & Paul S Mueller, "Ethical Decision Making with End-of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments" (2010) 85:10 Mayo Clin Proc 949 at 952; Massimo Reichlin, "On the Ethics of Withholding and Withdrawing Medical Treatment", online: (2014) 9:1 Multidiscip Respir Med 39 at 3 <https://link.springer.com/content/pdf/10.1186%2F2049-6958-9-39.pdf>; Jos VM Welie & Henk AMJ ten Have, "The Ethics of Forgoing Life-Sustaining Treatment: Theoretical Considerations and Clinical Decision Making", online: (2014) 9:1 Multidiscip Respir Med 14 at 3 <https://link.springer.com/content/pdf/10.1186%2F2049-6958-9-14.pdf>.

[58] See e.g. BMA Ethics Department, "End of Life Decisions: Views of the BMA" (London: British Medical Association, 2009) at 3–5, online: <bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a23_1/apache_media/VITJEQ4TGE1SQBYYUCDDQ2T93SAHVT.pdf>.

[59] For a discussion of the distinction in law in several jurisdictions, see Keown, *supra* note 29 at 5–17. Note that at the time of the judgment, only four jurisdictions allowed physicians to be directly involved in the active ending of patients' lives (Belgium, the Netherlands, Luxembourg, and Colombia) but, even in these countries, the practice involves special requirements that are not engaged by withdrawal or refusal of treatment.

[60] *Carter* BCSC, *supra* note 16 at para 1240.

problems with capacity assessment in the context of health care.[61] We may rely on capacity assessment as a necessary but imperfect construct to enable decision making in one context but could, and should, remain concerned, based on its theoretical and practical limitations, about the impact of relying on the same construct much more heavily in the context of complex end-of-life decision making, particularly when it comes to a decision that results in the ending of a person's life.

Finally, Justice Smith discussed in detail the jurisdictions that have legalized some level of access to MAID. After reviewing detailed evidence from, among other jurisdictions, Oregon and Washington, the Netherlands, Belgium, and Switzerland, she accepted that "[a]lthough the record is extensive, it is not exhaustive."[62] She went on to state that the

> data do not permit firm conclusions about certain matters … Further, independent analysis of the data beyond that which the expert witnesses have undertaken is not possible.[63]

She also acknowledged, in her evaluation of evidence as to the appropriate functioning of the safeguards to protect vulnerable people in different jurisdictions, that there are significant issues with compliance.[64] She further

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[61] See Louis C Charland, Trudo Lemmens & Kyoko Wada, "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders", online: (2016) 9 J Ethics Mental Health at 4–7 <www.jemh.ca/issues/v9/documents/JEMH_Open-Volume_Benchmark_Decision_Making_to_Consent_to_Medical_Assistance_in_Dying-May2016-rev.pdf>; Scott YH Kim & Trudo Lemmens, "Should Assisted Dying for Psychiatric Disorders Be Legalized in Canada?" (2016) 188:14 CMAJ E337 at E338. See also Rosario G Cartagena et al, *Understanding the Relationship between Suffering and Capacity at the End-of-Life: A Pilot Study* (Toronto: Law Commission of Ontario, 2016) at 50–54 (recent qualitative study on physicians' perspective on the impact of suffering at the end of life on capacity, which also evokes challenges to capacity assessment in this context).

[62] *Carter* BCSC, *supra* note 16 at para 647.

[63] *Ibid*.

[64] See e.g. *ibid* at paras 656 (in relation to the Netherlands, where she states that compliance "is not yet at an ideal level"), 657 (in relation to Belgium, where she notes a 53% rate of reporting in 2007 and high rates of euthanasia without explicit requests).

recognized that the data largely relied on self-reporting, which clearly creates concerns about their reliability.

Two conclusions drawn from the evidence of the regulatory regimes in other countries appear to support the claim that we should be confident that a regulatory regime in Canada will work well to protect the vulnerable; yet these two conclusions are inconsistent with one another. First, Justice Smith put forward that the

> expert opinion evidence from persons who have done research into the question is that, with respect to all three jurisdictions, Oregon, Belgium and the Netherlands, the predicted abuse and disproportionate impact on vulnerable populations has not materialized.[65]

Earlier on, in her discussion of remaining challenges of regulatory compliance, she recognized the compliance issues but positively emphasized that compliance in several of these regulatory systems is improving, which should at least raise some questions as to the reliability of the conclusion that there is no disproportionate impact on vulnerable populations. Indeed, if there are compliance issues and underreporting continues, it seems difficult to conclude with confidence that abuse and disproportionate impact have not materialized. Second, as if to counter the potential claim that the decision relies too heavily on the assumption that regulatory regimes work well, when put against the light of the evidence that there are compliance issues and that some vulnerable people may be at risk, she points out that

> possible concerns about the level of compliance with legislation in those countries do not necessarily transpose into concerns about Canada. The experience of compliance in Oregon is more likely to be predictive of what would happen in Canada if a permissive regime were put in place, although even there only a weak inference can be drawn.[66]

Here, Justice Smith has it both ways: using the evidence of existing regulatory regimes to support the claim that a less stringent approach than a total criminal prohibition works well, while also rejecting a possible claim that evidence of problems in those regimes illustrates that Canada may

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[65] *Ibid* at para 684.

[66] *Ibid* at para 683.

have difficulty developing a proper regulatory regime. In other words, she accepts favourable evidence from other jurisdictions in support of her ruling while at the same time rejecting unfavourable aspects by suggesting key differences in the overall legal and socio-cultural context.[67]

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[67] Justice Smith appears to rely on statements of only a few expert witnesses to support this claim. For example, one of the expert witnesses suggested that "physicians have a strong position in those cultures, such that they feel able to disregard the law" (*ibid* at para 679). Justice Smith further refers to expert evidence that indicates that euthanasia was practiced in those countries before it was legalized and she suggests that this is not the case in Canada, "with very few exceptions" (*ibid* at para 680). This indicates, according to Justice Smith, that "[Canadian] physicians would also be compliant with any regulatory regime concerning the practice" (*ibid*). A detailed analysis of these rather broad claims exceeds the scope of this paper, but some observations are apposite. One of the authors (TL) has worked on issues related to the regulation of health professions, particularly in relation to conflicts of interests, both in Belgium and Canada. Both countries struggle with comparable issues of compliance to regulatory and ethical standards in various aspects of professional practice. Numerous disciplinary and judicial decisions in Canada raise questions about Justice Smith's confidence in regulatory compliance in Canada. This trust appears unwarranted and contradicted by ongoing, serious transgressions in many areas of professional practice. It is not clear why this would be different in the context of MAID. Moreover, even if the large majority of physicians comply (as they arguably also do in the Belgian and Dutch context), havoc can be created by very few physicians (as discussed further in this article). This raises particular concerns when the professional transgressions result in patients' death because of the seriousness and irreversible nature of the procedure, but also because physicians are less likely to be held accountable for their transgressions when patients are no longer there. In Canada, the recent murder conviction of Ontario nurse Elizabeth Wettlaufer, who pled guilty to accusations of murder of eight elderly patients, is noteworthy in this context. See Thu Thanh Ha, "Ex-Nurse Elizabeth Wettlaufer Sentenced to Life in Prison for Nursing Home Murders", *The Globe and Mail* (26 June 2017), online: <https://www.theglobeandmail.com/news/national/ex-nurse-serial-killer-wettlaufer-prison/article35460700>. It reveals, first, how some Canadian professionals indeed, at times, violate the most important professional norms; second, how one health professional's transgressions can result in the death of many vulnerable people; and, third, that there may be serious problems with the governance of health care for the elderly, as well as with regulatory oversight by the health professions. Disciplinary proceedings before the College of Nurses of Ontario following Wettlaufer's conviction revealed, for example, that the College had been informed that she was fired for wrong use of medication before she killed other patients, but that the College failed to investigate further. See Emma McIntosh, "College of Nurses Declined

It is therefore particularly important to critically reassess the evidence she relied upon, as well as some of the evidence that has become available subsequent to the trial court decision in 2012. We do so further in this paper with respect to the evidence in Belgium, with references to the Netherlands as well.

Justice Smith's suggestion that Oregon is a more appropriate reference jurisdiction for Canada[68] is also worth noting. It suggests that she had in mind, as we will discuss further, that Canada could develop a narrower approach to MAID than in Belgium and the Netherlands, with more stringent safeguards. Although she did not explicitly reiterate this in her conclusion of the discussion of the evidence, she emphasized in her analysis that "the effectiveness and enforceability" of regulation will depend on the type of access restrictions that remain in place, suggesting even that prohibiting the prescription of lethal medication to anyone who is depressed, without qualification, would be a more cautious approach.[69] This would be even more restrictive than under Oregon law, where such prescriptions are only prohibited if the depression causes impaired judgment.[70]

The British Columbia Court of Appeal allowed Canada's appeal and reversed Justice Smith's decision, affirming that *Rodriguez* was still a binding precedent.[71] The Court of Appeal ruled that the new legislative and social facts which had emerged since *Rodriguez* were insufficient to distinguish *Rodriguez* and they disagreed that there has been sufficient change in the law concerning the section 1 justification of the *Charter*.[72] Due to the doctrine of *stare decisis*, the court held that it is only for the Supreme Court to review the constitutional validity of section 241.[73] The respondents were granted leave to appeal to the Supreme Court.

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to Investigate Elizabeth Wettlaufer after 2014 Firing", *Toronto Star* (25 July 2017), online: <https://www.thestar.com/news/gta/2017/07/25/serial-killer-elizabeth-wettlaufer-faces-disciplinary-hearing-at-college-of-nurses.html>.

[68] See *Carter* BCSC, *supra* note 16 at para 683.

[69] *Ibid* at 681 (referring here to the evidence by Dr. Ganzini).

[70] See *ibid*.

[71] *Carter* BCCA, *supra* note 21 at para 346.

[72] *Ibid* at para 103.

[73] *Ibid* at para 352.

The Supreme Court reversed the Court of Appeal's decision. In a unanimous judgment, the Supreme Court agreed with Justice Smith's trial decision that *Rodriguez* was not binding because of the existence of a new legal test in relation to section 7 of the *Charter* and because new evidence had emerged since *Rodriguez* that was highly relevant for an analysis of the reasonableness of the restriction of the *Charter* rights involved.[74] Contrary to Justice Smith's judgment, the Supreme Court did not consider whether the section 15 *Charter* right to equality was infringed.[75] Instead, it focused its analysis on the question of whether sections 14 and 241(b) of the *Criminal Code* unjustifiably infringed section 7 of the *Charter*. It concluded that this was the case to the extent that the law prohibited MAID for a competent adult person who

> (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition … that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[76]

The Supreme Court also affirmed the well-recognized right to refuse treatment,[77] thus seemingly confirming that a refusal of treatment is not incompatible with a request for MAID.

The Supreme Court agreed with Justice Smith that the absolute prohibition on MAID may force some individuals to take their own lives prematurely in fear that they would be incapable of doing so by the time their suffering becomes intolerable.[78] It further agreed that an individual's response to a grievous and irremediable medical condition is a matter of dignity and autonomy.[79] This infringement of section 7 of the *Charter* was held to be not justifiable under section 1. The prohibition was found to be disproportionate to the objective because the evidence did not show that a blanket prohibition was necessary for substantially meeting the govern-

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[74] *Carter* SCC, *supra* note 1 at paras 46–47.

[75] *Ibid* at para 93.

[76] *Ibid* at para 4.

[77] *Ibid* at para 67.

[78] *Ibid* at paras 57–58.

[79] *Ibid* at para 66.

ment's objective of protecting the vulnerable.[80] Moreover, the Court found that the trial judge made no error in concluding that a permissive regime with properly designed and administered safeguards could protect vulnerable people from abuse and error.[81] Therefore, the absolute prohibition was also found not to be minimally impairing.[82]

The then Conservative federal government of Stephen Harper was slow in its reaction to *Carter* SCC. After a lengthy period of inaction, the government finally set up a federal committee to investigate the potential legislative options in response to *Carter* SCC.[83] The committee's composition was immediately criticized for the fact that it had two members who had been expert witnesses for the government in *Carter* and were considered supportive of a criminal prohibition.[84] The committee consulted broadly and visited various jurisdictions that had introduced regulations in relation to assisted suicide and euthanasia, including the US states with legislative provisions

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[80] *Ibid* at para 86.

[81] *Ibid* at para 114–17.

[82] *Ibid* at para 121.

[83] The panel was established in July 2015, five months after the *Carter* decision, and the deadline for the panel report was set for October. See Joan Bryden, "Conservative Government Finally Launches Assisted Dying Consultation", *The Star* (17 July 2015), online: <https://www.thestar.com/news/canada/2015/07/17/conservative-government-finally-launches-assisted-dying-consultation.html>.

[84] See Laura Payton, "Doctor-Assisted Suicide Panel Includes Original Crown Witnesses", *CBC News* (17 July 2015), online: <www.cbc.ca/news/politics/doctor-assisted-suicide-panel-includes-original-crown-witnesses-1.3157361>; Joan Bryden & Kristy Kirkup, "Critics Fear Bias on Harper Government Panel Studying Doctor-Assisted Suicide", *The Star* (17 July 2015), online: <www.thestar.com/news/canada/2015/07/17/critics-fear-bias-on-harper-government-panel-studying-doctor-assisted-suicide.html>. The same type of criticism was not voiced in relation to other influential committees pre- and post-*Carter*. For example, of the influential Royal Society of Canada Expert Panel on End-of-Life Decision Making (Schüklenk et al, *supra* note 18), which issued a report that was entered into the evidentiary record in *Carter* by Justice Smith, at least four out of six had already explicitly endorsed legalization of MAID prior to their participation. Several members of the panel participated as expert witnesses for the plaintiffs in *Carter*, with one member supporting the case with active legal advice. Some of the same people also participated in other committees post-*Carter*, such as the Provincial-Territorial Expert Advisory Group (see below).

and countries such as Belgium, the Netherlands, and Switzerland.[85] Following the election of a Liberal government, the committee continued its work but it was instructed by the new government not to make any specific recommendations with respect to the legislative choices.[86] It issued its report on 18 January 2016 in which it discussed, based on its comparative review, different regulatory options and the evidence in relation to these options.[87]

In early 2016, the Attorney General of Canada asked that the twelve-month suspension of the declaration of invalidity in *Carter* SCC be extended by six months on the basis that Parliament had been dissolved for four months during the federal election.[88] The Supreme Court held that the length of the interruption of work due to the federal election constituted a justification for an extension, but granted Parliament only four months to come up with appropriate legislation.[89] The Court also granted Québec an exemption from the four-month extension, without commenting in its judgment on the validity of Québec's *own* end-of-life legislation, the *Act*

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[85] See Government of Canada, Department of Justice, News Release, "Federal Panel Studies U.S. Approach to Physician-Assisted Dying" (7 October 2015), online: <www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/nr-cp.html>; Government of Canada, Department of Justice, News Release, "Federal Panel Gains Insight into Assisted Dying Practices in European Countries" (21 September 2015), online: <www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/nr-cp.html>.

[86] See Government of Canada, Department of Justice, News Release, "Ministers Wilson-Raybould and Philpott Provide a New Mandate to the External Panel on Options for a Legislative Response to *Carter v. Canada*" (14 November 2015), online: <https://www.canada.ca/en/department-justice/news/2015/11/ministers-wilson-raybould-and-philpott-provide-a-new-mandate-to-the-external-panel-on-options-for-a-legislative-response-to-em-carter-v-canada.html>.

[87] See Canada, External Panel on Options for a Legislative Response to *Carter v. Canada*, *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings – Final Report* (Ottawa: Public Works and Government Services Canada, 2015). See also Government of Canada, News Release, "Federal Government Releases Report of the External Panel on Options for a Legislative Response to *Carter v. Canada*" (18 January 2016), online: <https://www.canada.ca/en/department-justice/news/2016/01/federal-government-releases-report-of-the-external-panel-on-options-for-a-legislative-response-to-carter-v-canada.html> (announcing public release of the report).

[88] See *Carter* 2016 SCC, *supra* note 8 at para 2.

[89] *Ibid* at para 2.

*respecting end-of-life care* (the Québec *Act*), enacted in 2014 but not yet in force at the time of *Carter* SCC.[90] As a result, Québec could start providing access to MAID awaiting final revisions of the federal criminal law provision. The Québec *Act* provides access to MAID for patients who are (1) covered by Québec health insurance, (2) adult and competent to consent to care, (3) at the end of life, (4) suffering from a serious and incurable illness, (5) suffering from an advanced state of irreversible decline in capability, and (6) suffering from constant unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable.[91] In granting this exemption to Québec, the Supreme Court indirectly confirmed, in our view, that this law, which is narrowly focused on end-of-life situations, provided sufficient (in the interim) access to life-ending measures in a way that is generally in line with the *Carter* SCC parameters.[92]

## *B. The legislative response to* Carter

### 1. The road to Bill C-14

Following *Carter* SCC, a significant debate took place regarding Parliament's legislative options. Some commentators focused on how the Supreme Court had for the first time recognized a *Charter*-protected right to obtain support for active life-ending measures by physicians.[93] The position that MAID should be broadly accessible first dominated the official responses to the *Carter* decision. For example, a Provincial-Territorial Expert Advisory Group (the Advisory Group) set up in the wake of *Carter*,[94] came out with

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[90] CQLR 2014, S-32.0001 [Québec *Act*].

[91] *Ibid*, s 26.

[92] The Supreme Court stated explicitly that it did not make any statement about the validity of the Québec *Act* (*Carter* 2016 SCC, *supra* note 8 at para 4). In our view, this statement relates more to the potential *ultra vires* nature of the *Act*, since the *Act* deals with a criminal law matter, not to its *Charter* compliance. This is also why the Court points to the fact that the Attorneys General do not oppose the request from Québec to grant this exemption (*ibid* at para 9).

[93] See e.g. Grace Pastine, "The Death with Dignity Decision Explained", (6 February 2015) *British Columbia Civil Liberties Association*, online: <https://bccla.org/2015/02/the-death-with-dignity-decision-explained>.

[94] See Ontario, Ministry of Health and Long-Term Care, News Release, "Provinces, Territories Establish Expert Advisory Group on Physician-Assisted Dying"

sweeping recommendations for “a uniquely Canadian approach.”[95] It had been established at the invitation of the Ontario Minister of Health and Long-Term Care and the Ontario Attorney General, with other provinces and territories expressing an interest in receiving the advice of the group.[96] With its recommendations,[97] the report largely accepts that the parameters of *Carter* SCC provided sufficient detail for a legislative framework determining who should qualify for access to medical assistance in dying.[98] The Advisory Group recommendations appeared particularly geared towards ensuring

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(14 August 2015), online: <news.ontario.ca/mohltc/en/2015/08/provinces-territories-establish-expert-advisory-group-on-physician-assisted-dying.html>.

[95] Advisory Group Report, *supra* note 19, Letter from the Co-Chairs (preface to the report, written by co-chairs Dr. Jennifer Gibson and Maureen Taylor).

[96] *Ibid*. In discussing its own mandate, the Advisory Group states that “[t]his advice is not binding on participating or non-participating jurisdictions, and each government will maintain its authority to respond to the *Carter* decision as it deems appropriate” (*ibid* at 12).

[97] Although it is not clear from the general text of the report and not mentioned in the recommendations section, the report’s recommendations were apparently not supported by all members of the Advisory Group. As Nuala Kenny, a member of the Advisory Group, explained to Trudo Lemmens in an email, she objected to a statement in the penultimate draft of the report as to “unanimous support for the recommendations” and asked for the following section to be included:

> Stakeholders hold diverse opinions on physician-assisted dying. While the majority of Canadians are supportive of the *Carter* decision, the idea of physician-assisted dying remains ethically challenging for some. As well, important values are at stake (and potentially in conflict) with respect to various elements that comprise the proposed regulatory framework for physician-assisted dying. Acknowledgement of the differing ethical positions on physician-assisted dying in general and a careful ethical analysis of specific issues related to implementation must accompany the development of any policies, legislation and regulations (Advisory Group Report, *supra* note 19 at 2).

[98] This is reflected in its discussion of the legal context, where the report emphasizes that

> the Supreme Court did not limit the ruling to those unable to take their own lives, to cases of terminal illness, or to people near death. The Court’s declaration is also not restricted to physical illnesses, diseases or disabilities, and includes mental illness (*ibid* at 15).

access and were arguably less concerned with establishing safeguards to protect people from premature death. The emphasis on access is already clear from the second recommendation, which calls for provincial and territorial to collaborate and coordinate "as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada."[99] It is further reflected in, for example, the following recommendations: nurse practitioners, in addition to physicians, should be allowed to provide MAID;[100] there should be no requirement that a physician be present;[101] health care providers should be protected from liability for good faith actions or omissions in the context of MAID;[102] there should be no delineation in legislation or regulation as to specific medical conditions that qualify;[103] advance requests should be permitted;[104] no age limits should be imposed;[105] there should not be an appeal process when a health care provider refuses a request and patients should be allowed to ask another physician;[106] no obligatory wait period should be imposed (regardless of the basis of the request);[107] and various

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The Advisory Group also points out that the *Carter* case contains no definition of "grievous" medical condition; it simply accepts that no further definition can be provided (*ibid* at 35).

[99] *Ibid* at 21.

[100] *Ibid* at 26 (recommendation 8). Note the use of "physician-assisted death" even when, according to the report's recommendations, it should also be possible for a nurse practitioner to direct its provision.

[101] *Ibid* at 41 (recommendation 28).

[102] *Ibid* at 26 (recommendation 9).

[103] *Ibid* at 35 (recommendation 19).

[104] *Ibid* at 30 (recommendation 12).

[105] *Ibid* at 34 (recommendation 17).

[106] *Ibid* at 39 (recommendation 25). The absence of an appeal procedure could be seen as a factor limiting access. But, when combined with the recommendations that physicians have an obligation to refer and the option for the patient to ask other physicians, it facilitates access, since a formal appeal procedure could lead to an independent confirmation of the refusal and thus put an end to the request (consider, for example, Ontario's Consent and Capacity Board hearings). Here the recommendation is to facilitate choice until a request is fulfilled.

[107] *Ibid* at 40 (recommendation 26). The Advisory Group recommends leaving it

recommendations to ensure that conscientious objections by physicians or institutions do not hinder access to MAID.[108]

In contrast, the safeguards recommended by the Advisory Group that specifically aim at providing protection are limited. They include recommendations related to data gathering,[109] the completion and witnessing of a patient declaration form,[110] an assessment by two physicians to determine that all criteria have been met,[111] and mandatory reporting to a review body.[112] Other issues mentioned in the recommendations are not really about providing additional safeguards. Some only formulate requirements in terms of other forms of medical practice, such as the Advisory Group's recommendation that "existing processes in the health care system to assess competency and consent" should be used.[113] Others are too vague or aspirational to constitute a real safeguard, such as the recommendation that a pan-Canadian palliative care strategy be developed.[114] In fact, the report recommends against imposing palliative care as a safeguard, which it would be if access to MAID were to be made conditional on a prior offer of palliative care. As the report states,

> withholding physician-assisted dying from everyone until palliative care is available and offered to all is not the appropriate response, as it denies those who are eligible the right to die in the manner they choose.[115]

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up to the individual physician to determine how much time is needed to determine consent and capacity.

[108] *Ibid* at 43–49 (recommendations 31 to 39).

[109] *Ibid* at 32–33 (recommendations 15 and 16).

[110] *Ibid* at 29 (recommendation 11).

[111] *Ibid* at 38 (recommendation 22).

[112] *Ibid* at 41 (recommendation 29).

[113] *Ibid* at 35 (recommendation 20). See also *ibid* at 38 (recommendation 24).

[114] *Ibid* at 20 (recommendation 1).

[115] *Ibid*. Note, however, that the argument for making MAID conditional on the availability of palliative care is precisely that meaningful consent would be undermined if access to palliative care is not a realistic option. Imposing an offer of palliative care as a precondition would simply change the eligibility criteria, with the result that it would not deprive anyone "eligible" from access

Overall, the report reflects a clear confidence in existing capacity and consent procedures and a reliance on post factum review, deemed to "ensure transparency and confirm compliance with existing policies and procedures."[116] The only additional layer of protection recommended, standing between the patient request and the ending of the patient's life, is an opinion by a second physician.

A Special Joint Parliamentary Committee on Physician-Assisted Dying (the Joint Committee) set up by the new Liberal government largely followed the recommendations of the Advisory Group for wider access to MAID. Following an intense period of hearings in which a large number of expert witnesses testified,[117] the Joint Committee submitted its report, *Medical Assistance in Dying: A Patient-Centred Approach*, to Parliament in February 2016. The report was strongly supportive of a very open-ended assisted-dying regime and recommended an even more permissive regime than the Advisory Group report. Many of the recommendations focused on widening the scope of eligibility and increasing the accessibility of assisted dying. Some of the more controversial recommendations from the Joint Committee's report include: those with a non-terminal grievous and irremediable medical condition should have access to MAID, people with a psychiatric condition should have access to MAID, MAID should be available pursuant to advance directives, conscientious objection should be respected but effective referral should be required, all publicly funded hospitals should provide access to MAID, and there should be no obligatory period of reflection between the time of the request and the life-ending action.[118] The Joint Committee also explicitly recommended against a prior review and approval process by an independent board or tribunal, either at the federal or provincial level,[119] thus trying to prevent provincial governments from imposing additional safeguards. Although the Joint Committee recommended the improvement of palliative care across the country,[120] it failed to recommend a "palliative filter," whereby access to MAID would only be available

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to MAID: the person would not be eligible in the first place because of the absence of meaningful choice.

[116] *Ibid* at 41 (recommendation 29).

[117] See Joint Committee Report, *supra* note 19, Appendix A (list of witnesses).

[118] *Ibid* at 35–37.

[119] *Ibid* at 37 (recommendation 15).

[120] *Ibid* at 38 (recommendation 19).

if a person was first offered palliative care. The Joint Committee also found that existing medical practices could adequately assess the capacity to provide informed consent of those requesting MAID, though it acknowledged the need to pay particular attention to potential vulnerabilities in end-of-life circumstances.[121] Remarkably, it failed to recommend that a psychiatric assessment be required, even where a person was requesting access to MAID for suffering associated with a mental health condition.

If these recommendations had been followed, Canada would have had a system that is at least as open-ended as the Belgian and Dutch MAID regimes with, in some respects, fewer procedural safeguards.[122] Only the recommendation to have a binding second opinion appears stricter than in Belgium and the Netherlands, where the second (or third) opinion is not binding.[123]

While some commentators applauded the reports of both the Advisory Group and the Joint Committee,[124] others were critical and argued for more

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[121] *Ibid* at 35 (recommendation 5).

[122] For example, the Belgian regime imposes an obligatory waiting period of one month (itself remarkably short as a safeguard in the context of mental health treatment) when patients are not at the end of life and requires having at least a psychiatric assessment when the request was made in relation to the suffering associated with a mental health condition. *Wet betreffende euthanasie 28 mei 2002* [*Law Concerning Euthanasia of 28 May 2002*], Belgian Official Journal, 22 June 2002, 28515, C – 2002/09590, s 3(3)(2) [*Belgian Euthanasia Act*]. For an unofficial version used as reference for English translations throughout this article, see David Albert Jones, Chris Gastmans & Calum MacKellar, eds, *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge: Cambridge University Press, 2017) at 305–15.

[123] See *Belgian Euthanasia Act*, *supra* note 122, s 3(2)(3); *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [*Termination of Life on Request and Assisted Suicide (Review Procedures) Act*], Netherlands, 12 April 2001, art 2(1)(e).

[124] See e.g. Chantal Hébert, "Committee of Senators, MPs Steers Assisted Suicide Debate Back to Parliament", *The Star* (27 February 2016), online: <https://www.thestar.com/news/canada/2016/02/27/committee-of-senators-mps-steers-assisted-suicide-debate-back-to-parliament-hbert.html>; Mia Robson, "Assisted Dying Report 'Thoughtful'", *Winnipeg Free Press* (26 February 2016), online: <https://www.winnipegfreepress.com/local/assisted-dying-report-thoughtful-370231031.html>.

restricted access to MAID and more stringent safeguards. A variety of commentators, including one of the authors,[125] felt that if the Advisory Group and Joint Committee recommendations were to be implemented, they would fail to adequately protect people against premature death, particularly those who are vulnerable. Many experts and disability and health advocacy organizations had also shared their concerns about the Advisory Group recommendations during the hearings of the Joint Committee and were critical of the Joint Committee's clear endorsement of these recommendations. Shortly after the Joint Committee submitted its report to Parliament, a new coalition was set up with the goal of pressuring Parliament to develop substantial regulatory standards to protect the vulnerable. The Vulnerable Person Standard coalition brings together a wide variety of organizations with divergent views on the issue of MAID.[126] While it does include some organizations that have been explicitly opposed to legalization of euthanasia such as the Physicians' Alliance Against Euthanasia, other groups involved emphasized the need for better safeguards and were arguably more open to some form of legalized MAID. The Canadian Association for Community Living and the Council of Canadians with Disabilities are two of the lead organizers of this coalition, which further includes disability advocacy groups, professional organizations such as the Canadian Society of Palliative Care Physicians and the Canadian Hospice Palliative Care Organization, and several faith-based organizations, including Catholic, Evangelical, Islamic, and Jewish organizations.[127] In response to the Joint Committee's recommendations, the coalition put forward the "Vulnerable Person Standard," which contained detailed recommendations for legislative and regulatory action that in its

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[125] See e.g. Baker & Lemmens, *supra* note 20; Thomas Walkom, "Parliamentary Report Takes a Too-Casual Approach to Doctor-Assisted Death", *The Star* (28 February 2016), online: <https://www.thestar.com/news/canada/2016/02/28/parliamentary-report-takes-a-too-casual-approach-to-doctor-assisted-death-walkom.html>; Denise Batters, "Help the Mentally Ill. Don't Kill Them", *National Post* (14 March 2016), online: <nationalpost.com/opinion/denise-batters-help-the-mentally-ill-dont-kill-them>.

[126] See Vulnerable Persons Standard, "How the VPS Was Created", online: <www.vps-npv.ca/how-the-vps-was-created>. One of the authors of this paper (TL) accepted to join the VPS as an advisor and participated in press conferences and events in support of the coalition.

[127] For a list of organizations supporting the standard, see Vulnerable Persons Standard, "Advisors to the Vulnerable Persons Standard" (21 September 2017) at 6, online: <www.vps-npv.ca/s/VPS-Advisors-Orgs-MASTER-ENG-Sept2017.pdf >.

view would better protect vulnerable people.[128] Several of the coalition's recommendations were in direct opposition to some of the key recommendations of the Advisory Group and the Joint Committee. First, it recommended restricting access to MAID to

> end-of-life conditions for adults in a state of advanced weakening capacities with no chance of improvement and who have enduring and intolerable suffering as a result of a grievous and irremediable medical condition.[129]

With these access criteria, the coalition thus indirectly asked for the new legislation to provide more details than the broad parameters of the Supreme Court in *Carter*. In addition, while the coalition did not recommend excluding access for psychiatric patients, the narrower criteria for access excluded access to MAID on the basis of mental illness alone.[130] Second, it strongly emphasized the risk that psychosocial factors and social and economic conditions might influence decision making in relation to MAID. For that reason, it recommended a detailed vulnerability assessment by physicians, followed by an expedited prior review and authorization by a judge or independent body.[131] The Vulnerable Persons Standard emphasized as its guiding principle that the law should not "perpetuate disadvantage or contribute to social vulnerability."[132]

### 2. Bill C-14

Somewhat surprisingly, the government's Bill C-14 on medical assistance in dying as introduced to the House of Commons for First Reading on 14 April 2016 (the Bill),[133] failed to follow some of the key recommenda-

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[128] Vulnerable Persons Standard, "Vulnerable Persons Standard" (May 2017), online: <www.vps-npv.ca/read-the-standard-20> [VPS, "The Standard"].

[129] *Ibid.*

[130] *Ibid* (emphasis on the "end-of-life" state of the patient).

[131] *Ibid*, s 4. This recommendation is likely inspired by David Baker, Gilbert Sharpe & Rebeka Lauks, "Federal and Provincial Responsibilities to Implement Physician-Assisted Suicide", (2016) 36:3 Health L Can 148 at 152–53.

[132] VPS, "The Standard", *supra* note 128.

[133] Bill C-14, *An Act to amend the Criminal Code and to make related amend-*

tions of the Joint Committee. It recommended access to MAID more in line with the Vulnerable Person Standard, although it did not require a prior review and authorization by an independent body. The Bill in its initial form set out the following six key requirements for eligibility to request MAID: the applicant must (1) be eligible for government-funded health services in a Canadian jurisdiction, (2) be at least 18, (3) have capacity to make health-related decisions, (4) have a grievous and irremediable medical condition, (5) make a voluntary request for medically-assisted suicide, and (6) give informed consent.[134] The most substantial departure from the Joint Committee's Recommendations could be found in the Bill's provision of a more detailed definition of a "grievous and irremediable" condition: an advanced state of irreversible decline in capability brought on by an illness, disease, or disability that is serious or incurable; that causes enduring and intolerable physical or psychological suffering that cannot be relieved under subjectively acceptable conditions; and that makes natural death reasonably foreseeable.[135]

In order to prevent abuse of process and protect vulnerable populations, the following key safeguards were included: a medical or nurse practitioner's opinion that all eligibility criteria are met, along with a written, signed, and independently witnessed request (made after natural death has become reasonably foreseeable); the opinion of a second independent medical or nurse practitioner; a minimum 15-day time period between the date of the request and the medically-assisted dying; the ability to withdraw the request at any time; and the opportunity to withdraw the request immediately prior to the medically-assisted dying.[136] The Bill also ensured that the medical and nurse practitioners, as well as those who assist them, such as pharmacists, are exempt from *Criminal Code* offences provided the necessary conditions are met.[137] Importantly, the Bill also mandated a parliamentary review of the legislation five years after it becomes law.[138]

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*ments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016 (first reading 14 April 2016).

[134] *Ibid*, cl 3 (s 241.2(1) of the *Criminal Code* as proposed by Bill C-14).

[135] *Ibid* (s 241.2(2) of the *Criminal Code* as proposed by Bill C-14).

[136] *Ibid* (s 241.2(3) of the *Criminal Code* as proposed by Bill C-14).

[137] *Ibid*, cl 4 (s 241.3(4) of the *Criminal Code* as proposed by Bill C-14)

[138] *Ibid*, cl 10.

### 3. House of Commons and Senate Committee amendments

The government pressured the House of Commons and the Senate to submit the Bill on an exceptionally tight review and approval schedule. Following new hearings and subsequent recommendations by the House of Commons Standing Committee on Justice and Human Rights, some important amendments were made to the Bill, though these did not affect the overall structure and key components.[139] The Bill was then submitted to the Standing Senate Committee on Legal and Constitutional Affairs. Following a set of hearings, the Senate Committee submitted its report on 17 May with amendment recommendations that altered the Bill substantially, some bringing it in line with the key recommendations of the Joint Committee, others narrowing the Bill to a situation of "terminal illness."[140] The most significant change proposed by the Senate Committee and subsequently adopted by the Senate was the removal of the detailed definition of "grievous and irremediable," which restricts access to an end-of-life context and largely excludes access to MAID for psychiatric conditions.[141] Some amendments that were only supported by a minority of the Senate were similar to some of the safeguards proposed in the Vulnerable Person Standard for ensuring a proper vulnerability assessment. They included an amendment to require a psychiatric assessment of capacity in all cases where mental illness is

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[139] See *Second Report: Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* (May 2016), online: <www.parl.gc.ca/Committees/en/JUST/StudyActivity?studyActivityId=8874111>. Important amendments included the need for a ten-day period between the signing of a request for MAID and the performance of MAID, an explicit provision that no one can be compelled to perform or assist with MAID, and an amendment to include in the Bill the duty to initiate independent reviews of issues relating to MAID requests by mature minors, to advance requests and to requests where mental illness is the sole underlying condition within six months after the Act becomes law.

[140] Senate, Standing Senate Committee on Legal and Constitutional Affairs, *Third Report: Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* (May 2016), online: <https://sencanada.ca/en/committees/report/32014/42-1> [Senate Committee Report].

[141] See *Debates of the Senate*, 42nd Parl, 1st Sess, Vol 150, No 45 (8 June 2016) at 964 (vote to amend the Bill and omit the detailed definition) [*Debates of the Senate*, 8 June 2016].

deemed to be present and an amendment to ensure that the patient undergoes a palliative care consultation.[142]

The government immediately made it clear that, while it accepted some amendments to the Bill, it viewed some of the key amendments adopted by the Senate as significantly undermining the delicate balance between providing access to MAID to some and the protection of those who are vulnerable to premature death.[143] It insisted that the concept of "grievous and irremediable medical illness" had to be defined in line with the detailed definition in the original version of the Bill.[144] It also rejected the idea of allowing advance requests for MAID.[145] Though there was concern regarding the strong opposition of some members of the Senate Standing Committee towards the narrower, end-of-life focus of the Bill, the Senate ultimately approved the Bill, which received Royal Assent on 17 June, less than 65 days after having been first introduced in Parliament – an extraordinarily fast turnaround for such an important piece of legislation.

Under the *MAID Act*, a person is deemed to have a grievous and irremediable medical condition only if (1) they have a serious and incurable illness, disease or disability; (2) they are in an advanced state of irreversible decline in capability; (3) the illness, disease, or disability or the 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 (4) their natural death has become reasonably foreseeable,

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[142] See Senate Committee Report, *supra* note 140 (under "Recommendations supported by a minority of members", recommendations 7 and 5).

[143] See *Debates of the Senate*, 42nd Parl, 1st Sess, Vol 150, No 41 (1 June 2016) at 743–46 (Hon. Jody Wilson-Raybould, Minister of Justice), 760–61 (Hon. Jane Philpott, Minister of Health) [*Debates of the Senate*, 1 June 2016].

[144] See e.g. *ibid* at 745 ("broader eligibility would frustrate a number of the objectives of Bill C-14"), 746 ("The eligibility criteria and definition around 'grievous and irremediable' are meant to be read in their totality, given all of the circumstances of a particular individual"), 754 (Minister Wilson-Raybould's detailed response to Senator Joyal).

[145] See *ibid* at 745. Specifically, Minister of Justice Jody Wilson-Raybould stated:

> This is an extraordinary step, a step that we are not compelled to take as a result of *Carter* and a step that creates risks we are only just beginning to grasp. Because of the similarities with substitute decision-making in health care, we need to take time to fully consider advance requests (*ibid*).

taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the requesting person has remaining.[146] The *MAID Act* thus maintains an emphasis on end-of-life contexts by requiring that the natural death be reasonably foreseeable, although it does not specify the length of time that they should have remaining. The *MAID Act* also requires the Minister of Justice and the Minister of Health to initiate one or more independent reviews on issues relating to MAID requests by mature minors, advance requests, and requests where mental illness is the sole underlying medical condition within six months.[147] The effectiveness and impact of provisions are to be reviewed by a committee in five years.[148]

An important issue still to be addressed is the monitoring of the practice. If there is agreement on one issue in this debate, it is on the importance of collecting reliable data in order to monitor the practice and its development over time. This requires detailed reporting obligations. The *MAID Act* mandates the Minister of Health to make regulations relating to monitoring of the provisions of MAID in Canada.[149] But it is within the provincial jurisdiction to design specific regulatory schemes that are consistent with the federal legislation. Several provinces have already moved forward with the introduction of specific reporting obligations. For instance, in Ontario[150] and

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[146] *Supra* note 6, s 1 (enacting s 241.2(2) of the *Criminal Code*). The last criterion in particular appears open to interpretation and leaves room for clinical discretion and interpretation in individual cases. Justice Perell of the Ontario Superior Court provided a broad interpretation of the term in *AB v Canada (AG)*, 2017 ONSC 3759 at para 81, 139 OR (3d) 139:

> [T]he language reveals that the foreseeability of the death must be connected to natural causes" but "that the natural death need not be connected to a particular terminal disease or condition and rather is connected to all of a particular person's medical circumstances.

He held in that case that "an almost 80 year old woman in an advanced state of incurable, irreversible, worsening illness with excruciating pain and no quality of life" clearly fulfilled the criteria (*ibid* at para 87).

[147] *Ibid*, s 9.1(1).

[148] *Ibid*, s 10(1).

[149] *Ibid*, s 1 (enacting s 241.31(3) of the *Criminal Code*).

[150] See Bill 84, *An Act to amend various Acts with respect to medical assistance in dying*, 2nd Sess, 41st Leg, Ontario, 2017.

British Columbia,[151] new legislation has been drafted – and in the case of British Columbia, assented to – under which all MAID deaths will have to be reported directly to the Coroner's office by the health practitioner. In Québec, the reporting process that has been introduced is much more internal: the physician reports to the executive director of the institution who then makes an annual report to the board of directors and so on.[152] Ideally, the mandated parliamentary review would also explore the differences between the provinces' oversight regimes and establish a uniform reporting system that allows the federal and provincial governments, as well as interested scholars and civil society, to study the practices in a comparative context. It will therefore be essential to have access to "deep" data that contain sufficient detail to fully analyze the circumstances in which people request access, how access is being granted, where issues of capacity arise, and how these issues are being dealt with.

Soon after it received Royal Assent, several claims were filed against Bill C-14. Two cases, supported by advocacy organizations such as Dying with Dignity, challenge the constitutionality of the restrictions posed by the federal government's assisted-dying legislation.[153] They involve patients who could arguably continue to live for a significant period of time and whose natural deaths might therefore not be reasonably foreseeable. Another case filed by the Christian Medical and Dental Society of Canada was recently decided by the Ontario Superior Court of Justice.[154] The claim was directed against the College of Physicians and Surgeons of Ontario's assisted dying guidelines stating that conscientious objectors must provide effective referral "to a non-objecting, available, and accessible physician, other health-care professional, or agency … in a timely manner."[155] The Christian Society's position was that effective referrals force physicians

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[151] See *Coroners Act*, SBC 2007, c 15, s 2(1)(g); *Coroners Regulations*, BC Reg 298/2007, s 1.1.

[152] See Québec *Act*, *supra* note 90, ss 8, 17, 18, 37.2.

[153] See *Lamb* Notice of Civil Claim, *supra* note 10; *Truchon et Gladu* Judicial Application, *supra* note 11.

[154] See *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2018 ONSC 579, [2018] OJ No 205 (QL) [*CMDSC v CPSO*].

[155] *Ibid* at para 11, citing "Policy Statement #4-16: Medical Assistance in Dying" (June 2016) at 5, online: <www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/medical-assistance-in-dying.pdf>.

who have conscientious objections to participate in the provision of an assisted death.[156] The court sided with the College and upheld the "effective referral" requirement as a reasonable and justifiable infringement on the rights of some individual physicians to religious freedom.[157]

### *C. Can the narrower regime introduced by Bill C-14 be reconciled with* **Carter***?*

As pointed out earlier, the government's Bill received significant criticism when it was first tabled. Several commentators suggested that the Bill was not in line with the *Carter* decision.[158] This was also the reason that several parliamentarians, both in the House of Commons and the Senate, strongly objected to the Bill, including some members of the Liberal caucus.[159] Some members of the Joint Committee clearly had difficulty accepting the legislation's disregard of some of the Joint Committee's key recommendations.[160] The broad parameters of the Supreme Court as well as

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[156] See *CMDSC v CPSO*, *supra* note 154 at para 93.

[157] *Ibid* at para 230.

[158] See e.g. Jocelyn Downie, "Bouquets and Brickbats for the Proposed Assisted Dying Legislation" (April 20 2016), *Policy Options* (blog), online: <policyoptions.irpp.org/magazines/april-2016/bouquets-and-brickbats-for-the-proposed-assisted-dying-legislation>; Juliet Guichon, "Canada Backpedals on Medical Aid in Dying" (April 20 2016), *Hastings Center Ethics Forum* (blog), online: <www.thehastingscenter.org/canada-backpedals-on-medical-aid-in-dying>.

[159] See e.g. Marie-Danielle Smith, "Senators to Debate Whether to Concede or Fight over Amendments to Assisted Dying Bill", *National Post* (16 June 2016), online: <news.nationalpost.com/news/canada/canadian-politics/senators-set-to-debate-whether-to-concede-or-fight-over-amendments-to-assisted-dying-bill>; Rob Oliphant, "Medically Assisted Dying Bill 'Not Good Enough,' Says Liberal MP", *CBC News* (27 April 2016), online: <www.cbc.ca/news/canada/toronto/programs/metromorning/oliphant-medically-assisted-dying-1.3554579>.

[160] See e.g. James Cowan, "Second Reading of Bill C-14, an Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)" (2 June 2016) *Liberal Senate Forum* (blog), online: <www.liberalsenateforum.ca/hansard/senator-james-s-cowan-second-reading-of-bill-c-14-an-act-to-amend-the-criminal-code-and-to-make-related-amendments-to-other-acts-medical-assistance-in-dying>; Kyle Duggan, "Committee Members Express Dismay at Assisted Dying Bill" (19 April 2016) *iPolitics* (blog),

some of its statements in relation to the similarity between other end-of-life decisions such as treatment withdrawal and refusal and active life-ending MAID can be seen as providing support for a more open-ended interpretation of *Carter* SCC. The Supreme Court's endorsement of the trial judge's argument that capacity and voluntariness assessments are already part and parcel of end-of-life care and that they can play a similar role in the context of active life-ending decisions arguably provides support for this position as well. As pointed out earlier, this rights-focused model is reflected in the recommendations by the Advisory Group and the Joint Committee.[161]

Other commentators, including one of the authors (TL), have argued in submissions to both Parliamentary committees[162] and in papers[163] that

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online: <www.ipolitics.ca/2016/04/19/committee-members-express-dismay-at-assisted-dying-bill>.

[161] See Advisory Group Report, *supra* note 19; Joint Committee Report, *supra* note 19.

[162] See e.g. Dianne Pothier, "Grievous and Irremediable in Bill C-14: Why 'Advanced State of Irreversible Decline' and Death Being 'Reasonably Foreseeable' Are Both Consistent with *Carter* and *Charter* Compliant", Submission to the House of Commons Standing Committee on Justice and Human Rights (26 April 2015), online: Government of Canada <www.parl.gc.ca/Content/HOC/Committee/421/JUST/Brief/BR8240268/br-external/PothierDianne-e.pdf>; *Proceedings of the Standing Senate Committee on Legal and Constitutional Affairs*, 42nd Parl, 1st Sess, No 9 (10 May 2016) at 22–34 (Hamish Stewart's oral submissions) [Standing Senate Committee, *Proceedings No 9*]; Trudo Lemmens, "Critical Reflections on Bill C-14 on Medical Assistance in Dying: Submission to the Standing Committee on Legal and Constitutional Affairs Re Bill C14, Medical Assistance in Dying" (28 April 2016) at 1, online: Senate of Canada <https://sencanada.ca/content/sen/committee/421/LCJC/Briefs/LCJC_May5,2016_SN_Lemmens_e.pdf>; Trudo Lemmens, "Response to the Comments Made during the Committee Hearing of January 2016: Memorandum to the Members of the Special Joint Committee on Physician-Assisted Dying" (2 February 2016) at 1–4, online: House of Commons <https://www.ourcommons.ca/Content/Committee/421/PDAM/Brief/BR8092561/br-external/2016-02-03_follow-up_Trudo_Lemmens_e-e.pdf>.

[163] See e.g. Baker, Sharpe & Lauks, *supra* note 131 at 149–51; Dianne Pothier, "Doctor-Assisted Death Bill Falls Well within Top Court's Ruling" (29 April 2016), *Policy Options* (blog), online: Institute for Research on Public Policy <policyoptions.irpp.org/2016/04/29/doctor-assisted-death-bill-falls-well-within-top-courts-ruling>; Dianne Pothier, "The Parameters of a *Charter* Compliant Response to *Carter v. Canada (Attorney General)*, 2015 SCC 5" (2016)

there is another reading of the decision. This alternate reading focuses on the Supreme Court's recognition of the relevant role of the criminal law in this area and the clear emphasis placed on the need for a very strict regulatory regime to balance the interest of those who want access to MAID with the need for protection of the vulnerable. These commentators also point out that the Court restricted its analysis to the specific end-of-life circumstances of Ms. Taylor, one of the applicants in *Carter*. This stricter reading of the decision supports the claim that the legislative regime of the *MAID Act* is in line with *Carter* SCC and respects the *Charter*. Support for this reading can be found in various aspects of and explicit statements in the Supreme Court's decision. Some of these statements may seem to clash with the rather open-ended support for a right to MAID found in the general parameters of the Supreme Court and could therefore be brushed aside as *obiter dicta*. But when combined with the decisions to suspend the invalidity of the *Criminal Code* provision and to later prolong that suspension, which was explicitly aimed at enabling Parliament to enact a new regulatory regime, these statements provide strong support for a narrower interpretation. Indeed, the integrity of the Supreme Court decision can, in our view, only be maintained if these statements are seen as a strong expression of support for a restrictive regime that allows MAID only in specific circumstances and with appropriate balancing of the interests of those requesting access with the protection of the vulnerable.[164]

First, the Supreme Court provides parameters in overly general terms, yet it limits those parameters by repeatedly stressing that the specific facts of *Carter* involved unique end-of-life circumstances. When discussing whether the restrictions on the right to MAID are in line with the principles of fundamental justice, the Supreme Court only considers the absolute criminal law restriction to be overbroad since, "in at least some cases" – with Ms. Taylor being one example – it affects people who are not vulnerable.[165]

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at 1 [unpublished, archived online: SSRN <papers.ssrn.com/sol3/papers.cfm?abstract_id=2753167>] [Pothier, "Parameters"]; Jacques Fremont, "Some Thoughts Concerning Parliament's Legislative Leeway in a Post-*Carter* Era" (2016) at 2, 7 [unpublished, archived online: SSRN <papers.ssrn.com/sol3/papers.cfm?abstract_id=2760574>].

[164] The apparent clash of the general parameters with some statements, as well as other seemingly contradictory elements in the decision suggests that, rather than reflecting unanimity, the decision may be a compromise among competing visions.

[165] *Carter* SCC, *supra* note 1 at para 86.

The Supreme Court reiterates at the end of the judgment the narrow basis of its decision: "The scope of this declaration is intended to respond to the factual circumstances in this case. We make *no pronouncement on other situations* where physician-assisted dying may be sought."[166] In fact, when discussing the "fresh evidence" brought to the Supreme Court, it stated that the reports of particularly problematic life-ending acts in Belgium were not relevant because they relate to cases "which would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions."[167] It seems difficult to find a clearer statement in support of the argument that the Supreme Court did not intend its ruling to open the door widely to MAID for people who are not in a situation like Ms. Taylor's. The Supreme Court clearly felt the need to put forward that they were not deciding on the issues of MAID for mental illness or minors.

Second, the Supreme Court emphasized that a detailed regulatory regime aimed at protecting the vulnerable is necessary in this context. As the Supreme Court stated, "[c]omplex regulatory regimes are better created by Parliament than by the courts."[168]

The suspension of invalidity also arguably reflects an appreciation of the unusually complex nature of balancing individual rights in this context and the difference with, for example, the abortion context. In a recent article on suspensions of invalidity, Robert Leckey critically compares the suspension of invalidity in the *Carter* case with the much firmer immediate invalidation of the criminal law provisions related to abortion in *R v Morgentaler*.[169] In our view, Leckey's critique of the approach in *Carter* ignores the fundamental differences between the abortion context and end-of-life context. This suspension of invalidity reflects the much more complex impact an outright recognition of the right to MAID may have in the absence of a more rigorous regulatory regime that protects the vulnerable. A number of differences can briefly be mentioned here. Although in both instances the security and liberty of the person are at stake, in the abortion context, fast intervention is deemed important because of the risks and potential trauma of continued pregnancy and late-term abortions. In the context of MAID,

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[166] *Ibid* at para 127 [emphasis added].

[167] *Ibid* at para 111.

[168] *Ibid* at para 125.

[169] "The Harms of Remedial Discretion" (2016) 14:3 Intl J Const L 584 at 588–89.

continued suffering can also be considered traumatizing, but this has to be weighed against the risks of prematurely ending a person's existence. In other words, in MAID we have a dilemma between two choices, both of which can seriously affect the physical integrity and even existence of the person. In the context of MAID, the *Charter* rights restrictions are, certainly in part, aimed at protecting the life of people who are vulnerable. It thus involves a tension between competing individual rights (right of a person seeking access to MAID and the right of individuals in need of protection), which is not the case in abortion (a foetus is not recognized as a rights holder). Capacity issues are also a more significant concern in the context of MAID. The presence or absence of palliative care may also significantly influence whether the patient has other options. Family dynamics and interests are further an important component in MAID.[170] The death of a person has a huge impact on those around. Finally, one has to hope that, for the various reasons pointed out before, health care providers will continue to be very hesitant about taking the life of a person. Their focus is on the well-being of the person they have in front of them and we should be worried, as a society, if health care providers were to become too comfortable and no longer see any dilemma in ending their own patient's life.[171]

The suspension of the *Criminal Code* provision's invalidity thus confirms the Supreme Court's recognition of the fact that MAID is a complex issue in which enabling the exercise of individual rights must be balanced against legitimate governmental obligations related to the protection of the vulnerable. Even though the Supreme Court accepts the trial judge's finding that capacity assessments and informed consent procedures are a reliable component of end-of-life care, the Supreme Court clearly ruled based onthe premise that more is needed when access to MAID is being considered than what currently exists in standard medical care. This can be seen in its frequent reference to the need for a strict regulatory regime – for example, when it approvingly cites Justice Smith's confidence in the possibility of developing "a carefully-designed system imposing stringent limits that are

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[170] While family dynamics may also play a role in the abortion context, the family interests in the dying context tend to be quite unique, both materially and emotionally. Financial costs of care can be significant, inheritance issues are at stake, and the emotions associated with the passing of a loved one tend to be pronounced. The rituals surrounding the passing of a person reflect the social nature of the event.

[171] Some of the points raised here are also made in Baker, Sharpe & Lauks, *supra* note 131 at 152–53.

scrupulously monitored and enforced."[172] That such a regime goes far beyond simple reliance on capacity assessment is even more apparent from the Court's rationale for rejecting the "Belgian evidence." As mentioned earlier, the Court had exceptionally allowed the federal government to produce new evidence at the Supreme Court level, which they argued revealed growing problems with the type of regulatory regime that exists in Belgium. After hearing the evidence, the Court rejected its relevance. The Court argued

> that the cases described by Professor Montero were the result of an oversight body exercising discretion in the interpretation of the safeguards and restrictions in the Belgian legislative regime — *a discretion the Belgian Parliament has not moved to restrict*. These cases offer little insight into how a Canadian regime might operate.[173]

In other words, the Supreme Court indicated that the new evidence related to Belgian developments could not debunk the claim that a good regulatory system can work, since the Canadian Parliament could opt for an oversight body that operates with less discretion and with tighter safeguards and restrictions. Oddly enough, the Belgian evidence is therefore made very relevant for the implementation of *Carter*, in particular as a model that the Court suggests us to avoid.

A further argument relates to the Supreme Court's acceptance of the Québec *Act* as an interim regime that could be used to determine access awaiting further federal legislation. The Québec *Act* is narrow in scope and explicitly focuses on end-of-life situations. Its section 26 provides access to MAID for patients who are "of full age and capable of consenting to care," "at the end of life," "suffering from a serious and incurable illness," "in an advanced state of irreversible decline in capability," and experiencing "constant and unbearable physical or psychological suffering which cannot be relieved in a manner that the patient deems tolerable."[174] Unsurprisingly, one commentator pushing for the more lenient Advisory Group and Joint Committee approach claimed that the Québec model was too restrictive and not in line with *Carter* SCC, and suggested that the Québec legislator would

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[172] *Carter* SCC, *supra* note 1 at para 105, citing *Carter* BCSC, *supra* note 16 at para 883.

[173] *Ibid* at para 113 [emphasis added].

[174] Québec *Act*, *supra* note 90, s 26.

have to adjust its legislation to be broader and align with new federal legislation.[175] Although one should not overstate the relevance of the Supreme Court's second decision in *Carter* for interpreting the first, it is worth noting that the Supreme Court majority in the second decision, dealing with the extension of the suspension of invalidity of the *Criminal Code* provisions, explicitly accepted that the Québec *Act* could start operating immediately to offer redress to those needing access to MAID. This suggests that the Court considered this legislative action to be at least *a reasonable interim response* to addressing the rights at stake in relation to MAID. If the Court had found the Québec *Act* to be too restrictive, it could easily have stated, as it did with regard to access to MAID in other provinces, that individuals could ask for judicial authorization to obtain MAID awaiting final federal legislation. Indeed, it would seem odd to accept that the Québec regime could operate in the interim if it was *prima facie* violating the holding in *Carter* SCC. In our view, this decision suggests that the majority considered this legislation to be a reasonable response and largely in line with *Carter*'s broader parameters.

Finally, it is worth noting that the trial judgment itself – which, as Diane Pothier points out, was not contradicted by the Court on the need for carefully designed safeguards and on the restriction to people with "advanced weakening capacities"[176] – was narrow in scope. Justice Smith makes several statements in which she underscores how access to MAID would have to remain an exceptional procedure, surrounded by stringent safeguards. For example, she summarizes her discussion of the ethical acceptability of MAID as follows:

> there appears to be relatively strong societal consensus [that] human life is of extremely high value, and society should never, or only in very exceptional circumstances, permit the intentional taking of human life.[177]

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[175] Udo Schuklenk, "Assisted Dying Coming to Canada" (7 February 2015), *Udo Schuklenk's Ethx Blog* (blog), online: <ethxblog.blogspot.ca/2015/02/assisted-dying-coming-to-canada.html> ("thanks to the SCC decision, [the limitation to end-of-life situations] will have to be taken out of Quebec's legislation again as it would unjustly deprive people of access to assisted dying who are not close to the end of their lives").

[176] "Parameters", *supra* note 163 at 3, 6, citing *Carter* BCSC, *supra* note 16 at para 1393.

[177] *Carter* BCSC, *supra* note 16 at para 357.

In her conclusion, she even suggests that the "salutary effects" of the criminal law-based legislation "can be preserved by an almost absolute prohibition ... permitting only stringently-limited exceptions."[178] It is difficult to formulate a more restrictive approach short of an absolute prohibition.

Justice Smith also limited her declaration of invalidity of the *Criminal Code* provisions to people in the narrow circumstances of the plaintiffs and clearly took into consideration concerns about vulnerability. She emphasizes, for example, that the declaration only applies to people who are free from coercion and undue influence, not clinically depressed, suffering from a serious illness, and in a state of "advanced weakening capacities with no chance of improvement."[179] She explicitly rejects that the term "grievously and irremediably ill persons" should incorporate reference to "psychosocial suffering."[180] Finally, throughout her judgment, she emphasizes, as the Supreme Court does after her, that the risks involved in MAID have to be significantly reduced by "a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced."[181]

Much has been made of a May 2016 judgment in *Canada (AG) v EF* (*EF*) by the Alberta Court of Appeal, which dealt with an application for judicial authorization of MAID in the period prior to the enactment of the Bill and following the extension of the suspension of invalidity.[182] As discussed earlier, this procedure was in line with the Supreme Court's second *Carter* judgment in which it explicitly allowed requests for MAID to be submitted for judicial review, awaiting federal legislation.[183] In this case, the applicant was E.F., a 58-year-old woman who endured chronic suffering as a result of a medical condition diagnosed by her treating physician as severe conversion disorder, which is a psychogenic movement disorder.[184] One of the problematic components of this case is that no independent psychiatric expert met the person to confirm her capacity and her diagnosis at the

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[178] *Ibid* at para 1283.

[179] *Ibid* at para 1393.

[180] *Ibid* at para 1390.

[181] *Ibid* at para 883, cited by *Carter* SCC, *supra* note 1 at para 105.

[182] 2016 ABCA 155 at paras 27, 33, 403 DLR (4th) 461 [*EF*].

[183] *Carter* 2016 SCC, *supra* note 8 at para 6.

[184] See *ibid* at para 7.

time of her request. The psychiatrist who was consulted on the case only reviewed the file and expressed agreement solely on this basis.[185] The failure to have the person directly assessed by specialists in conversion disorder is unfortunate because of the exceptional nature of the condition and the challenges with its diagnosis (i.e., it often hides another undiagnosed neurological problem).[186] The governments of Canada and British Columbia opposed her motion for judicial authorization, challenging the reliability of evidence produced at trial and taking the position that E.F. did not come within the criteria set out in *Carter* SCC for two reasons: (1) her illness was not regarded as terminal and (2) her illness had as its root a psychiatric condition.[187] The Alberta Court of Appeal rejected these two objections, arguing that the Supreme Court in *Carter* did not *expressly* limit the right to access MAID to those with terminal and non-psychiatric illnesses. The Court of Appeal held that the Supreme Court therefore *chose* not to limit its ruling to those experiencing terminal and non-psychiatric illnesses, even after hearing evidence on the specific issue of whether such individuals should be excluded from the declaration of invalidity.[188]

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[185] See *ibid* at para 64.

[186] See Trevor A Horwitz, "Euthanasia and Mental Illness – Part 1" (2018) [submitted for publication; on file with Trudo Lemmens] (Dr. Horwitz, a neuropsychiatrist at the University of British Columbia and one of the few Canadian specialists on conversion disorder, raises questions as to how patient E.F. was assessed, since none of the specialists in Alberta or British Columbia – where E.F. was euthanized – had, to his knowledge, been consulted in the context of the MAID request). In *EF*, the treating physician reported that the patient had been diagnosed with conversion disorder nine years earlier, had tried several treatments, had been seen by several psychiatrists and at least one neurologist, and that her condition had remained largely unchanged in the last four years (*supra* note 182 at para 62). Although the Court of Appeal expresses confidence in the motions judge's reliance on this report, Horvitz emphasizes that this disorder is often misdiagnosed and that, prior to the irreversible decision to end the patient's life, a specialist on this complex disorder should have been consulted to ensure all options were identified.

[187] See *EF*, *supra* note 182 at para 9.

[188] *Ibid* at para 59. For an interesting decision during the constitutional exemption period that seems much more in line with and respectful of the narrower circumstances of *Carter*, including in its reference to the situation of Ms. Taylor, see *Re HS*, [2016] ABQB 121 at para 110, 394 DLR (4th) 664 (the judge emphasizes that the applicant, an ALS patient like Ms. Taylor, clearly suffered from a grievous and irremediable medical condition as her "illness [was] terminal and her prognosis [was] less than six months").

The judgment in *EF* focuses on the broad parameters of the criteria set out in paragraph 127 of *Carter* SCC without accepting the limiting language found in other portions of the decision.[189] It also ignores, in our view, the judicial context in which *Carter* was decided by the Supreme Court – that is, the Court had to decide whether an absolute prohibition was constitutional. As well, largely following Justice Smith's reasoning at the trial level, the Court emphasized on the truly exceptional circumstances in which access to MAID should be granted.

Finally, and most importantly, the Alberta Court of Appeal wrote its decision without the benefit of legislative text. While the constitutional exemption language found in paragraph 127 of *Carter* SCC is indeed very general, it was issued in anticipation of further legislative action – action which the Supreme Court and Justice Smith emphasized as crucial to protecting the vulnerable. Even if the Alberta Court of Appeal was right in how it applied the constitutional exemption granted by the Supreme Court based on the broad paragraph 127 parameters, its decision is only relevant for reading this specific constitutional exemption. Now that legislation has been issued, courts must show deference to the legislator, who has some level of discretion in deciding how best to protect vulnerable people and determine what protections are necessary with the benefit of democratic debate and deliberation. Arguably, as we pointed out earlier, the Supreme Court did not include those suffering from non-terminal or psychiatric illnesses in paragraph 127 of *Carter* SCC with the intention of leaving this determination to the legislator. This decision is therefore not directly relevant in the further discussion of the constitutionality of the *MAID Act*. The Alberta Court of Appeal even explicitly confirms this: "Issues that might arise regarding the interpretation and constitutionality of eventual legislation should obviously wait until the legislation has been enacted."[190]

The narrower interpretation of *Carter* we put forward in this article supports the claim that the Supreme Court invited Parliament to develop

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[189] See e.g. *Carter* SCC, *supra* note 1 at paras 65 (reference to "people like Ms. Taylor"), 111 (exclusion of the Belgian evidence on the basis that it pertained to situations that "would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions"). Yet one way to read the last sentence is in conjunction with the limiting "parameters" of the judgment. In other words, one could argue that people with psychiatric conditions or minors were considered not to fall within the parameters to the extent that they lacked capacity.

[190] *EF*, *supra* note 182 at para 72.

legislation that could fit situations similar to the health situation of Ms. Taylor, while at the same time respecting the broad parameters the Court provided. Parliament appropriately interpreted these parameters and arguably developed a legislative framework with narrow and more specific terminology that fills in the broad parameters. The Supreme Court provided guidance and it was up to Parliament to make an informed, responsible, democratic decision as legislator on how best to balance the competing interests at stake. Indeed, as Dianne Pothier points out, Parliament had no choice but to engage in a balancing act since competing *Charter* rights are at stake here: the newly recognized right of those who require, in limited circumstances, access to MAID, with the section 7 right to life and security of the person and the section 15 right to equal protection against premature death for those who are vulnerable.[191] If Parliament ignored the rights of the latter, it would open the door to a constitutional challenge based on the failure to protect their *Charter* rights. While this litigation would be more complex to launch, since the vulnerable person whose life has been ended prematurely would obviously not be in a position to launch a court challenge, public interest litigation could be launched by the many health advocacy and disability rights organizations that are expressly concerned about the implications of an open-ended MAID regime. One should hope that human rights commissions and organizations would also be interested in investigating the implications of an overly broad MAID regime that exposes the most vulnerable of our society to the risk of premature death and that these entities would take up the challenge of litigating on their behalf.

As mentioned earlier, a constitutional challenge to the "reasonably foreseeable death" and "decline in capabilities" criteria of the law has already been launched.[192] Time will tell whether the courts, potentially even the Supreme Court, will accept that, contrary to an absolute ban, the remaining restrictions on MAID are compliant with the *Charter*. The language in *Carter* SCC itself suggests that deference will be paid to Parliament when it comes to the determination of the shape and form of a regulatory regime that must, under section 7, balance competing rights and allow access in exceptional circumstances, such as the circumstances of the applicants found in *Carter*.[193] It is further worth pointing out, as Hamish Stewart did in a

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[191] "Parameters", *supra* note 163 at 2–4.

[192] *Lamb* Notice of Civil Claim, *supra* note 10.

[193] See supra note 1 at para 98.

submission for a parliamentary committee hearing on Bill C-14,[194] that recent case law, including *Carter*, indicates the Court will be willing to take into consideration broader evidentiary and societal concerns to determine whether a violation of section 7 can be justified under section 1. When evaluating the reasonableness of the restrictions, the Court will have to look again at the relation between the restrictions and the stated policy objectives of the legislation. In *Carter*, the Supreme Court framed the goal of the criminal prohibition more narrowly as being aimed at protecting vulnerable people from committing suicide at a time of weakness. With the *MAID Act*, however, Parliament has explicitly endorsed that the access restrictions and safeguards aim at protecting several broader policy goals, in addition to protecting vulnerable people from being induced to end their lives. These goals include the recognition that "robust safeguards, reflecting the irrevocable nature of ending a life, are essential to prevent error and abuse"; the affirmation of "the inherent and equal value of every person's life"; the need to avoid "encouraging negative perceptions of the quality of life of persons who are elderly, ill, or disabled; and the recognition of suicide as a significant public health issue that impacts on individuals, families and communities."[195] In considering whether the restrictions on access to MAID in the Canadian law are reasonable in relation to these goals, the distinction between section 7 and section 1 analysis becomes relevant[196] and some of the more complex ways in which evolving practices in existing open-ended regimes may affect the stated values and norms will therefore be essential. This type of evaluation was arguably not undertaken in the context of the *Carter* case. New evidence that has emerged from these regimes will also be important.

Restricting access to MAID, as the federal legislation does, to situations where a person has an irreversible decline in capability and where death is reasonably foreseeable is thus, in our view, in line with *Carter*, *Charter* compliant, and an overall reasonable approach.

Some concerns remain as to how the law will be implemented. Indeed, to capture the situation of all the plaintiffs in *Carter*, the legislation's reli-

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[194] See Standing Senate Committee, *Proceedings No 9*, *supra* note 162 at 23. See also Hamish Stewart, "Constitutional Aspects of Canada's New Medically-Assisted Dying Law" (2018) 85 SCLR (2d) 435.

[195] *MAID Act*, *supra* note 6, Preamble.

[196] See Hamish Stewart, "*Bedford* and the Structure of Section 7" (2015) 60:3 McGill LJ 575 at 588–89.

ance on concepts such as "reasonably foreseeable" death and "decline in capabilities" facilitates a flexible interpretation.[197] Media reports of MAID cases already show how some health care providers may interpret this requirement very widely.[198] There is a risk that some will disconnect the criteria from what Parliament clearly intended. For example, two scholars – one of whom criticized the Bill when it was originally introduced in Parliament for being too narrow and for excluding MAID for mental health conditions[199] – have already used the definition to stretch the application of the law. They now argue that the *MAID Act* allows people with a variety of mental health conditions to request MAID on the sole basis of mental illness, arguably even outside the broadly conceived "end-of-life" context.[200] In the *Journal of Ethics and Mental Health*, Jocelyn Downie and Justine Dembo state that people suffering solely from mental illness can request MAID under the new law. To make this argument, they go over the criteria in the definition of grievous and irremediable medical condition and find for each of them either an extreme example of a mental health condition that could fulfill that specific criterion or some general statistical evidence.[201] They do not, however, make a convincing case for how mental health conditions more generally fulfill all the criteria and do not sufficiently recognize the unique challenges associated with mental health. One of their key points is that statistical evidence shows that some people who suffer from severe

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[197] See *Debates of the Senate*, 1 June 2016, *supra* note 143 at 746 (Minister Wilson-Raybould explains that the definition chosen for the Supreme Court's term, "grievous and irremediable," was to "inject a bit more flexibility in terms of who can access medical assistance in dying." She also expresses confidence that Kay Carter would have qualified under the Bill).

[198] See e.g. Brian Hutchinson, "The Right to Die on One's Own Terms: At 94, Sick, Tired and Living Alone, 'Dad Got the Death He Wanted'", *National Post* (20 October 2016), online: <nationalpost.com/news/canada/the-right-to-die-on-ones-own-terms-at-94-sick-tired-and-living-alone-dad-got-the-death-he-wanted>.

[199] See House of Commons, Standing Committee on Justice and Human Rights, *Evidence*, 42nd Parl, 1st Sess, No 13 (4 May 2016) at 31–32 (Jocelyn Downie, appearing before the Committee as an individual).

[200] Jocelyn Downie & Justine Dembo, "Medical Assistance in Dying and Mental Illness under the New Canadian Law", online: (2016) 9 J Ethics Mental Health, <https://www.jemh.ca/issues/v9/documents/JEMH_Open-Volume_Benchmark_Medical_Assistance_in_Dying_and_Mental_Illness_Under_the_New_Canadian_Law-Nov2016.pdf>.

[201] *Ibid* at 3–6.

depression, for example, never recover.[202] This means, according to Downie and Dembo, that this disease is often irremediable. They further refer to the physical, psychological, and social decline many people with bipolar disorder experience, including social isolation, breakdown in relationships, and homelessness, which would be an indication of how mental disorders can lead to an irreversible decline in capabilities.[203] A point-by-point rebuttal of the arguments they make in their discussion of the access criteria exceeds the scope of this paper.[204] But it suffices here to comment on some key problems with their arguments and, more importantly, to point out how, in their desire to broaden the application of the law, they overlook the rules of statutory interpretation, in particular because of their explicit rejection of Parliament's intent.

With respect to the argument that some never recover from mental illness, there is a difference between retrospectively concluding, on the basis of general statistical data accumulated over time, that some patients never recover from major depression and prospectively deciding in a specific case that a patient will never recover. Some may never recover from severe depression but the majority will,[205] and we do not know who will and who will not. As Thomas Blikshavn and colleagues point out, "the nature of psychiatric diagnoses and treatment imply that knowledge of poor prognosis on a group level cannot be transferred to the individual."[206] The example of

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[202] *Ibid* at 4.

[203] *Ibid* at 5.

[204] One of the authors (TL) provided a rebuttal at a conference where Jocelyn Downie also presented these arguments and will be responding directly in the *Journal of Ethics in Mental Health*. For a recording of this conference, see Jocelyn Downie, "How We Got Here and What Should Come Next" (Lecture delivered at the Colloquium on Medical Aid in Dying (MAID) for Persons with Mental Illness, Faculty of Law, University of Toronto, 29 January 2017), online: <https://camh.adobeconnect.com/p5ar4bac69a>; Trudo Lemmens, "Physician-Hastened Death for Mental Health Disorders: What Euthanasia Practice in the Low Countries Tells Us about Its Reality" (Lecture delivered at the Colloquium on Medical Aid in Dying (MAID) for Persons with Mental Illness, Faculty of Law, University of Toronto, 29 January 2017), online: <https://camh.adobeconnect.com/p6uel48wcmj>].

[205] See Abebaw Fekadu et al, "Prediction of Longer-Term Outcome of Treatment-Resistant Depression in Tertiary Care" (2012) 201:5 Br J Psychiatr 369 at 372.

[206] Thomas Blikshavn, Tonje Lossius Husum & Morten Magelssen, "Four Rea-

depression also makes it clear what other aspects of the statute's definition will normally not be fulfilled in the context of mental health disorders: the statute offers access to MAID for patients where the natural course of the illness will in the reasonably foreseeable future result in their death. In the context of several forms of mental disorder, the death we are trying to avoid via treatment is not a predictable biological outcome of the disease itself. Blikshavn and colleagues summarize it aptly:

> Mental diagnoses, then, are in this respect unlike most somatic diagnoses, such as cancer or amyotrophic lateral sclerosis, where one, in addition to the purely statistical prediction of prognosis, may actually be able to identify andcharacterize the pathophysiological mechanism that inexorably produces deterioration. In contrast, for a mental illness, a prediction of prognosis can be made from a basis of statistics only. This implies neglecting the symptom-producing mechanisms, attention to which may be key to recovery. Assuming that this particular patient, fulfilling any of the current sets of [treatment-resistant depression] criteria, is exceedingly unlikely to recover therefore amounts to an unjustified generalization to the individual from an actuarial risk assessment.[207]

There is also a difference between a natural decline in physical capabilities when a person is dying as a result of a fatal illness and the potentially debilitating but often fluctuating loss of capabilities that characterizes many mental health disorders. In the context of the latter, there will often be cyclical periods of good quality of life that are hard to predict but that will depend on the quality of care patients receive.[208] The significant difficulty in predicting individual recovery and the trajectory of the disease is one of the defining features of mental disorders.[209]

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sons Why Assisted Dying Should Not Be Offered for Depression" (2017) 14:1 J Bioeth Inq 151 at 152.

[207] *Ibid* at 153.

[208] See Carla A Green et al, "Recovery from Serious Mental Illness: Trajectories, Characteristics, and the Role of Mental Health Care" (2013) 64:12 Psychiatr Serv 1203.

[209] See Blikshavn, Husum & Magelssen, *supra* note 206 at 153–54; Alexander IF Simpson, "Medical Assistance in Dying and Mental Health: A Legal, Ethical, and Clinical Analysis", Perspective, (2018) 63:2 Can J Psychiatry 80 at 81–82; Centre for Addiction and Mental Health, "Policy Advice on Medical Assist-

Downie and Dembo further fail to appreciate the unique challenges of dealing with treatment refusal in the context of mental health. They rightly recognize and even emphasize that patients often refuse psychiatric treatment because they find the treatments offered intolerable. When they refuse, they argue, the disease becomes incurable.[210] Yet, the tendency to refuse treatment among many people affected by mental illness is precisely one of the core challenges, as it is often also an expression of the underlying illness.[211] Abstaining from invading the bodily integrity of people struggling with mental illness through forced treatment is one thing; offering as an alternative to treatment an active ending of their life is quite another, particularly when the desire to die may be a symptom of, or interact with, their illness. In end-of-life situations involving somatic illnesses, the fact that most people want to continue living makes refusal of effective treatments less likely; it is therefore less of a concern that treatment refusal will lead to the choice of premature death on a large scale.[212] Another key issue is that many patients spontaneously recover, even when they refuse treatment. One systematic review of studies focusing on major depression, for example, estimated that 53% of patients with major depression spontaneously recover within 12 months.[213]

The Downie and Dembo argument further overlooks the clearly expressed intent of the legislator and the context surrounding the legislation, which are established elements of statutory interpretation. The doctrine of parliamentary sovereignty imposes on courts and other interpreters – academic scholars included – a duty to determine legislative intent when interpreting a statute.[214] Section 10 of the *Interpretation Act* states, for ex-

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ance in Dying and Mental Illness" (October 2017), online: <https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMH-Position-on-MI-MAiD-Oct2017.pdf>.

[210] Downie & Dembo, *supra* note 200 at 5.

[211] See Scott YH Kim, Raymond G De Vries & John R Peteet, "Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014" (2016) 73:4 JAMA Psychiatry 362 at 365.

[212] See Kim & Lemmens, *supra* note 61 at E337–38.

[213] Harvey A Whiteford et al, "Estimating Remission from Untreated Major Depression: A Systematic Review and Meta-Analysis" (2013) 43:8 Psychol Med 1569 at 1580.

[214] See Ruth Sullivan, *Statutory Interpretation*, 3rd ed (Toronto: Irwin Law,2016 at 32.

ample, that effect must be given to a statute according to "its true spirit, intent and meaning."[215] In *Re Rizzo & Rizzo Shoes Ltd*, the leading modern case on statutory interpretation, Justice Iacobucci highlighted and adhered to Driedger's modern principle of statutory interpretation: "the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the objective of the Act, and the intention of Parliament."[216] Courts have long rejected a literal approach to statutory interpretation and the grammatical and ordinary sense of a section is not considered determinative.[217] The total context of the provision also includes its drafting history.[218]

The legislative intent and context of the *MAID Act* are far from ambiguous: Justice Minister Wilson-Raybould and Health Minister Philpott unequivocally and publicly stated on several occasions, including in parliamentary committee hearings, that mental illness as a sole underlying condition was excluded from the eligibility criteria set out in the Bill as it is now adopted.[219] In addition, the preamble of the legislation, which is to be read as a "part of the enactment intended to assist in explaining its purport

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[215] RSC 1985, c I-21.

[216] [1998] 1 SCR 27 at para 21, 36 OR (3d) 418, Iacobucci J, citing Elmer Driedger, *Construction of Statutes*, 2nd ed (Toronto: Butterworths, 1983) at 87.

[217] See e.g. *Chieu v Canada (Minister of Citizenship and Immigration)*, 2002 SCC 3 at para 34, [2002] 1 SCR 84; *ATCO Gas & Pipelines Ltd v Alberta (Energy & Utilities Board)*, 2006 SCC 4 at para 48, [2006] 1 SCR 140.

[218] See Sullivan, *supra* note 214 at 49, 52. The context analysis involves reconciling the first impression meaning formed based on the text with the indicators of legislative intent derived from the larger context (see *ibid* at 49). Admissible elements of context include

> factual and ideological setting of legislation, a setting that includes the historical, social, political, cultural, economic and institutional conditions in which legislation is enacted and in which it operates after enactment (*ibid* at 52).

[219] See e.g. Senate, *Proceedings of the Standing Senate Committee on Legal and Constitutional Affairs*, 42nd Parl, 1st Sess, No 8 (4 to 6 May 2016) at 12–13 (Minister Wilson-Raybould), 40 (Minister Philpott) [Standing Senate Committee, *Proceedings No 8*]; *House of Commons Debates*, 42nd Parl, 1st Sess, Vol 148, No 62 (31 May 2016) at 3798 (Minister Wilson-Raybould, on third reading of Bill C-14).

and object,"[220] states the government's commitment to further research the issue of "mental illness as the sole basis," in conjunction with the issues of advanced directives and MAID for mature minors. In commenting on this commitment, Minister Wilson-Raybould clarified that the commitment to study the issues was "not put there to presuppose an answer that, ultimately, medical assistance in dying would be made available in these three particular categories,"[221] thus again confirming it was not part of the Bill in the first place. The amendments passed between the Senate and the House of Commons also inform us of the legislative intent regarding the breadth of the legislation. On 8 June, prior to the Bill's third reading, the Senate motioned for the removal of the "reasonably foreseeable death" criterion by replacing it with "after the condition has begun to cause enduring suffering that is intolerable to the person,"[222] which was rejected by the House of Commons on 16 June. Many Senators expressed discontent with the House of Common's insistence on this narrower approach towards MAID that excluded mental health and advanced directives.[223] Yet, the government's further amendments and rejections of the Senate amendments were ultimately heeded, including the decision to preserve a narrower "reasonably foreseeable death" criterion.[224]

Downie and Dembo conclude their paper by calling on the government to "amend its published documents and future public statements to correct the misinformation they have provided."[225] Even if this were a situation of two equally reasonable interpretations, accusing the government of misinformation and calling for a public correction seems rather presumptuous. In this case, however, we have two academic commenta-

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[220] *Interpretation Act*, *supra* note 215, s 13.

[221] Standing Senate Committee, *Proceedings No 8*, *supra* note 219 at 58.

[222] *Debates of the Senate*, 8 June 2016, *supra* note 141 at 938, 952.

[223] See *ibid*.

[224] See *Debates of the Senate*, 1 June 2016, *supra* note 143 at 760 (Minister Philpott explains that access to MAID for those with mental illness, among other access restrictions, "fall[s] outside the bill's criteria" and would "need more study before we consider taking further steps"), 760–61 (Minister Philpott indicates that some members of the House of Commons would have preferred the Bill to be broader, "even allowing access to … people with a mental illness as a main underlying condition").

[225] *Supra* note 200 at 6.

tors requesting an explicit post factum change of legislative intent. Further, they claim the government should be considered "responsible for the extended, enduring, and intolerable suffering of those individuals denied access to the medical assistance in dying, to which they are entitled under the legislation."[226] We would suggest that the authors carefully reflect on their own responsibility in this context. Academic papers by influential scholars that produce an unreasonable interpretation of the MAID legislation risk opening the door to practices that were clearly not intended by Parliament and where further study was deemed essential. Further study may convince Parliament either to keep the current approach and to continue prohibiting MAID in situations where a mental illness is the sole basis of the request; or to allow some specific practices in the psychiatric context, but with additional and more stringent safeguards; or, indeed, to expand the legislation without any further requirements. What is clear is that, at this stage, both the federal and provincial governments are still struggling with the implementation of a proper regulatory system, including a proper reporting system. At a time when the legislative and regulatory frameworks are still developing, such interpretations, which appear driven by the authors' strong support for a more open system, risk putting some of the most vulnerable members of society at risk of premature death. Particular prudence is also warranted because of the danger of creating problematic expectations among people who, as a result of their mental health condition, may already be looking for a way to end their life. Sending the message that they are eligible under the current legislation may disrupt already challenging treatment relations, including through the creation of false expectations that may influence patients' hope.[227] Mental health care providers may then also feel pressured to refer a patient requesting access to MAID to someone else rather than reject the request as unfounded.

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[226] *Ibid* at 7.

[227] On the complex interaction between offering access to MAID and hope, see Blikshavn, Husum & Magelssen, *supra* note 206 at 155. Interestingly, the most recent official review of the Dutch euthanasia law reports that the *demand* for euthanasia has increased dramatically in the last five years, in line with the recent increase in the number of cases of euthanasia performed for mental illness and growing public discussion about these cases: whereas only 300 people asked for euthanasia for mental illness in 1995, this had increased to 1,100 in 2015. Bregje Onwuteaka-Philipsen et al, *Derde Evaluatie Wet Toetsing Levensbeëindiging Op Verzoek en Hulp Bij Zelfdoding* [*Third Evaluation Law on the Verification of Ending Life on Request and Assistance with Suicide*] (The Hague: ZonMW, 2017) at 138. This suggests, in our view, that public awareness and debate about the option can increase the perceived need for it.

Another reason to be cautious is that the inherent flexibility of the broad end-of-life focused criteria may lead overzealous physicians to further challenge the boundaries of the law. They might embrace academic publications with such interpretations as a shield against possible criminal liability. Indeed, health care providers who acted under a "reasonable but mistaken belief" that a person could legitimately request MAID are protected by the exemption from the criminal prohibition.[228] In this respect, April 2017 changes to the government's website aimed at providing information about the law are not helpful. This version of the information page states that "[i]f you have a mental illness or a physical disability and wish to seek medical assistance in dying, you may be eligible. Eligibility is assessed on an individual basis, looking at all the relevant circumstances."[229] While it reiterates that eligibility criteria have to be fulfilled, this general suggestion sends the wrong message and may create an expectation among those who are struggling with mental health issues that they qualify for MAID. It would be more accurate to state, as we argued here and as the government otherwise has clearly stated, that mental illness on its own is not a sufficient basis for access to MAID under the current law.

The legislation in its present form may not be the end of the road, even if courts uphold it. Parliament will be studying the issue of MAID on the basis of advance directives, for mature minors, and in the context of mental illness, informed by the work of expert committees set up by the Council of Canadian Academies. These ongoing discussions make it particularly important to take a critical look at the experience in Belgium, a jurisdiction that provides more expansive access and where increasing concerns have been raised due to recent developments, particularly in the context of mental health.

## II. THE BELGIAN EXPERIENCE

### *A. The regulation of euthanasia in Belgium*

Belgium legalized euthanasia in May of 2002. The *Law Concerning Euthanasia of 28 May 2002* (*Belgian Euthanasia Act*)[230] has a number of

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[228] *MAID Act*, *supra* note 6, s 1 (enacting s 241(6) of the *Criminal Code*).

[229] Government of Canada, "Medical Assistance in Dying" (26 April 2017), online: <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>.

[230] *Supra* note 122.

conditions and procedural requirements. Euthanasia is permissible if the patient "is in a medically hopeless condition experiencing constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident."[231] In addition, the patient must be a legally competent adult or emancipated minor who has made a voluntary request to be euthanized.[232]

The *Belgian Euthanasia Act* further introduces a number of procedural requirements that apply to standard requests for euthanasia by competent adult individuals at the end of life. The first requirement is that there must be a discussion with the patient about her condition, about her prognosis, and about the different treatment options, including palliative care.[233] The second is that the physician must "[a]scertain the continued physical or mental suffering of the patient and of the recurring nature of his/her request." The law requires that this be done over "several conversations" spread over a "reasonable period of time."[234] A third formal requirement is a consultation with an independent physician about the "serious and incurable nature of the disorder." The goal is to allow the second physician to confirm "the constant, unbearable nature of the physical or mental suffering that cannot be alleviated."[235] There are some requirements related to contacting members of the treatment team – if there is one, they must be consulted – and family members – if the patient so desires.[236]

Additional requirements and restrictions exist for patients who are not at the end of life, for mature minors, and for euthanasia requests of incompetent patients based on advance directives. When patients are not at the end of life, a third physician who is either a specialist in the condition of the patient or a psychiatrist must be consulted and an obligatory waiting period

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[231] *Ibid*, s 3(1) [English translation by Jones, Gastmans & MacKellar, *supra* note 122 at 306].

[232] *Belgian Euthanasia Act*, *supra* note 122, s 3(1).

[233] *Ibid*, s 3(2)(1).

[234] *Ibid*, s 3(2)(2) [English translation by Jones, Gastmans & MacKellar, *supra* note 122 at 306].

[235] *Belgian Euthanasia Act*, *supra* note 122, s 3(2)(3) [English translation by Jones, Gastmans & MacKellar, *supra* note 122 at 306].

[236] See *Belgian Euthanasia Act*, ss 3(2)(4), 3(2)(5).

of one month is imposed on the patient.[237] This mandated reflection period demonstrates a heightened concern for euthanasia in these circumstances and the need to ensure that the request is well considered.

Following amendments in 2014, access to euthanasia was extended to patients under the age of 18 but only for physical suffering at the end of life,[238] after consultation with a child psychiatrist or a psychologist, and with agreement from the parents.[239]

The law also makes euthanasia available via advance directive, but only for patients who are in a situation of irreversible unconsciousness[240] – this excludes patients whose capacity is diminished, such as dementia patients. There are procedural requirements related to the presence of witnesses and an important time limit is put on the validity of the advance directive: the written request cannot be more than five years old.[241] These additional requirements reflect the often problematic and complex nature of advance directives, especially in the end-of-life context.

An important component of the legislation is the reporting obligation. In the Belgian system, the key review body is the Federal Control and Evaluation Commission (the Federal Commission). It has a specific role with respect to the review of each euthanasia case and an overall reporting obligation about euthanasia practices in the country through biennial reports to Parliament.[242] The Federal Commission is an interdisciplinary body with 16 members – 8 physicians, 4 lawyers or law professors, and 4 members from "groups responsible for addressing the challenges faced by people affected by an incurable illness."[243] The Federal Commission reviews a physician's report

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[237] See *ibid*, s 3(3).

[238] See *ibid*, s 3(1).

[239] See *ibid*, s 3(2)(7).

[240] *Ibid*, s 4(1).

[241] See *ibid*.

[242] See *ibid*, ss 8–9. For a discussion of the role and functioning of the Federal Commission, see Herman Nys, *Geneeskunde: Recht en Medisch Handelen* (Mechelen, Belgium: Wolters-Kluwer, 2016) at 353–57.

[243] *Belgian Euthanasia Act*, *supra* note 122, s 6(2) [English translation by Jones, Gastmans & MacKellar, *supra* note 122 at 310–11]. For a detailed review of problems with the Federal Commission, see Trudo Lemmens, "*Charter* Scru-

on the performance of euthanasia, which contains two different parts. A first sealed part contains identifying information on the patient, the physician who performed the euthanasia, and any person consulted. A second part contains anonymous general patient information and other specific aspects of the euthanasia request, such as the nature of the illness, the nature of the suffering, the reasons why the suffering was qualified as impossible to alleviate, the existence of an advance directive, the procedures followed, and whether the patient was about to die in the near future.[244] If a two-thirds majority of the Federal Commission determines that the requirements of the euthanasia legislation have not been respected, the case is forwarded to the public prosecutor, who reviews the file and decides whether the case should be prosecuted.[245]

## *B. Concerns raised in the context of the Belgian system*

### 1. Pressure to extend the legislative framework

Several initiatives in Belgium have been aimed at expanding the practice in new area not contemplated in the original legislation. Originally, children were explicitly excluded from the ambit of the law because "it was deemed so controversial that including it would have threatened approval of the Euthanasia Bill."[246] But in 2014, following intense debate in the legislature, euthanasia was made available to mature minors; that is, those below 18 years of age who are deemed capable of understanding and appreciating the consequences of their request for euthanasia.[247] Additional procedural safeguards, including psychological or psychiatric assessment and parental

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tiny of Canada's Medical Assistance in Dying Law and the Shifting Landscape of Belgian and Dutch Euthanasia Practice" (2018) 85 SCLR (2d) 459 [Lemmens, "*Charter* Scrutiny"].

[244] See *Belgian Euthanasia Act*, *supra* 122, s 7.

[245] See *ibid*, s 8.

[246] John Griffiths, Heleen Weyers & Maurice Adams, *Euthanasia and Law in Europe* (Portland: Hart, 2008) at 328.

[247] See *Wet tot wijziging van de wet van 28 mei 2002 betreffende de euthanasie, teneinde de euthanasie voor minderjarigen mogelijk te maken* [*Law to amend the law of 28 May 2002 Concerning Euthanasia, in order to allow euthanasia for minors*] Belgian Official Journal, 19 November 2014, 91001, C – 2014/00800. For a critique of the amendment, see Andrew M Siegel, Dominic

consent, were included,[248] likely to ensure a majority of votes in Parliament. Children were also only given access to euthanasia for physical suffering, arguably a recognition by the legislator that mental health issues raise unique concerns in this population.

There have also been proposals to amend the provisions on advance directives and extend access to dementia patients. The Belgian legislation allows the use of advance directives for euthanasia requests but the directives only remain valid for five years after they have been drafted and only apply to situations where a patient has become irreversibly unconscious.[249] Because of the limitations on the use of advance directives, people who start suffering from dementia may be asking for euthanasia earlier to ensure that they are still considered to have capacity.[250]

Yet there is a rationale behind restricting the application of advance directives to situations of "irreversible unconsciousness." Euthanasia must be motivated by a person's subjective experience of intolerable suffering, but assessing future suffering is difficult and unreliable – people can only imagine, not predict, how much they will subjectively suffer as a result of future medical events. The triggering condition for euthanasia by advance directive in Belgium, irreversible unconsciousness, is one that can at least be objectively determined by physicians and is arguably unrelated to current patient suffering.[251] Yet at the same time, euthanasia in that context

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A Sitsi & Arthur L Caplan, "Pediatric Euthanasia in Belgium: Disturbing Developments" (2014) 311:19 JAMA 1963.

[248] See *Belgian Euthanasia Act*, *supra* note 122, s 3(2)(7).

[249] *Ibid*, s 4. But see Herman Nys, "A Presentation of the Belgian Act on Euthanasia against the Background of Dutch Euthanasia Law" (2003) 10:3 Eur J Health Law 239 at 254, n 13 (arguing that the exact wording in the statute supports the interpretation that they remain valid after the five-year period, as long as incapacity occurs within five years of signing the advance directive).

[250] See Raphael Cohen-Almagor, "First Do No Harm: Euthanasia of Patients with Dementia in Belgium" (2016) 41:1 J Med Philos 74 at 77 [Cohen-Almagor, "Dementia"].

[251] See Penney Lewis & Isra Black, "Adherence to the Request Criterion in Jurisdictions Where Assisted Dying is Lawful? Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon, and Switzerland" (2013) 41:4 JL Medicine & Ethics 885 at 893. The difficulty of establishing whether a patient with cognitive decline and who has an advance directive is suffering unbearably is

cannot be based on unbearable suffering, since the patient is no longer concretely experiencing suffering. The proposed expansion of the validity of advance directives to situations of mental incapacity where the patient is still conscious would require some other decision maker to assess the patient's subjective experience of suffering. Empowering others to decide whether a person with cognitive impairments is suffering enough to legally trigger euthanasia makes incompetent patients vulnerable to abuse and error. It could lead to ending the life of a person who appears to have a decent quality of life and enjoys their new form of existence, yet is incapable of expressing a change of mind as a result of lack of capacity. Finally, a regulatory system that endorses ending a person's life based on a previously expressed wish to die when there is irreversible loss of memory and other cognitive decline can be seen as expressing a negative view about the value of life of those with cognitive limitations.

In his affidavit in *Carter* SCC, Professor Montero mentioned other legislative initiatives aimed at expanding euthanasia to disabled newborns and to incompetent people who have not expressed a prior desire to be euthanized (i.e., non-voluntary euthanasia).[252] Raphael Cohen-Almagor also suggests that "[o]ne cautionary barrier after the other is removed to allow greater scope for euthanasia."[253] These developments are often referred to as a sign of a slippery slope. It suggests that the adoption of somewhat narrow life-ending practices will inevitably lead to practices that were originally not considered appropriate by the legislators. Whether we qualify it as a slippery slope or not, it is interesting that, in Belgium, certain life-ending actions were specifically left out of the initial legislative proposals, making their adoption more palatable. In other words, those pushing for legalization may have realized that there was a lack of widespread support for euthanasia in more controversial areas, such as with euthanasia for minors. But once a palatable form of MAID finds political support, it can create a momentum towards the inclusion of other forms of active life-ending medical decisions. The same is arguably occurring in Canada, where the pressure to expand MAID is growing. For example, Québec's Minister of Health stated that the province would be studying whether its provincial MAID legisla-

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a key reason why the expansion of the practice of euthanasia involving such patients has been the subject of heated debate in the Netherlands. On that topic, see the discussion in Lemmens, "*Charter* Scrutiny", *supra* note 243.

[252] See *supra* note 1 at paras 110–13.

[253] "Dementia", *supra* note 250 at 86.

tion should be expanded to allow people who develop Alzheimer's to opt for MAID by advance directive so that they can receive it once the disease has progressed.[254] A healthy debate should include considerations about the desirability of social and legal changes that may shift Canada's overall approach to end-of-life care in the long run.[255]

### 2. Increase in euthanasia practices: An empirical slippery slope

An empirical discussion of the slippery slope is more complex. It generally involves a detailed discussion of data and the numerous empirical studies done both pre- and post-legalization of the practice in its various components. A first point that has been made is that, following legalization in Belgium, the number of *reported* euthanasia cases increased significantly over time. In the first 15 months after the law was introduced, there were 259 reported cases of euthanasia. The numbers increased to 393 in 2005, 495 in 2007, 822 in 2009, 1,133 in 2011, 1,816 in 2013, and 2,022 in 2015.[256]

There is a striking, largely unexplained discrepancy in reported cases between the two largest linguistic groups in the country. The French-speaking population, spread out over Wallonia (French-speaking, with a small minority German speaking) and Brussels (bilingual but with a large majority French-speaking), accounts for about 40% of the country's population, and yet roughly only 20% of the euthanasia cases reported to the Federal Commission are in French.[257] Studies based on anonymous surveys aimed

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[254] See Allan Woods, "Quebec Considers Assisted Death for Dementia Patients", *The Star* (24 March 2017), online: <https://www.thestar.com/news/canada/2017/03/24/quebec-considers-assisted-death-for-dementia-patients.html>.

[255] For an interesting application of Eugene Volokh's theory of slippery slope through law in the euthanasia context, see Mary Shariff, "Assisted Death and the Slippery Slope – Finding Clarity Amid Advocacy, Convergence, and Complexity" (2012) 19:3 Curr Oncol 143.

[256] Federale Controle en EvaluatieCommissie Euthanasie, *Zevende verslag aan de wetgevende kamers, jaren 2014-2015* [*Seventh Report to the Parliamentary Chambers, Years 2014–2015*] (Brussels: FCEE, 2016) at 14, online: <overlegorganen.gezondheid.belgie.be/nl/advies-en-overlegorgaan/commissies/federale-controle-en-evaluatiecommissie-euthanasie>.

[257] *Ibid* (21% of cases in 2014, 19.4% in 2015). For an archive of the Federal Control and Evaluation Commission's reports, see Belgium, Federale Over-

at gauging the practice of euthanasia, including potential unreported cases, have been undertaken only in Dutch-speaking Flanders. These studies indicate that MAID constituted 1.9% of all deaths in 2007, which had increased to 4.6% in 2013, meaning that 1 out of every 20 patients had died with euthanasia.[258] The surveys also indicate a significant increase in the proportion of requests that are granted, from 56.3% in 2007 to 76.8% in 2013, suggesting a growing comfort level among physicians in granting requests and in performing euthanasia.[259] It is also worth noting that a majority of ungranted requests were the result either of patients dying before the request could be granted (in 2013, 58.5% of ungranted requests) or of patients withdrawing the request (17.9% in 2013). In other words, in 2013, doctors refused to grant a request in a very small number of cases – just 5.98% of requests.[260]

But does this indicate an empirical slippery slope? There are difficulties with the interpretation of the evidence provided in, for example, the Dutch and Belgian euthanasia reports. Importantly, there are no reliable figures about the number of cases before the introduction of the euthanasia law. Reports suggest that euthanasia was being practiced in Belgium,[261] as is undoubtedly the case in most, if not all, jurisdictions, but it is difficult to

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heidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu, “Federale Controle en Evaluatiecommissie Euthanasie”, online: <overlegorganen.gezondheid.belgie.be/nl/advies-en-overlegorgaan/commissies/federale-controle-en-evaluatiecommissie-euthanasie>. The percentage of reporting in French has increased slightly since the early years, but has remained more or less constant since 2009. In 2005, the percentage of reports in French was 15% (Second Report, Years 2004-2005 at 11). Since then it has hovered around the 20% mark. In 2009, 20% of reports were in French (Fourth Report, Years 2008-2009 at 7) and in 2010 and 2011 combined, 18% of reports were in French (Fifth Report, Years 2010-2011 at 11).

[258] Kenneth Chambaere et al, “Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium” (2015) 372:12 N Engl J Med 1179 at 1179 [Chambaere et al, “Recent Trends”].

[259] *Ibid.*

[260] Sigrid Dierickx et al, “Comparison of the Expression and Granting of Requests for Euthanasia in Belgium in 2007 vs 2013” (2015) 175:10 JAMA Intern Med 1703 at 1705.

[261] See Luc Deliens et al, “End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey” (2000) 356:9244 Lancet 1806.

obtain reliable data and thus to draw clear conclusions about the prevalence of a hidden, criminalized practice. While it can be argued that there is now at least more transparency and reliable data about the material results of the legalization of the practice, it is difficult to determine how the reported cases relate to the unreported cases.

One of the arguments in favour of legalization is that, with a legalized practice and resulting self-reporting, there will be clear data and a better understanding of the scope of the practice in the field. As we will see below from the reports on euthanasia practices in Belgium and the Netherlands, a legal structure with reporting obligations does not solve the problems of under- and misreporting. The argument that a legalized system creates transparency and understanding must therefore be qualified: while more data is available, hidden practices remain and interpretation of the reported cases of compliance and non-compliance would require further refinement. It could very well be that there is simply a shift, with previously hidden practices now regulated and other forms of euthanasia, including non-voluntary euthanasia and practices that do not respect the legal procedures, actually increasing. The post factum reporting systems of Belgium and the Netherlands do not prevent those hidden practices and do not provide more certainty about what is happening. They could in fact give a false sense of security and control over the practice.

The growing reported numbers confirm that the practice is becoming normalized, that more patients request euthanasia, and that more requests are fulfilled. Those who have ethical or policy-related concerns are likely worried about this significant increase. It may suggest that, even among those who request euthanasia when they are terminally ill, some who otherwise would still have enjoyed some quality of life in the context of palliative care may now opt for euthanasia, that there may be growing pressure to end one's life with euthanasia, and that, within such a large group, it is likely that some were vulnerable and died prematurely.

### 3. Expansion of the practice in problematic areas

A different and more pernicious slippery slope presents itself when legislation originally designed to cover one specific set of circumstances leaves room for a more *flexible* interpretation that can lead to a significant expansion of the practice once adopted. The concern here is that it can be very difficult to delineate what constitutes acceptable practice and ensure that other unintended practices do not gradually occur. It would be problematic to not take into consideration the risk that vague criteria may lead to practices that the legislator did not intend.

The *Belgian Euthanasia Act* introduces specific criteria for obtaining euthanasia, both objective and subjective, which must be verified by a physician and submitted for consultation to an independent colleague.[262] On the one hand, the objective components are that the situation must be "medically hopeless" and result from a "serious and incurable disorder caused by illness or accident." On the other hand, the experience of "physical or mental suffering" is a subjective factor: it is the patient who determines whether the suffering is unbearable. The vague and open-ended nature of the term "medically hopeless situation" and an increasingly subjective interpretation of the term "constant and unbearable physical or mental suffering" have opened the door to many instances of euthanasia that are controversial and which are worth mentioning here. As we will discuss, there is growing criticism of the expansion of euthanasia in areas including existential suffering, disabilities, and, increasingly, mental illness.[263] These conditions were not the focus when the law was introduced. Comments made in parliamentary commissions and in parliamentary debates suggest, for example, that the legislator did not intend to facilitate euthanasia for mental illness.[264] Yet, the vague criteria enabled expansion in these areas. This expansion can seriously affect people who are experiencing life-changing disabilities or situations which are associated with loneliness, isolation, social stigmatization and rejection, difficulties with managing daily activities, and difficulties functioning independently.

Cases reported in the media, which often received international attention, showcase this development. One of the authors discusses in more detail

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[262] See *supra* note 122, ss 3(2)(2), 3(2)(3).

[263] See *infra* notes 264–73.

[264] See Belgisch Raadgevend Comité voor Bioethiek, "Advies Nr. 73 van 11 September 2017 betreffende euthanasia in geval van niet-terminale patiënten, psychisch lijden en psychiatrische aandoeningen" ["Advice Concerning Euthanasia of Non-Terminally Ill Patients, Psychological Suffering, and Psychiatric Conditions"] at 47-49, online: Federal Public Service <https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/advies_73_euthanasie.pdf> (recent opinion of the Belgian Federal Bioethics Advisory Committee, referring to the parliamentary debates and statements by parliamentary members) [translated by TL].

elsewhere[265] how, in Belgium, euthanasia has been performed on people who expressed a fear of becoming dependent on others as a result of disability,[266] on others who were "tired of life,"[267] and on a transgendered person experiencing social and psychological struggles following their transition.[268] A man convicted of murder and various sexual offences also created a dilemma for the government when he received authorization for euthanasia because of the absence of appropriate treatment for his sexual deviation in the Belgian prison setting – authorization which was later suspended by

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[265] See Lemmens, "Conflict", *supra* note 12; Lemmens, "*Charter* Scrutiny", *supra* note 243.

[266] See e.g. Erik Raspoet, "10 jaar LEIF: moet er nog euthanasia zijn?" (November 2013), *Erik Raspoet* (blog), online: <www.erikraspoet.be/?p=355> (in an interview, Dirk Verbessem, the brother of two euthanized twins who were deaf-mute and were becoming blind, explains that the prospect of becoming totally isolated and dependent was too much for them).

[267] See e.g. Hanne Van Tendeloo, "Samen sterven: Ann en François aan de vooravond van hun euthanasie", *Humo* (17 June 2014), online: <www.humo.be/humo-archief/290374/samen-sterven-anne-francois-aan-de-vooravond-van-hun-euthanasie>; Jan Lippens, "De vrouw die niet zonder dochter wilde leven", *KNACK* (18 November 2015) at 68–69. This is, in fact, the only case so far that the Federal Commission has decided to forward to the prosecutor. See Graeme Hamilton, "Belgian Doctor Facing Possible Murder Charge for Euthanizing Senior Seen as Warning for Canada", *National Post* (29 October 2015), online: <news.nationalpost.com/news/belgian-doctor-facing-possible-murder-charge-for-euthanizing-senior-seen-as-warning-for-canada>. On the development towards euthanasia for "tired of life" cases, particularly in Belgium and the Netherlands, and the ethical issues this raises, see Raphael Cohen-Almagor, "Euthanizing People Who Are 'Tired of Life' in Belgium", in Jones, Gastmans & MacKellar, *supra* note 122, 188 [Cohen-Almagor, "Tired of Life"].

[268] See Veerle Beel, "Eerste maar niet laatste euthanasie bij transgenders" ["First but Not Last Euthanasia Involving Transgender People"], *De Standaard* (2 October 2013), online: <www.standaard.be/cnt/dmf20131001_00769803> (interviewed for this article, Dr. Wim Distlemans, co-chair of the Federal Commission, revealed that several transgendered people had requested euthanasia) [translated by TL]. See also: "Ook vriendin van transgender Nathan pleegt binnenkort euthanasie" ["Friend of Transgender Nathan Will Soon Also Receive Euthanasia"], *Het Laatste Nieuws* (5 October 2013), online: <www.hln.be/hln/nl/957/Binnenland/article/detail/1717203/2013/10/05/Ook-vriendin-van-transgender-Nathan-pleegt-binnenkort-euthanasie.dhtml> [translated by TL].

the Minister of Justice.[269] Another controversy arose when a women with chronic depression was euthanized, without prior warning to her family, in a period that she had lost contact with her children and grandchildren.[270] The case evoked concern about euthanasia involving people struggling with mental health issues and revealed the potentially devastating impact of euthanasia on loved ones.

These cases do not represent the majority of euthanasia cases in Belgium but they are real euthanasia experiences that may have resulted in arguably premature deaths of vulnerable people, traumatization of family members, imposition of moral anguish among health care providers, and disturbance of the established commitment of medicine towards those in need. To be sure, this has to be weighed against the relief that legalized euthanasia has provided to people who preferred to have access to a more controlled death. Still, it seems problematic to conclude that the premature deaths of some people and the significant emotional and societal turmoil within a lightly regulated regime are acceptable prices to pay to ensure that as many people as possible have access to euthanasia. These cases are not more anecdotal than the cases that have, say, gone to the Supreme Court in Canada in which people request access to some form of MAID. In fact, for many of these cases, more information is available than in some of the court cases involving people requesting access to euthanasia, in the form of reports and interviews with some of the people involved, including physicians, family members, and sometimes the people themselves. These concerns ought to be taken very seriously when considering further changes to the legislation in Canada.

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[269] See Dirk Leestmans, "Kroniek van een aangekondigde euthanasia" ["Chronicle of an Announced Euthanasia"], *VRT Nieuwsdienst* (15 January 2015), online: De Redactie <www.deredactie.be/cm/vrtnieuws/binnenland/1.2209391> [translated by TL]; Bruno Waterfield & Andrew Marszal, "Belgian Serial Rapist Will Not Be Euthanised", *The Telegraph* (6 January 2015), online: <www.telegraph.co.uk/news/worldnews/europe/belgium/11327541/Belgian-serial-rapist-will-not-be-euthanised-as-planned.html>. A transfer to a newly established treatment facility was organized.

[270] See Rachel Aviv, "The Death Treatment", *The New Yorker* (22 June 2015), online: <www.newyorker.com/magazine/2015/06/22/the-death-treatment>.

### 4. The mental health context

Specific concerns have been voiced about the expansion of requests for euthanasia in the context of mental health. In Belgium, the proportion of euthanasia deaths involving neuropsychiatric disorders increased from 9 cases (1% of all cases) in 2004–05, to 58 cases (3%) in 2010–11, to 120 cases (4%) in 2012–13, to 124 cases (3.1%) in 2014–15.[271] There are also indications in Belgium that the number of people with mental illness who have expressed an interest in euthanasia has increased significantly.[272]

A 2015 study published in BMJ Open illustrates the practice of euthanasia in the case of people with mental health issues in Belgium. The study

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[271] Belgium, Federale Controle en Evaluatiecommissie Euthanasie, *Tweede verslag aan de wetgevende kamers, jaren 2004-2005* [*Second Report to the Legislative Chambers, Years 2004-2005*] (Brussels: FCEE, 2006) at 16, online: Federal Public Service <overlegorganen.gezondheid.belgie.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie/14088500.pdf>; Belgium, Federale Controle en Evaluatiecommissie Euthanasie, *Vijfde verslag aan de wetgevende kamers, jaren 2010-2011* [*Fifth Report to the Legislative Chambers, Years 2010-2011*] (Brussels: FCEE, 2012) at 8, online: Federal Public Service <overlegorganen.gezondheid.belgie.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie/19078961.pdf>; Belgium, Federale Controle en Evaluatiecommissie Euthanasie, *Zesde verslag aan de wetgevende kamers, jaren 2012-2013* [*Sixth Report to the Legislative Chambers, Years 2012-2013*] (Brussels: FCEE, 2014) at 8, online: Federal Public Service <overlegorganen.gezondheid.belgie.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie/19097638.pdf> [FCEE, *Sixth Report*]; Belgium, Federale Controle en Evaluatiecommissie Euthanasie, *Zevende verslag aan de wetgevende kamers, jaren 2014-2015* [*Seventh Report to the Legislative Chambers, Years 2014-2015*] (Brussels: FCEE, 2016) at 6, online: Federal Public Service <overlegorganen.gezondheid.belgie.be/sites/default/files/documents/7_euthanasie-verslag_2014-2015-nl_0.pdf>.

[272] See e.g. Lieve Thienpont, *Libera Me: Over Euthanasie en Psychisch Lijden* [*Free Me: About Euthanasia and Psychological Suffering*] (Tielt, Belgium: Witsand Uitgevers, 2015) at 204 [Thienpont, *Free Me*]. Dr. Thienpont, a psychiatrist, is arguably the most active practitioner of euthanasia in psychiatric patients in Belgium. See Stephen Claes et al, "Euthanasia for Psychiatric Patients: Ethical and Legal Concerns about the Belgian Situation", Responses, BMJ Open (6 November 2015), online: <bmjopen.bmj.com/content/5/7/e007454.responses>. She states that in the first three years following the 2011 establishment of the new end-of-life consultancy service, about 50% of the 900 consultations involved patients with primarily psychiatric problems (Thienpont, *Free Me*, *supra* note 272 at 204).

involved 100 patients who had requested euthanasia and were assessed by a consulting psychiatrist between 2007 and 2011.[273] Patients suffered from a variety of disorders, including mood and personality disorders, post-traumatic stress, anxiety, and eating disorders, as well as schizophrenia, addiction, autism, and complicated grief, along with co-morbidities.[274] Every patient was deemed competent but no information was available about how this was determined in the complex population. The authors also deemed that "[i]n all patients, the suffering was chronic, constant and unbearable, without prospect of improvement due to treatment resistance."[275] Yet, the outcome of the study, in which 37 patients were euthanized, 38 requests were withdrawn, and 11 cases of euthanasia were postponed after requests were granted, raised serious doubts about how patients were evaluated in terms of resistance to treatment, impossibility of recovery, and degree of capacity.

Indeed, following its publication, 65 prominent Belgian psychiatrists, psychologists, health care professionals, and ethicists severely criticized the study in various forums, including in a letter to BMJ Open and in leading newspapers.[276] They questioned various components of the *Belgian Euthanasia Act*, including the capacity assessment, the high number of approved cases, the treatment-resistant nature of the conditions, and the appropriateness

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[273] See Lieve Thienpont et al, "Euthanasia Requests, Procedures and Outcomes for 100 Belgian Patients Suffering from Psychiatric Disorders: A Retrospective, Descriptive Study", online: (2015) 5:7 BMJ Open at 3, <bmjopen.bmj.com/content/bmjopen/5/7/e007454.full.pdf>.

[274] See *ibid* at 5.

[275] *Ibid*.

[276] Claes et al, *supra* note 272. See also Ariane Bazan et al, "Euthanasie bij psychisch lijden: een wankel wettelijk kader en maatschappelijk ondermijnende gevolgen" ["Euthanasia for Psychological Suffering: An Unstable Legal Framework and Troubling Societal Consequences"], *Artsenkrant* (25 September 2015), online: <www.actiegezin-actionfamille.be/wp-content/uploads/2015/10/OpinieEuthanasieArtsentkrant20150925.pdf> [translated by TL]; Ariane Bazan, Gertrudis Van de Vijver & Willem Lemmens, "Schrap euthanasie op basis van louter psychisch lijden uit de wet: De dood als therapie?" ["Remove Euthanasia on the Basis of Psychological Suffering from the Law: Death as Therapy?"], *De Morgen* (8 December 2015), online: <www.demorgen.be/opinie/schrap-euthanasie-op-basis-van-louter-psychisch-lijden-uit-de-wet-b277b650> [translated by TL].

of a single psychiatrist holding primary responsibility for a substantial percentage of Belgian euthanasia cases involving mental health patients. They wrote that psychiatric conditions ought to be removed from the *Belgian Euthanasia Act* as a basis for euthanasia.[277] Others responded in support of the current practice.[278]

Problems with euthanasia for cases of mental suffering are similar in the Netherlands, a country for which there is more publicly available information. Psychiatrist-bioethicist Scott Kim and colleagues have been studying the individual case summaries of persons who have received euthanasia for psychiatric disorders in the Netherlands.[279] They have identified several problems that are not reflected in the large-scale surveys of self-reporting physicians and in official reports. For instance, it is often presented as though euthanasia is only practiced in extreme cases of psychiatric suffering such as "treatment-resistant depression."[280] However, Kim and colleagues have found that, while depressive disorders were the primary psychiatric issue in 55% of these cases, euthanasia is also provided to people with psychosis, post-traumatic, somatoform, neurocognitive, and eating disorders, as well

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[277] Claes et al, *supra* note 272. Note that Claes et al calculate that Dr. Thienpont is individually involved in more than 35%, and probably closer to 50%, of the cases of euthanasia for psychiatric disorders in the period covered by the study (*ibid*). Yet, if one excludes Alzheimer cases from the overall number of psychiatric euthanasia cases (they are included in the Belgian statistics of that period), the percentage is much higher.

[278] Johan Braeckman, An Ravellingien & Maarten Boudry, "Banaliseer psychisch lijden niet" ["Don't Trivialize Psychological Suffering"], *De Morgen* (11 December 2015), online: <www.demorgen.be/opinie/banaliseer-psychisch-lijden-niet-bdb8ed05> [translated by TL]. See also Ariane Bazan et al, "Psychisch lijden is nooit banaal" ["Psychological Suffering Is Never Trivial"], De Morgen (14 December 2015), online: <www.demorgen.be/opinie/psychisch-lijden-is-nooit-banaal-b8e8699f/1CfTcY> (response to Braeckman, Ravellingien & Boudry) [translated by TL].

[279] Kim, De Vries & Peteet, *supra* note 211.

[280] Paul S Appelbaum discusses this in his response to Dr. Kim's article. See "Physician-Assisted Death for Patients with Mental Disorders – Reasons for Concern", Editorial, (2016) 73:4 JAMA Psychiatry 325 [Appelbaum, "Reasons for Concern"]. See also Paul S Appelbaum, "Should Mental Disorders Be a Basis for Physician-Assisted Death?" (2017) 68:4 Psychiatr Serv 315 (a more recent publication in which Appelbaum expresses his concerns and comments on the Canadian debate).

as prolonged grief and autism.[281] In 56% of the case summaries they studied, the reports mention explicitly social isolation or loneliness.[282] More than half of the patients also appeared to have personality-related problems.[283] Further, they found that there is frequent disagreement among physicians in psychiatric cases as to whether the regulatory criteria for euthanasia have been met. Physicians disagreed in 24% of cases, generally regarding whether the criteria of capacity and futility had been satisfied. Euthanasia proceeded with these disagreements unresolved in most cases.[284] Kim and colleagues also identified problems with capacity assessment in these cases: despite this assessment being particularly complex in the psychiatric context, there was no independent psychiatrist involved in the patient's evaluation in 11% of the cases.[285] In most cases, the physician was a general practitioner with no particular expertise in capacity assessment. A final point of interest in the Kim et al. study is the ratio of women to men accessing euthanasia – 2.3 to 1 – a ratio which is consistent with the rate of suicide *attempts* among the general population.[286] Kim and colleagues note the possibility that the availability of euthanasia renders the desire to die in female psychiatric patients more effective, an interpretation which they argue is consistent with the fact that most patients in the study had previously attempted suicide.

Concerns about the practice of MAID in the context of mental health reveal the overall problematic nature of a regulatory system that relies on the administration of capacity assessments and informed consent procedures by individual physicians. Assessing capacity in medical decision making is notoriously difficult.[287] Determining capacity in the more complex and challenging context of a euthanasia request warrants due time, specific

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[281] Kim, De Vries & Peteet, *supra* note 211 at 364–65.

[282] *Ibid* at 365.

[283] *Ibid* at 364.

[284] *Ibid* at 365.

[285] *Ibid.*

[286] *Ibid* at 366.

[287] See generally Scott YH Kim, *Evaluation of Capacity to Consent to Treatment and Research* (New York: Oxford University Press, 2010) at 79–100 (discussing the challenges of gathering relevant data for capacity assessments), 101–28 (discussing the challenges related to the interpretation of the data in order to come to a judgment as to capacity).

expertise, and repeated careful evaluation.[288] Physicians often lack a good grasp of the concept and often have limited appreciation of the inherent difficulties in capacity assessment. Furthermore, the beliefs and value system of those assessing capacity influence whether they perceive a patient to be competent in making the request. Physicians who are firmly committed to MAID may therefore be more likely to judge patients competent to opt for MAID, even when they suffer from depression or other mental health conditions. This has already been documented in the MAID context with a study of capacity assessment in Oregon.[289] It is precisely in dealing with patients suffering from a mental health condition and experiencing a desire to die that capacity assessments are likely to vary significantly depending on the assessor's commitment to MAID. As Annabel Price points out, "[i]t is in the grey areas that capacity is the most difficult to determine, and these grey areas are where clinicians' individual values are most likely to affect the process."[290]

The Belgian and Dutch experience regarding euthanasia for mental illness is particularly relevant for the future debate in Canada, since this is one of the key issues that the government has committed to studying. For reasons set out above, extending a right to access MAID to patients on the basis of psychological suffering alone risks putting some of our most vulnerable citizens at risk. The pressure to extend it in this area is, however, very strong, as the reports from the Advisory Group and Joint Committee reveal. The proposals to extend access in this area often refer to the concept of equality. Yet, as Pothier rightly points out in her analysis of the constitutional options following *Carter*,[291] the concept of equality, particularly as it has evolved in Canadian law, also involves the notion of equal protection. For the reasons set out above, there is reason to be concerned about the

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[288] See Joris Vandenberghe, "Euthanasia in Patients with Intolerable Suffering Due to an Irremediable Psychiatric Illness: A Psychiatric Perspective" in Jones, Gastmans & Mackellar, *supra* note 122, 150 at 157 [Vandenberghe, "Psychiatric Perspective"]; Joris Vandenberghe, "Physician-Assisted Suicide and Psychiatric Illness", Perspective, (2018) 378:10 N Engl J Med 885 at 887 [Vandenberghe, "Psychiatric Illness"].

[289] Linda Ganzini et al, "Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists" (2000) 157:4 Am J Psychiatry 595 at 597–98.

[290] "Mental Capacity as a Safeguard in Assisted Dying: Clarity Is Needed", Personal View, online: (2015) 351 Br Med J h4461 at 1, <www.bmj.com/content/bmj/351/bmj.h4461.full.pdf>.

[291] "Parameters", *supra* note 163 at 4.

disproportionately negative impact on the protection of people with mental disabilities if the law were to explicitly allow MAID on the basis of psychiatric conditions.

Even some physicians currently involved in the practice of euthanasia for mental health conditions in Belgium have been urging for much more stringent procedures than those currently in place. Those supporting the introduction of mental illness as a sufficient basis for MAID in Canada should look carefully at the concerns expressed in the Belgian and Dutch context and at the proposals for more stringent safeguards. Belgian psychiatrist Dr. Joris Vandenberghe, for example, has put forward in recent publications that opening the door to euthanasia for mental illness should only be considered if several procedural safeguards can be properly implemented – safeguards which, in his opinion, are not currently realized in Belgium and the Netherlands.[292] First, he recommends a sufficiently long period between the patient's written request and the provision of MAID. This would allow time for the patient and the physician to carefully consider the request and to try various available treatments.[293] Though the appropriate time would depend on the circumstances of each case, Vandenberghe recommends an evaluation process of at least one year and with at least ten contacts with the psychiatrist as a reasonable minimal standard, given the complexity and the number of considerations that must be addressed.[294] This would, in his view, also take heed of the available data regarding the high percentage of mental illness-based MAID requests that are withdrawn by the patient. Without a mandatory wait period, such patients would not have the chance to withdraw an ill-considered request if being seen by a physician who grants requests too quickly and moves ahead with the life-ending procedure.

Second, in the case of MAID requests because of mental illness, it is imperative that independent psychiatrists be consulted on the case, in addition to any reviewing physician. Vandenberghe further emphasizes that to deter-

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[292] "Psychiatric Illness", *supra* note 288 at 887.

[293] "Lessons from the Belgian Experience with Euthanasia in Patients with Psychiatric Illness" (10 February 2016) at 2, online: Government of Canada <www.parl.gc.ca/Content/HOC/Committee/421/PDAM/Brief/BR8112148/br-external/2016-02-09_Letter_Joris_Vandenberghe_Belgium_e-e.pdf> (submission of a Belgian psychiatrist and member of the National Bioethics Commission to the Parliament of Canada).

[294] "Psychiatric Perspective", *supra* note 288 at 162.

mine whether a psychiatric condition is "irremediable," "[o]perationalised diagnosis-specific criteria … should be devised by a panel including experts in every specific diagnosis."[295] Interestingly, he points out that in Belgium it is currently easier to qualify for euthanasia than to receive an invasive psychiatric treatment such as deep brain stimulation, even though the latter is explicitly aimed at providing treatment.[296]

Vandenberghe also discusses the need for an ongoing parallel focus on recovery. He refers to this as a dual track approach, where a comprehensive exploration of therapy and recovery is taken simultaneously and parallel to the assessment of the euthanasia request.[297]

Finally, Vandenberghe suggests that the irremediable nature of an illness should be based on an objective and formal psychiatric assessment and that an illness cannot be deemed irremediable unless all treatments with reasonable prospective have been exhausted.[298] The right to refuse treatment is, both in Belgium and in Canada, a well-established principle. It was reaffirmed by the Supreme Court in *Carter*. Still, this principle has never before been connected with the option to ask for state support in active ending of a person's life in the context of mental health treatment. Treatment refusal poses a particular challenge in the context of mental health because of the difficulty involved in disentangling why patients refuse treatment and establishing whether it is the well-informed choice of a competent person.

We are, at present, certainly less demanding than Vandenberghe would recommend in terms of exhaustion of all treatments when faced with patients' treatment refusal. But respecting patients' treatment refusal and not invading their bodies against their will with what is often demanding treatment is one thing. Offering as an explicit alternative to treatment a life-ending option, which in fact precisely invades their bodies in a drastic and irreversible way, is something quite different. We should be worried about introducing this as an option in the already challenging context of mental health.

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[295] *Ibid* at 164.

[296] *Ibid* at 164–65; "Psychiatric Illness", *supra* note 288 at 886.

[297] "Psychiatric Perspective", *supra* note 288 at 161; "Psychiatric Illness", *supra* note 288 at 886.

[298] "Psychiatric Perspective", *supra* note 288 at 157–58; "Psychiatric Illness", *supra* note 288 at 886.

### 5. The limits of the Belgian regulatory and reporting system

Yet another concern relates to the regulatory structure around euthanasia. Physicians are given an extraordinary amount of power in the Belgian euthanasia system. As discussed, they decide whether patients fulfill the criteria of the legislation. Even though they are obliged to ask for a second consultation, this second consultation is not binding. They are further in charge of filling out the required forms after performing euthanasia, and thus determine how to present the case to the review agency that decides whether further inquiry or referral for prosecution is warranted. When a physician rules that some of the legal requirements are not met, there is nothing that prevents the patient from seeking a more lenient physician. This leaves room for zealous and flexible physicians to attract many requests for euthanasia. Particularly when the criteria for permitting euthanasia are vague, this raises serious concerns about premature deaths. Since there is no requirement that physicians have a long-standing therapeutic relationship with the patient, physicians can develop a euthanasia-focused practice, with significant professional interest in recruiting patients.[299] Again, it seems naïve to think that in the absence of a rigorous review and active disciplinary system there will be no abuse and professional conflict of interest driven behaviour.

Furthermore, the specific organization of the post factum reporting system in Belgium is problematic. The Federal Commission that *examines* cases and decides whether they should be forwarded to the federal prosecutor is composed in part of physicians involved in the provision of euthanasia cases that it evaluates. Dr. Wim Distelmans, the co-chair of the Federal Commission, for example, has been involved in several of the more controversial cases.[300] He has also publicly commented on

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[299] See Kim, De Vries & Peteet, *supra* note 211 at 364 (their research on euthanasia and mental illness found that 27% of patients received the procedure from physicians who were new to the patient. Most patients studied received it from physicians at the End-of-Life Clinic, a specialized euthanasia clinic that has as its mandate to offer access to euthanasia for patients whose own physician is reluctant). On the growing role of specialized end-of-life clinics, see the detailed discussion in Lemmens, "*Charter* Scrutiny", *supra* note 243 and other references there.

[300] For example, Dr. Distelmans was involved in the provision of euthanasia to the Verbessem brothers, discussed above at *supra* note 266. See Graeme Hamilton, "Death by Doctor: Controversial Physician Has Made his Name Delivering Euthanasia When No One Else Will", *National Post* (15 January 2015), online: <nationalpost.com/news/canada/death-by-doctor-controversial-

some of these controversial cases in which he was involved.[301] It should be noted that he is one of the founders of ULteam, a specialized end-of-life service, which provides access to patients when their own physician refuses to do so.[302]

Recent controversies also raised questions about the Federal Commission's rigour when it comes to applying the law. A November 2016 editorial reported that the Federal Commission saw no reason for further inquiry when it received a case report for which the physician performing euthanasia and the physician consulted were brothers, thus violating the legal requirement of independence of the second physician. In addition, the editorial alleged that one of the brothers was a member of the Federal Commission.[303] More recently, a member of the Federal Commission resigned after a minority of the Commission blocked the referral for prosecution of a case in which a physician allegedly ended the life of an incapacitated patient who suffered from dementia and Parkingson's disease, at the request of the family and without an advance request.[304] These examples showcase how the most basic conflict of interest violations and legal transgressions are sometimes ignored. They also reflect the fact that there is a truly extraordinary confidence in the integrity of all those involved in making crucial decisions in the context of active life-ending acts.

The Belgian experience further shows that post factum reporting is limited in promoting transparency and providing a clear understanding of medical practice. Under-reporting and errors in reporting continue in Belgium,

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physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will> [Hamilton, "Death by Doctor"]. For a list of some other cases he was involved in, see Aviv, *supra* note 270.

[301] See Beel, *supra* note 268 (comments by Dr. Distelmans regarding euthanasia of Nathan Verhelst, a transgender person).

[302] See LEIF, "UL Team", online: <leif.be/ulteam>. See also Hamilton, "Death by Doctor", *supra* note 300; Aviv, *supra* note 270.

[303] Kasper Raus et al, "Mogen we nog vragen stellen?" ["Are We Still Allowed to Ask Questions?"], *De Standaard* (15 November 2016), online: <www.standaard.be/cnt/dmf20161114_02572135> [translated by TL].

[304] See Maria Cheng, "Ethics Dispute Erupts in Belgium over Euthanasia Rules", *AP News* (16 February 2018), online: <https://apnews.com/38a0e46387ef45839ba7e84830ea0c40>. As noted earlier (*supra* note 245 and accompanying text), a two-thirds majority is needed to refer a case for prosecution.

with one 2010 study estimating that only one in two cases of euthanasia are reported.[305] Studies also suggest that physicians continue to practice euthanasia without consent and these instances obviously tend to be not officially reported.[306] Thus, some hidden practices may have become visible as a result of the decriminalization coupled with reporting, but other practices remain hidden. What is hidden may simply have shifted. In fact, the reporting system may create a false sense of control over the practice and lead to

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[305] Tinne Smets et al, "Reporting of Euthanasia in Medical Practice in Flanders: Cross Sectional Analysis of Reported and Unreported Cases", online: (2010) 341 Br Med J c5174 at 3 <www.bmj.com/content/341/bmj.c5174>. The authors conclude: "Countries debating legalisation of euthanasia should simultaneously consider developing a policy facilitating the due care and reporting obligations of physicians" (*ibid* at 1). Under-reporting likely continues. According to Statistics Belgium, there were 61,621 deaths in Flanders in 2013. Chambaere et al, "Recent Trends," *supra* note 258 at 1179, suggests that 4.6% of deaths involved euthanasia. That amounts to 2,834 cases. Yet, the Federal Commission received only 1,454 reports of cases in 2013. See FCEE, *Sixth Report*, *supra* note 271. See also Raphael Cohen-Almagor, "First Do No Harm: Pressing Concerns Regarding Euthanasia in Belgium" (2013) 36:5–6 Intl J L & Psychiatry 515 at 519 [Cohen-Almagor, "Pressing Concerns"].

[306] See Raphael Cohen-Almagor, "First Do No Harm: Intentionally Shortening Lives of Patients without Their Explicit Request in Belgium" (2015) 41:8 J Med Ethics 625 at 626 (analysis of various empirical studies); Cohen-Almagor, "Pressing Concerns", *supra* note 305 at 516; Kenneth Chambaere et al, "Characteristics of Belgian 'Life-Ending Acts without Explicit Request': A Large-Scale Death Certificate Survey Revisited", online: (2014) 2:4 CMAJ Open E262 at E264–65, <www.cmajopen.ca/content/2/4/E262.full>. Chambaere and colleagues try to explain away the significant number of physicians who mentioned in the anonymous survey undertaken by the authors that they ended the life of a person without request, but we do not find their arguments fully reassuring. They suggest that in many of these cases, patients may still have expressed at one point a desire to die. The fact remains that, in these cases, according to the physicians' responses, there was no clear and unambiguous request to do so at the time that their death may have been hastened. They further suggest that, in many other cases, the medication given was more in line with symptom control and was unlikely to have caused the immediate death of the patient. The fact remains, here as well, that the physicians declared in their response to the survey that they had the intent to end the life of the person. The authors explicitly agree that this remains a significant ethical problem (*ibid* at E265). See also Kenneth Chambaere et al, "Physician-Assisted Deaths under the Euthanasia Law in Belgium: A Population-Based Survey" (2010) 182:9 CMAJ 895 at 896 (anonymous survey suggests that 1.8% of all deaths in Flanders are cases of "physician-assisted deaths" without explicit request).

an overly bureaucratic assessment of cases on the basis of limited practical information, with few incentives to intervene after the fact.

On this point, the study by Kim and colleagues of individual case summaries in the Netherlands is again revealing. Their findings of problems related to capacity, expansion in problematic areas, and serious disagreements among physicians are not reflected in the data produced by the official review agencies and in large-scale anonymous surveys of physicians.[307] Moreover, in Belgium, there are indications that physicians are not respecting the reporting requirements.[308] Yet, the Federal Commission has forwarded only one file to the public prosecutor out of more than 11,000 patients who have had their life terminated.[309] Considering the often public confessions of physicians that they have disregarded the requirements,[310] it would be surprising if this were truly the first and only case of rule violation that merited scrutiny by a public prosecutor.

As discussed above, some Canadian commentators tend to ignore the problems with the Belgian governance of euthanasia practices and continue to refer to the system as supportive of the broad claim that regulatory systems work well. In contrast, Belgian experts are increasingly vocal in their criti-

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[307] Kim, De Vries & Peteet, *supra* note 211 at 364–66.

[308] See Cohen-Almagor, "Pressing Concerns", *supra* note 305 at 519 (review of literature indicating low reporting rates).

[309] See Sophie Vanlommel, "Streed dokter Marc Van Hoey te ijverig vooreuthanasia?" ["Did Doctor Marc Van Hoey Fight Too Zealously for Euthanasia?"], *De Morgen* (29 October 2015), online: <https://www.demorgen.be/wetenschap/streed-dokter-marc-van-hoey-te-ijverig-voor-euthanasie-b1f40c38> [translated by TL]; Frédéric Soumois, "Euthanasie: un dossier transmis au Parquet pour la première fois" [Euthanasia: A File Referred to the Parquet for the First Time"], *Le Soir* (28 October 2015), online: <www.lesoir.be/archive/recup/1028850/article/actualite/sciences-et-sante/2015-10-28/euthanasie-un-dossier-transmis-au-parquet-pour-premiere-fois-video> [translated by editors].

[310] See e.g. Veerle Beel & Lieven Sioen, "In de VS zat ik al lang achter de tralies. En jij samen met mij" ["In the US, I'd Already Be in Prison a Long Time Ago. And You with Me"], *De Standaard* (21 December 2013), online: <www.standaard.be/cnt/dmf20131219_00896009> (in an interview, Dr. Mark Cosyns, who has performed many euthanasia procedures, affirms that he still does not report to the Federal Commission because, in his view, doctors do not have to "justify each time we do an operation why this doesn't constitute assault" [translated by TL]).

cism of the reassurances reflected in the official reports. On 16 November 2016, a group of leading academic experts in law, medicine, and bioethics who explicitly state that they are not in principle opposed to euthanasia, penned an editorial in the leading Flemish newspaper *De Standaard* under the evocative title "Are We Still Allowed to Ask Questions?"[311] In it, they decry the tendency in Belgium to cast aside the opinion of those who are critical of some aspects of the euthanasia practices and regulations. Their editorial offers a stinging critique of the work of the Federal Commission and its reporting. They point out three major issues that, in their opinion, are not, or are insufficiently, addressed or investigated by the Federal Commission. First, they point to the continued under-reporting of euthanasia cases, stating that one in three are still not reported, and the failure of the Commission to investigate instances of under-reporting, even when physicians explicitly state that they do not report. Second, they express concern over the fact that the Commission simply accepts that one in four individual euthanasia reports fails to comply with the law and sticks to the mantra that reporting is "improving." Third, they argue that the Commission exceeds its statutory authority by usurping the role of judge and even that of legislator. The Commission, according to the authors, exercises discretionary judgment about the type of violations of the law that merit referral for prosecution, even if it does not have this authority. It further would have expanded, through its own flexible interpretation of the legislation, the scope of euthanasia practices beyond what the legislation explicitly provides. The editorial thus confirms, with up-to-date examples, some of the serious flaws in the regulatory system surrounding the practice in Belgium.

### 6. Normalization of the practice in society

The normalization of euthanasia as a mode of dying in Belgium is another cause for concern. One might argue that this is not, in and of itself, problematic and reflects the fulfillment of a popular demand. Yet, it clearly shows a shift away from euthanasia as an exceptional procedure to deal with unbearable suffering to a procedure aimed at producing death more swiftly, in more controlled circumstances. It does raise questions about how societal and structural components (ease of access to appropriate care, the costs associated with elder care, palliative care, mental health services) could contribute to transforming MAID into a normalized

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[311] Raus et al, *supra* note 303 [translated by TL].

form of dying.[312] It is realistic to worry that facilitating availability to MAID could affect the types of end-of-life choices that people will deem reasonable. It is also reasonable to be concerned that, once implemented and more widely practiced, it could affect governmental decision making in terms of resource allocation, since MAID can save costs. As such, governments' incentives to invest more aggressively in appropriate elder care, long-term and complex mental health care services, disability support, and so on, may be affected.

It is important to realize that, once active life-ending decisions become part of medical practice, it can lead to a normalization of MAID in situations beyond those where it was initially seen to be a compassionate response (that is, as relief for significant physical suffering at the end of life). This normalization could result in more physicians feeling comfortable about practicing it outside of the legal framework. Several of the physicians who ardently support euthanasia and who are involved in it have made strong public statements about the need to widen the scope of its practice.[313] One has even publicly stated his rejection of some of the most basic regulatory requirements in the context of euthanasia, such as the reporting of cases or the imposition of a consultation with a second physician.[314] It reflects a comfort level in Belgium towards the practice of euthanasia outside the

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[312] The normalization of MAID in society may also have the effect of normalizing suicide more generally. See e.g. Theo A Boer, "Does Euthanasia Have a Dampening Effect on Suicide Rates? Recent Experiences from the Netherlands", online: (2017) 10 J Ethics Mental Health <www.jemh.ca/issues/v9/documents/JEMH%20article%20Boer%20final%20proof.pdf>; David Albert Jones & David Paton, "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" (2015) 108:10 South Med J 599. Both articles conclude that legalization of euthanasia or physician-assisted suicide may contribute to a rise in non-assisted suicide. *Contra* Matthew P Lowe & Jocelyn Downie, "Does Legalization of Medical Assistance in Dying Affect Rates of Non-Assisted Suicide?", online: (2017) 10 J Ethics Mental Health (the authors dispute the Jones and Paton analysis, but they do not provide a response to Boer's later-published analysis of the Dutch data).

[313] See e.g. Thienpont, *Free Me*, *supra* note 272 at 143 (she suggests that social determinants of health would be a good basis for determining access to euthanasia). See also Hamilton, "Death by Doctor", *supra* note 300 (comments by Dr. Distelmans arguing for an expansion to children and people suffering from dementia).

[314] See Raphael Cohen-Almagor, "Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement" (2009) 24:3 Issues L & Med 187 at 208–09.

contours of an already open-ended regulatory regime. This normalization is perhaps even more pronounced in the Netherlands, where the previous Dutch cabinet proposed legislation to provide people who feel their life is "completed," but otherwise do not qualify for life-ending measures under its euthanasia law, access to state-supported life-terminating actions.[315] Their request would be evaluated by a special Counselor in Dying who would assess whether the request was genuinely based on a sense of completed life and was not influenced by family pressures.[316]

## Conclusion: Lessons from Belgium for Canada

The Belgian system provides access to euthanasia on the basis of vague and flexible criteria, which gives individual physicians an extraordinary liberty to determine whether to grant requests. It has effectively led to an open-ended regime that has expanded significantly, including with respect to the types of situations in which euthanasia is provided. It has expanded into problematic areas, especially as a response to suffering in the context

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[315] EI Schippers & GA van der Steur, "Kamerbrief met kabinetsreactie en visie op burgerinitiatief Voltooid Leven" ["Letter to Parliament with the Reaction of the Cabinet and Vision on the Citizen's Initiative Completed Life"] (12 October 2016), online: Government of the Netherlands <https://www.rijksoverheid.nl/documenten/kamerstukken/2016/10/12/kabinetsreactie-en-visie-voltooid-leven> (letter submitted to Parliament by the Ministers of Health and Justice on behalf of the entire cabinet) [translated by TL]. The issue created problems during the formation of a new government and, as compromise, an agreement was reached to conduct a further study on the issue. Serious disagreement about the issue persists between the current parties in power. See Joost de Vries, "D66 en ChristenUnie botsen over 'voltooid leven': Pia Dijkstra wil tempo, Segers waarschuwt juist voor haast" ["D66 and ChristenUnion Clash Over 'Completed Life': Pia Dijkstra Wants to Go Fast, Segers Warns Precisely against Haste"], *de Volkskrant* (18 December 2017), online: <https://www.volkskrant.nl/politiek/d66-en-christenunie-botsen-over-voltooid-leven-pia-dijkstra-wil-tempo-segers-waarschuwt-juist-voor-haast~a4546368> [translated by TL].

[316] See Schippers & van der Steur, *supra* note 315 at 8. For a critical commentary by one of the authors, see Willem Lemmens, Trudo Lemmens & Arthur Caplan "Commentary: The Dangers of Euthanasia-on-Demand", *Chicago Tribune* (17 October 2016), online: <www.chicagotribune.com/news/opinion/commentary/ct-euthanasia-assisted-suicide-dutch-netherlands-perspec-1018-jm-20161017-story.html>. See also Cohen-Almagor, "Tired of Life", *supra* note 267 (on the *de facto* development of "tired of life" euthanasia in Belgium).

of mental health. The Belgian experience also shows that some physicians have become particularly active in providing access to MAID in controversial areas, with no regulatory intervention other than post factum review of reported cases, where only limited, self-reported information is provided.

The problematic components of the Belgian regime are important to recognize in the context of the *MAID Act* and in light of the future evaluations of the legislative framework. They are informative of the type of problems Canada could face if individual physicians are provided with too much liberty in interpreting access criteria for MAID. Parliament was correct in restricting access to end-of-life situations, but more stringent procedural protections would have been preferable. Procedurally, a review system at both the pre- and post-MAID stages would have been better. A MAID request could have been subjected to an expedited review and authorization by a judge or independent body with expertise in the fields of health care, ethics, and law. David Baker and Gilbert Sharpe developed a detailed proposal for an independent review structure that would have built on the existing federal review structure in the context of mental health for those held not criminally responsible because of mental illness.[317] This model was presented to the Joint Committee but was rejected. Instead, the Committee recommended a system with, as its key additional safeguard, the requirement that a capacity and clinical assessment be conducted by one physician and be confirmed by a second physician. Considering the risk of error and the potential for abuse with irreversible consequences, it would have been preferable to mandate an independent assessment by a committee prior to the procedure itself. In light of the frequent disagreements between physicians as to whether the criteria for MAID have been met,[318] an arm's-length prior review process would have avoided errors before a patient has actually died and would have promoted some level of coherence in the decision-making process. With the *MAID Act*, the government decided not to take that route, likely in part because it limited access to end-of-life contexts (broadly defined) as the key protective tool. This limitation does, indeed, significantly reduce the risk of error and loss of life among those who could otherwise still enjoy a certain quality of life. It is also true that in many end-of-life situations, access to MAID can be seen as relatively urgent. In

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[317] "Draft Federal Legislation to Amend the Criminal Code to Be Consistent with *Carter v. Canada (Attorney General)* 2015 SCC 5" (22 January 2016), online: Bakerlaw <https://www.bakerlaw.ca/wp-content/uploads/16-01-22-An-Act-to-Amend-the-Criminal-Code-Physician-Assisted-Suicide-_FINAL.pdf>.

[318] See Kim, De Vries & Peteet, *supra* note 211.

those situations, it may have been considered overly burdensome to add a layer of administrative decision making. These situations also resemble more closely the situations of treatment withdrawal and refusal, in which physicians already make important decisions without additional scrutiny. But it is therefore essential to recognize how these safeguards interact. The analysis of the Belgian situation shows how important it is to look at what happens when there is no restriction to the end of life context and physicians are given significant powers to interpret open-ended criteria.

In Canada, there is continued pressure to expand access to MAID to cases where the patient is not at the end-of-life. In fact, the criteria of the *MAID Act* are already being interpreted quite leniently by some as allowing access to MAID for patients clearly not close to death.[319] It will be crucial to gather sufficiently detailed information about the types of cases in which MAID is being granted in Canada.[320] The government should carefully consider this evidence when it reevaluates the legislation. If, as the developments in Belgium suggest, access criteria appear to be interpreted too leniently by some physicians, resulting in problematic practices, the federal or provincial governments and/or the regulatory colleges of the health professions will have to refine the definition. In the meantime, they should also consider providing more detailed guidance on how to interpret the access criteria, either through the federal regulations that are being developed as part of the implementation of a reporting system under the *MAID Act*,[321]

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[319] See Sandra Martin, "Fight to the Death: Why Canada's Physician-Assisted Dying Debate Has Only Just Begun", *The Globe and Mail* (28 January 2018), online: <https://www.theglobeandmail.com/opinion/sandra-martin-physician-assisted-death-debate/article37742446> (the author lauds Dr. Ellen Wiebe for her flexible – in our opinion, problematically so – interpretation of the "reasonably foreseeable death" criterion).

[320] See e.g. Joshua Landry, Thomas Foreman & Michael Kekewich, "Ethical Considerations in the Regulation of Euthanasia and Physician-Assisted Death in Canada" (2015) 119:11 Health Policy 1490 at 1497 (emphasizing the need for a process of review to track important data and trends and suggesting the establishment of multidisciplinary committees to evaluate the data).

[321] Government of Canada, "Monitoring of Medical Assistance in Dying Regulations", *Canada Gazette* (16 December 2017), online: <www.gazette.gc.ca/rp-pr/p1/2017/2017-12-16/html/reg6-eng.html> (draft regulations for which the government sought public consultation). Our recommendation is directly opposed to the recommendation in Jocelyn Downie & Jennifer A Chandler, *Interpreting Canada's Medical Assistance in Dying Legislation* (Montréal: Institute for Research on Public Policy, 2018). The authors call on the government

or through guidelines of the health professional colleges. In the long term, the data gathered should also inform a consideration of whether prior administrative review should be introduced to offer additional protection to the vulnerable.

Under the *Belgian Euthanasia Act*, physicians are given too much flexibility to interpret value-laden and open-ended concepts for which they can hardly be seen to have the required expertise. Allowing the provision of MAID to be completely dictated by individual physicians' judgments risks abandoning vulnerable patients at times when they need support and protection against self-harm. This is why a stricter regime with less flexibility for interpretation and an arm's-length prior review process provides more appropriate protection. While it would have been preferable for the *MAID Act* to mandate procedural protection through a prior review system, it rightly restricts access to MAID to the end-of-life context, which is at least one major advantage over the current Belgian regime. This is a reasonable attempt to balance the now constitutionally recognized right of some to obtain MAID with the constitutional right of vulnerable people to be protected against premature death. The *MAID Act* thereby also reaffirms the state's interest in opposing a negative perception of the quality of life of people who are elderly, ill, or disabled; in dealing with suicide as a significant public health issue that affects not just individuals but also families and communities; and in creating robust safeguards which reflects the fundamentally irrevocable nature of this unique practice. Future decisions under this law will illustrate whether the criteria of the *MAID Act* and the regulatory practices developed by governments and regulatory colleges will allow Canada to avoid some of the pitfalls of the Belgian system.

Finally, the developments in Belgium warn us of the risks of expanding the legislation, particularly to MAID for mental illness. It is worth reiterating here that even Belgian psychiatrists who are in principle supportive of access to MAID for psychiatric patients only support it if a very firm regulatory regime, better than that which currently exists in Belgium, can

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to confirm their open-ended interpretation of the law in the new regulations. We cannot respond here in detail to the recommendations of this report, which came out just prior to the publication of this paper. Although the recommendations are more detailed than the interpretation put forth in Downie & Dembo, *supra* note 200, and require an in-depth response, the core of our response to the earlier piece, grounded in the legislative history and Parliament's intent, also applies here.

realistically be developed. As Vandenberghe posits, with a stern warning for Canada:

> In my view, anything less – including the current Dutch-Belgian model – is worse than not allowing psychiatric [euthanasia] at all. Other jurisdictions, such as Canada, that are considering legalizing psychiatric [euthanasia] can learn from the Belgian and Dutch experience. Unless they can implement a truly rigorous prospective review system, I believe they should not legalize the practice.[322]

Scholars, policy-makers, and judges should be mindful of regulatory schemes that look nice on paper but may actually be unworkable in practice and spin out of control, with unintended long-term consequences. As Martha Albertson Fineman reminds us, institutions that are set up to protect us with our inherent vulnerability are, as all human constructs, vulnerable themselves.[323] The MAID developments in Belgium over the last decade reveal how regulatory schemes designed with the lofty goal of relieving suffering may expand in areas that put vulnerable people at risk of premature death when these schemes leave too much to the vagaries of human judgment. When it comes to issues of life and death, it is essential to err on the side of caution.

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[322] "Psychiatric Illness", *supra* note 288 at 887.

[323] "The Vulnerable Subject: Anchoring Equality in the Human Condition" (2008) 20:1 Yale JL & Feminism 1 at 12–15.

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