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ARTICLE

Medical Aid in dying in Quebec – legal considerations

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Abstract

Quebec is currently the only province in Canada, which has taken a decision on legalising euthanasia and physician assisted suicide. In Quebec, euthanasia and physician assisted suicide are labelled as medical aid in dying and perceived as part of healthcare. However, in Canada, at the federal level, euthanasia and physician assisted suicide remain punishable under the Canadian Criminal Code.

This article reviews Quebec's legal approach to medical aid in dying, highlights some of the legal challenges, and discusses the need to handle them. The authors first provide a brief background of the euthanasia and assisted dying debate in Canada and particularly in Quebec. Further, they explain the concept of medical aid in dying and analyse the criteria for accessing it. They will then provide an analysis of the constitutional legality of the Bill 52, an Act respecting end-of-life care allowing for medical aid in dying, as well as the possible legal consequences for a physician when medical aid in dying is provided.

Introduction

On the 5th of June 2014 Quebec's National Assembly passed Bill 52, an Act respecting end-of-life care (Act).[1] The Act introduces medical aid in dying as a part of health care, and lays down conditions for its access in Quebec. Medical aid in dying, namely, deliberately causing the death of a patient upon their request or aiding, or abetting to commit suicide are punishable acts

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1 Bill 52, *An Act Respecting End-of-Life Care*, 1th session, 40th Leg, Quebec. Online www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-52-40-1.html.

under Canada's Criminal Code, which is a federal law.[2] It is currently questionable whether these two legislations are compatible.

The overall aim of this article is to identify legal challenges related to providing medical aid in dying in Quebec. This article examines the rationale of the Act, the criteria for accessing medical aid in dying, and the potential conflict between the provincial and federal legislations that emerge due to regulating medical aid in dying. It begins by contextualising medical aid in dying as a foreseeable transformation, taking into consideration the growing Quebec public support for physician assisted suicide and euthanasia. Then it explains the concept of medical aid in dying and scrutinises the legal requirements for accessing it. Finally, it analyses the competence tensions at provincial and federal levels, and discusses the possible issues that could arise, should medical aid in dying be practised in Quebec.

I. Medical aid in dying – a foreseeable transformation in Quebec

Over the last decades, questions concerning euthanasia and physician assisted suicide have been raised in Canada. The common notion of assisted suicide means 'the act of helping a person commit suicide by providing him with the means to do so or information on how to proceed, or both'.[3] If a physician provides a patient with the means of suicide and the final act resulting in death is undertaken by the patient, it is labeled as physician assisted suicide.[4] Euthanasia commonly is referred to as 'an act that involves deliberately causing the death of another person to put an end to that person's suffering'.[5] It can further be divided in two categories, active and passive, and each of them might be either voluntary or involuntary. Assisted suicide and euthanasia are distinguishable based on the nature of the act, namely, whether the means are provided or whether the death is caused directly and actively.

Canadian Parliament has examined a number of bills attempting to amend the Criminal Code to enable euthanasia, assisted suicide, or both in

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2 Criminal Code, R.S.C., 1985, c. C-46. S. 229 (murder). Euthanasia might also violate a number of other provisions of the Criminal Code, such as s. 216 (Duty of Persons Undertaking Acts Dangerous to Life); s. 219 (Criminal Negligence); s. 222 (Homicide); s. 234 (Manslaughter), s. 245 (Administering Noxious Things) and various other provisions prohibiting assault and bodily harm. Physician assisted suicide may violate s. 241 (Counseling or Aiding Suicide).

3 J. Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (Toronto: Scholarly Publishing Division 2004), page 6 and The Select Committee, *supra* note 16, page 17.

4 D. Harris, B. Richard & P. Khanna, 'Assisted dying: the ongoing debate', *Postgraduate Medical Journal* 82 (2006): 479-482, page 480 (table 1). See also Carter, *supra* note 15, para 22 on the definition on physician assisted suicide.

5 J. Downie, *supra* note 3, page 6.

Canada.[6] Currently, there are two bills requesting amendments to the Criminal Code to decriminalise physician-assisted death, which includes both voluntary euthanasia and physician assisted suicide, awaiting for consideration of the House of Commons of Canada.[7] Until now, neither of the bills has resulted in subsequent amendments, and it remains to be seen whether the two pending bills will be successful.

Various provincial courts across Canada have been requested to adjudicate on cases dealing with euthanasia and physician assisted suicide.[8] In 1999 the first physician was convicted in Canada for physician-assisted suicide in the *R. v. Généreux* case. Dr. Généreux prescribed a lethal dose of a drug to two HIV infected patients, who were fearful of death from AIDS and requested assistance to commit suicide.[9] One year before the ruling in the *R. v. Généreux* case, another court was requested to hear a case concerning active involuntary euthanasia.[10] In this case, *R. v. Morrison*, the patient was dying in intensive care and his family and family doctor decided to remove his ventilator life support. It was expected that he would die of a cardiac arrest within a few minutes after the ventilator was removed. The patient did not die; instead, he was gasping for air and kept on breathing with great distress. He was given pain relief to keep him comfortable; however, it was not sufficient to relieve his pain and suffering. Subsequently, on the order of Dr. Morrisson the level and dose of the medication administered was increased several times. The patient died within less than three hours after the removal of the ventilator. Dr. Morrisson was accused of unlawfully causing the patient's death. The preliminary hearing judge concluded that there was no clear evidence that could support a guilty verdict on a first-degree murder and decided not to prosecute the physician.[11] However, a disci-

6 Bill C-407, *An Act to Amend the Criminal Code (right to die with dignity)*, 1st Sess, 38 Parliament, 2005. Online: www.parl.gc.ca/HousePublications/Publication.aspx?Pub=Bill&Doc=C-407&Language=e&Mode=1&Parl=38&Ses=1. Bill C-562, *An Act to amend the Criminal Code (right to die with dignity)*, 2nd Sess, 39th Parliament, 2008. Online: www.parl.gc.ca/HousePublications/Publication.aspx?DocId=3570851&File=24&Mode=1&Language=E. Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*, 2nd Sess, 40 Parliament, 2010. Online: www.parl.gc.ca/HousePublications/Publication.aspx?Docid=3895681&File=24.

7 Bill C-581, *An Act to amend the Criminal Code (physician-assisted death)*, 2nd Sess, 41th Parliament, 2014. Online: www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=6487912&File=4. Bill C-582, *An Act to establish the Canadian Commission on Physician-Assisted Death*, 2nd Sess, 41th Parliament, 2014. Online: www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=6487912&File=4.

8 B. Sneiderman & R. Deutscher, 'Dr. Nancy Morrison and Her Dying Patient: A Case of Medical Necessity', *Health Law Journal* 10 (2002): 1-30 at page 14; R. Ogden, 'The Right to Die: A Policy Proposal for Euthanasia and Aid in dying', *Canadian Public Policy* 20(1) (1994): 1-25, page 4-7.

9 *R. v. Généreux*, [1992] 1 S.C.R. 259.

10 *R. v. Morrison*, 1998 2075 CanLII 2075 (NS SC).

11 *Ibid*.

plinary board sanctioned her.[12] The disciplinary sanction was followed by expressions of support for her action from medical practitioners arguing that it was an act of compassion and that she acted in what was believed to be in the best interest of the patient.[13]

The question of physician assisted suicide and euthanasia in Canada has also been discussed amongst the population. Public opinions reflect considerable support for allowing physician-assisted suicide and legalising euthanasia in Canada, and specifically in Quebec. A survey conducted in 2013, which looked at Canadians' attitudes towards end-of-life issues, showed a 63% support for a law allowing physician-assisted suicide in Canada, and a 55% support for euthanasia.[14] Another survey conducted at the end of 2011 found that the majority (67%) of Canadians supported legalising physician-assisted suicide in Canada for the terminally ill. The strongest supporters were Quebecois (81%), followed by British Columbia and Ontario (65% and 60% respectively).[15] These results demonstrate public support for euthanasia and physician assisted suicide among the general population.

Despite the unsuccessful requests to decriminalise physician-assisted suicide and euthanasia at the federal level in Canada, Quebec has chosen to follow the changing trends in society,[16] and regulate medical aid in dying as a part of healthcare. It was done, following the recommendations of the Expert Panel of the Royal Society of Canada and the Québec National Assembly's Select Committee on Dying with Dignity, who suggested legislative amendments to permit physician assisted suicide and voluntary euthanasia.[17] This approach is contrary to the views of some, who have filed the motion before the Superior Court of the District of Montréal to challenge the relevant provisions of the Act allowing for medical aid in dying.[18] It is currently unclear how this motion will affect the possibility to practice medical aid in dying in Quebec.

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12 B. Sneiderman & R. Deutscher, *supra* note 8, page 10.

13 *Ibid*, page 10.

14 Environics Research Group, 'Canadians'Attitudes towards End-of-life Issues', a survey conducted on behalf of LifeCanada April 2, 2013, page 2-3. Online: http://right2life.ca/wp-content/uploads/2012/09/Environics-LifeCanada-Euthansia-Report-2013-FINAL.pdf.

15 Forum Research News Release. Online: http://farewellfoundation.ca/wordpress/wp-content/uploads/2011/12/Assisted-Suicide-in-Canada-Forum-Research-20111216ll.pdf.

16 Québec National Assembly's Select Committee on Dying with Dignity Report (The Select Committee), March 2012 at page 51 and 76. Online: www.dyingwithdignity.ca/database/files/library/Quebec_death_with_dignity_report.pdf.

17 *Carter v. Canada* (Attorney General) 2012 BCSC 886 (CanLII), para 39.

18 Motion for Declaratory Judgment, the Superior Court of the District of Montréal (May 27, 2014) Lisa D'Amico & Dr. Paul J. Saba. Online: http://stream1.newswire.ca/media/2014/05/27/20140527_C2330_PDF_EN_2302.pdf.

II. Legal requirements for accessing medical aid in dying

Medical aid in dying is regulated in Chapter IV of the Act under the title *Specific requirements for certain end-of-life care*. In order a patient qualifies for obtaining medical aid in dying, the cumulative criteria listed in Article 26 of the Act have to be met. In particular, the patient must:
'(1) be of full age, be capable of giving consent to care and be an insured person within the meaning of the Health Insurance Act (chapter A-29);
(2) suffer from an incurable serious illness;
(3) suffer from an advanced state of irreversible decline in capability; and
(4) suffer from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable.'

Some of the requirements enlisted are rather ambiguous, and deserve closer analysis. Generally in Quebec, a person obtains the right to consent to treatment at the age of 14.[19] Although medical aid in dying in Quebec is claimed to be a part of healthcare,[20] the underage patients are precluded from accessing it. Furthermore, the Act exempts adults who lack the ability to consent under the Quebec Civil Code from accessing medical aid in dying. These exclusions allow for avoiding the debate on such highly controversial and sensitive issues as the right and access of the underage and the incapacitated to euthanasia.

A patient who is capable of giving consent must do so in a free and informed manner, by signing a specific form.[21] As it will be discussed further, a physician is required to ascertain whether the patient is informed about prognosis, therapeutic possibilities and their consequences, and whether the decision has been made without external pressure. If a patient is physically incapable of signing and dating the form, a third person, who is an adult of a sound mind and is not a member of the team caring for the patient, might sign the request. The signature must take place in the presence of a health or social service professional, who is under the duty to countersign it.[22] The requirement of a patient or a person on behalf of the patient to sign a form of request only after it has been communicated seemingly precludes medical assistance in dying on numerous sensitive situations, such as when an individual is severely disabled after following an accident, when suffering from dementia caused by a degenerative brain disease, or when a request is expressed by means of an advance directive.[23]

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19 Civil Code of Québec, LRQ, c C-1991, c. 64, a. 14.
20 The Select Committee, *supra* note 16, page 19 and 89.
21 Bill 52, *supra* note 1, Division II, art. 26.
22 *Ibid*, art. 26 (1).
23 The Select Committee, *supra* note 16, page 91-92.

Article 26 of the Act does not explicitly require a person requesting medical aid in dying to be a resident of Quebec. However, the requirement of being insured within the meaning of the Health Insurance Act precludes people who are not residents or temporary residents of Quebec to access medical aid in dying.[24] Canadians and Canada's permanent residents hold a constitutional right to move to and take up residence in any province.[25] Such a right also extends to the family members of Canadians and Canada's permanent residents. It is more cumbersome for foreign nationals to establish residency in Quebec.[26] Arguably, if the Act enters into force, Quebec might be faced with interprovincial death tourism.

The Act requires that a patient, who requests medical aid in dying, must suffer from an incurable illness and constant physical and psychological pain. Furthermore, the pain suffered cannot be relieved in a manner the patient deems tolerable. Should there be means that help the patient to relieve physical or psychological pain, but the patient refuses it by exercising his autonomy, presumably, the criterion is met, as the Quebec Civil Code precludes care of any nature without the patient's consent.[27] Provided the other criteria enclosed in Article 26 of the Act are met, there is nothing hindering the patient from proceeding with the request for medical aid in dying.

A physician, who is to exercise medical aid in dying, is under the duty to assess the request. Article 28 of the Act requires the physician to ensure that the patient meets the listed criteria. In particular,

'before administering medical aid in dying, the physician must

(1) be of the opinion that the patient meets the criteria of section 26(...),

(2) make sure that the patient has had the opportunity to discuss the request with the persons they wished to contact; and

(3) obtain the opinion of a second physician confirming that the criteria set out in section 26 have been met.'

In order to ensure that the patient meets the criteria specified in Article 26, the physician must validate the request. Article 28.1 of the Act sets forth a number of tasks to be performed in order to determine whether the criteria listed in Article 26 are met. In particular, the physician must make sure that the request is being made freely and without any external pressure, confirm the persistence of suffering and that the wish to obtain medical aid in dying

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24 Chapter A-29 of the Health Insurance Act, RSO 1990, c H.6, states that an insured person is a resident or temporary resident of Québec who is duly registered with the Board.

25 The Constitution Act, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11 6.2.a.

26 *Supra* note 17, c. 64, a. 11. The right to refuse treatment has been upheld by provinvial courts. See Ontario Court of Appeal decision in *Nancy B. v. Hôtel-Dieu de Québec (1992)*, 86 D.L.R. (4th) 385 (Que. S.C.).

27 Civil Code of Québec, *supra* note 19, c. 64, a. 11.

remains unchanged, discuss the patient's request with any members of the care team who are in regular contact with the patient, and with those the patient is in close relations with, if the patient so wishes. The list of tasks that ought to be performed by a physician is open-ended and other tasks, not listed in the Act, might need to be performed to ensure the patient meets the listed criteria and qualifies for receiving medical aid in dying. It is currently unclear whether it is necessary to demonstrate if the tasks have been performed and how to demonstrate that. The lack of clarification may lead to situations where one can easily question whether the criteria are truly met before the aid was provided.

The Act does not specify the time for assessing whether the patient, who has requested for medical aid in dying, meets the criteria prescribed by law. Notably, different situations might require different lengths; yet, a prohibition of an undue delay, in the authors' view, would contribute to ensuring smooth access to the medical aid in dying, and would prevent such situations as where the assessment is purposely not undertaken or delayed.

After the physician has assessed the criteria, a second medical opinion from another physician needs to be obtained.[28] The physician, who is providing a second opinion on the patient's conformity to the criteria prescribed by law, is required to consult the patient's medical records and examine the patient.[29] The Act does not specify the period of the assessment performed by the second physician. With regards to constant pain, for example, it is unclear whether the physician needs to confirm that the pain is related to the respective illness, or that the patient has constant pain through observation over a certain period or consultation of the patient's records to confirm the presence of pain. Lack of specification of this requirement allows for discrepancies in accessing the medical aid in dying in practice not only among various health care facilities but also among various physicians. Although this can mean differences in accessing medical aid in dying, this also allows for some flexibility and a tailor-made assessment for each of the patients. It is unclear, whether this is intended or not.

The second physician's opinion must be given in writing.[30] This provides for a possibility to review the assessment should that be necessary. Such a requirement is not explicitly placed upon the physician validating the request and performing medical aid in dying. Instead, the physician is obliged to notify the Commission on end-of-life care in order for them to assess whether the tasks to validate the patient's request are performed.[31] Further, a decision of the patient's eligibility for medical aid in dying needs to be made. If a positive decision

28 Bill 52, *supra* note 1, art. 28 (3).
29 *Ibid.*
30 *Ibid.*
31 *Ibid*, art. 41.

is taken, the physician must, as previously mentioned, administer the aid personally and take care of the patient until their death.[32] In other words, the physician needs to provide the lethal dose to the patient. The Act specifies neither the period within which the aid must be administered after the positive decision is taken nor does it provide for a clear enforcement mechanism of the decision. Some authors have suggested that a short pause is necessary between when all the conditions are met and the time of administering the aid.[33] Yet, such a requirement is not enshrined in the Act. This allows questioning whether not specifying such an important detail in the legislation precludes possible related problems that could emerge.

A validation of a request for medical assistance in dying and administering the lethal dose is performed by the same physician. Should a situation arise, where a positive decision is made but the physician is unable to provide medical aid in dying himself, for example, due to leave or death, the procedure arguably needs to be repeated. Medical aid in dying might be thus delayed or, if the patient's condition has changed and the patient is not able to communicate the wish again, medical aid in dying will not be possible.

Overall, the Act indicates how an adult able to give consent can access medical aid in dying in Quebec. The Act limits the access to medical aid in dying only to those who meet the criteria prescribed by law. A closer look at the criteria allows identifying several legal as well as ethical problems that will need to be dealt with if the Act enters into force and medical aid in dying is practised in Quebec. In the authors' view, the legal problems need to be tackled, as they allow for discrepancies in determining who can access medical aid in dying and under what circumstances, and render it questionable under what circumstances medical aid in dying can legitimately be provided. A further assessment is necessary concerning the legal tools in Quebec that can be used to tackle these challenges.

III. The same concept, a new label?

The Act respecting end-of-life care regulates various questions relating to end of life care, including medical aid in dying to ensure that patients at the end stage of their lives are provided with care that is respectful of their dignity and autonomy.[34] Medical aid in dying is not defined in the Act. Instead, as previously discussed, it is addressed and regulated as a certain end-of-life

32 *Ibid*, art. 29.

33 S. Johannes, J. Downie, S. Mclean, R. Upshur & D. Weinstock, 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making', *Bioethics* 25 (2011): 1-73, page 72.

34 Bill 52, *supra* note 1, preamble.

care, and the rights and duties of the care provider and patient are delineated. Should a patient meet the criteria prescribed by law to qualify for medical aid in dying, the Act requires, as previously mentioned, the physician to administer the aid personally and take care of the patient until the patient's death.[35] To put it in other words, medical aid in dying is an act performed by a physician to hasten the death of a patient.

The Act neither labels medical aid in dying as active voluntary euthanasia, nor it calls it physician assisted suicide. Yet, it requires a physician to administer the aid personally. Depending on the interpretation of administering the aid, medical aid in dying under the Act could be either one of them. Presumably, the wording of the Act reflects the Royal Society of Canada Expert Panel's intention to make both assisted suicide and voluntary euthanasia available in Quebec.[36] Despite the fact that medical aid in dying is neither defined as active voluntary euthanasia nor as physician assisted suicide, assistance in dying actively provided by a physician upon a request of the patient may meet the features of either of them and therefore can be labelled accordingly.

IV. Is medical aid in dying a question of provincial or federal jurisdiction?

When Bill 52 was passed, questions were raised concerning its constitutional legality and jurisdiction competence.[37] On the one hand, an act performed by a physician that helps a patient to die within a medical framework falls under the provincial healthcare jurisdiction.[38] On the other hand, the same act falls within the scope of the exclusive jurisdiction of the federal government over criminal law.[39]

The opponents of the Act in the motion for declaratory judgment claim that the provisions of medical aid in dying contradict the prohibition in the Criminal Code and therefore are unconstitutional.[40] In the plaintiffs' view, medical aid in dying is not part of healthcare. They believe that the Act poses danger to

35 *Ibid*, art. 29.

36 Both assisted suicide and voluntary euthanasia must be available. The Panel found no morally significant difference between these two activities and, furthermore, found that the arguments canvassed in Chapter Three and the evidence presented in Chapters Two and Four undercut prohibiting either and support permitting both. S. Johannes, J. Downie, S. Mclean, R. Upshur & D. Weinstock, *supra* note 33, page 72.

37 A. Munro, Legislation on 'Right-to-die with Dignity' Introduced in Quebec, The law library of congress, Global legal monitor. Online: www.loc.gov/lawweb/servlet/lloc_news?disp3_l205403621_text.

38 The Select Committee, *supra* note 16, page 19 and 89.

39 *Ibid*.

40 Motion for Declaratory Judgment, the Superior Court of the District of Montréal, *supra* note 18.

prematurely end the lives of the vulnerable. They also question the legality of the provisions allowing for medical aid in dying and argue that medical aid in dying should not be practised in Quebec.[41]

The Select Committee on Dying with Dignity, which proposed the Act to the Parliament, acknowledged that criminal law in Canada falls under the federal jurisdiction. They are, however, assuming that the Act falls within the provincial jurisdiction in matters of health and social services. For this reason, they argue that medical aid in dying is a question that has to be regulated on a provincial level.[42] On top of that, the Committee also argues that enforcement of the criminal law falls within the competence of the provincial jurisdiction.[43] Accordingly, provinces have the power to implement policies and guidelines concerning the applicability of the criminal law. In the Committee's view, the Attorney General of Quebec should issue guidelines to ensure that physicians who provided medical aid in dying in accordance with the Act are not prosecuted.[44] The prosecutorial instructions provided by guidelines means that prosecutors have discretion to accept and dismiss cases depending on whether there is sufficient evidence to prosecute and whether it is in the public interest that a prosecution occurs.[45] The prosecutorial instructions are commonly issued by the Attorney General or by the Director of Public Prosecutions.[46] One might question whether these guidelines in fact or in practice do not decriminalise certain assisted dying practices, which fall under the federal jurisdiction. There is a risk that prosecutorial discretion, if taken to an extreme, can undermine the prohibition in the Criminal Code. If prosecutors are recommended not to prosecute physician that ordinates medical aid in dying, then what is the purpose of having assisted suicide criminalised?

It is hard to oversee the fact that medical aid in dying can constitute a criminal offence stipulated in the criminal code. Even though the Committee believes that the prosecutorial guidelines should be used to protect physicians who provide medical aid in dying, it remains uncertain whether the guidelines can fully guarantee such a protection. The prosecutorial discretion has to be applied on a case-by-case basis and the decision can therefore be somewhat unpredictable.[47] Because of this uncertainty, physicians cannot be fully assured that they

41 *Ibid*.

42 The Select Committee, *supra* note 16, page 19 and 89.

43 *Ibid*, page 19.

44 *Ibid*, page 89-91.

45 J. Downie & B. White, 'Prosecutorial Discretion in Assisted Dying in Canada: A Proposal for Charging Guidelines', *McGill Journal of Law and Health*. 6:2(2012): 114-168 at page 121. See also Carter, *supra* note 17, para 302.

46 *Ibid*, page 121.

47 J.A. Osborne, 'Prosecutor's Discretion to Withdraw Criminal Cases in the Lower Courts', *Canadian Journal of Criminology*, 25 (1983): 55-78; J. Downie & B.White, *supra* note 45, page 120. See also Heads of Prosecutions Subcommittee on the Prevention of Wrongful Convictions report, The Path to Justice: Preventing Wrongful Convictions (The Canadian Federal Report

will not be prosecuted for providing medical aid in dying, which could undermine the patient's possibility to access medical aid in dying.

Several constitutional questions have been raised with regards to the validity of the Act. On the one hand, it is claimed that the provisions of the Act regulating medical aid in dying are unconstitutional due to contradicting the Canadian Criminal Code. On the other hand, it can also be argued that the very same provision of the Criminal Code violates the fundamental rights and freedom of the terminally ill in ending their lives in a dignified manner and therefore can be seen as unconstitutional.

A very similar debate is reflected in some provincial court cases dealing with assisted dying practices and the patient fundamental rights, which have been appealed to the Supreme Court of Canada. For example, in *Rodriguez v. British Columbia*, a patient suffering from amyotrophic lateral sclerosis, requested a physician's help to end her life before she lost her ability to function and care for herself.[48] Her condition was deteriorating quickly and her life expectancy was estimated between 2 and 14 months. She applied to the Supreme Court of British Columbia claiming that the prohibition for assisted suicide in Section 241(b) of the Canadian Criminal Code violates her right to security under the Canadian Charter of Rights and Freedoms. The court dismissed the application and it was appealed to the Court of Appeal, which affirmed the previous judgment. Further, the decision was appealed to the Supreme Court of Canada and the majority of the Court held that the prohibition in the Criminal Code is not contrary to the Canadian Charter of Rights and Freedoms.[49] The judgment upholds criminalisation of assistance in suicide.

The Rodriguez case has been criticised for the strict and robust approach of the courts towards the fundamental right to security and for the reasoning behind the decision.[50] It has been argued that the case would have been decided differently today because of changes in public opinion towards decriminalisation of assisted suicide and significant changes that have occurred in the practice of the law.[51] The court clearly states in the judgment that the prohibition for assisted suicide in Section 241(b) '*deprive the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person.*'[52]

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of the fall 2011), see chapter 4 about tunnel vision and the risk of prosecutors biased approach. Online: www.ppsc-sppc.gc.ca/eng/pub/ptj-spj/ptj-spj-eng.pdf.

48 *Rodriguez v. British Columbia (Attorney General)* [1993] 3 S.C.R. 519.

49 *Ibid*, page 520.

50 J. Downie & S. Bern, 'Rodriguez Redux', *Health Law Journal Volume*, 16 (2008): 27-54, page 31.

51 *Ibid*, page 39.

52 *Rodriguez*, *supra* note 48, page 521.

The prohibition of assisted suicide can therefore deprive terminally ill patients of their right of security. However, the court came to the conclusion that the deprivation in the previous case was legitimate on the grounds that is was in accordance with the principle of fundamental justice. Some authors have argued that the justifiable grounds for the deprivation in the relevant case were not satisfactory and that the infringement of fundamental security was not in line with the principle of fundamental justice. The reason being that the restriction was seen as disproportionate to the protected interests.[53]

More than 20 years after the ruling in *Rodriguez v. British Columbia*, a new British Columbia case challenges the constitutional validity of the prohibition of physician-assisted suicide before the Supreme Court of Canada. In *Carter v. Canada (Attorney General)* several plaintiffs request legalising physician assisted in Canada.[54]At first, the plaintiffs challenged the constitutionality of Article 241 of the Criminal Code before the Court of British Columbia, claiming that it violates the Canadian Charter of Rights and Freedoms. The court granted one of the plaintiffs, Gloria Taylor, a constitutional exemption and permitted her to obtain physician-assisted death under certain conditions. However, she passed away before taking advantage of the granted exception. The court's decision was appealed by the Attorney General of Canada before the British Columbia Court of Appeal. This court followed the Supreme Court of Canada's previous ruling in *Rodriguez v. British Columbia* and stated that the lower court is bound by the decision of a higher instance court.[55] The British Columbia Court of Appeal emphasised that the constitutional validity of the Criminal Code and the constitutionality of the prohibition of assisted dying practices, should be dealt with by the Supreme Court of Canada and not by the provincial courts. The decision was appealed to the Supreme Court of Canada and is scheduled for a hearing on October 15, 2014.[56]

The hearing at the Supreme Court comes at a critical moment. Should the court decide that the prohibition in Section 241(b) of the Criminal Code, which precludes now counseling or aiding in suicide, infringes on the plaintiffs' rights granted by the Charter, Canada's Parliament may have to amend the relevant section of the Criminal Code in order to allow physician assisted suicide. It is unclear, whether the court will take a step further and elaborate on decriminalisation of euthanasia, which along with physical assisted suicide is at the core of the debate in Quebec. It is currently questionable how this ruling will affect the legality of the provisions of medical aid in dying in Quebec, since the case

53 J. Downie & S. Bern, *supra* note 50, page 39.
54 *Carter*, *supra* note 17, para 18-25.
55 *Ibid*, para 1331.
56 See the schedule of the Supreme Court of Canada for procedures in the Carter case. Online: www.scc-csc.gc.ca/case-dossier/info/dock-regi-eng.aspx?cas=35591.

brought before the Supreme Court of Canada originates from British Columbia and not Quebec.

V. Concluding remarks

The Act respecting end-of-life care treats medical aid in dying as part of health care. Its ideological base lies in acknowledging that end-of-life care is part of health care, and it is intrinsically linked to the notions of aid and medical, which denote the value of support provided by a physician and other health professionals.[57] An inseparable element of end-of-life care is death, and thus it should be regulated under what circumstances and how a person can access this care. In other words, through the Act death in Quebec is medicalised. Although the Quebec model for accessing medical aid in dying seems to be straightforward, it seemingly restricts access to medical aid in dying to a limited group of a society. Should medical aid in dying be practised in Quebec, a closer analysis is needed to examine the concerns raised in this paper related to the criteria for accessing medical aid in dying, such as the lack of clarification of how a physician should ensure that the patient meets the listed criteria for medical aid in dying and within which time period the aid must be administered after the positive decision is taken.

According to the Criminal Code of Canada, euthanasia and physician assisted suicide are crimes. Therefore, it is currently questionable whether medical assistance in dying will be provided in Quebec in accordance with the Act, and if provided, whether physicians' actions will be prosecuted. It is unclear whether this corundum can be solved by the Supreme Court of Canada's decision in *Carter v. Canada* (*Attorney General*) concerning the validity of the Criminal Code provision precluding counselling or aiding suicide in Canada. It is also not known what the effect of the declaratory judgment will be on the medical aid in dying practices in Quebec. In the authors' view, a follow up on these questions will be necessary.

57 The Select Committee, *supra* note 16, page 76.