

**Brief on Bill C-14 from Jocelyn Downie, SJD, FRSC, FCAHS, Professor, Faculties of Law and Medicine, Dalhousie University (May 1, 2016)**

**Proposed Change #1**

1. Delete s.241.2(2) and add “(including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition” to s.241.2(1)(c)
2. Add to s. s.241.1: “*irremediable* means cannot be alleviated by means acceptable to the person”
3. Replace references to “reasonably foreseeable” elsewhere in the Act with: a) “with a grievous and irremediable condition causing enduring and intolerable suffering” (Preamble); and b) “all of the criteria set out in subsection (1) have been met;” (s.241.2(3)(b)(ii)).

***Reasons for change***

1. s.241.2(2) unjustifiably reduces the access to medical assistance in dying

*(a) Contrary to the government’s assertions, Kay Carter would meet the SCC’s Carter criteria and would not meet the s.241.2(2)(d) criteria*

There is no indication in the decision that the SCC thought that Kay Carter’s “natural death” had become “reasonably foreseeable” in terms of temporal proximity.

There was no evidence on the record before the Court that Kay Carter’s death was “reasonably foreseeable” in any temporally proximate way. In fact, just the opposite. As Kay Carter wrote in her letter to Dignitas (entered into evidence): “The neurologist, Dr. Cameron of North Vancouver, assessed me and I had a CAT scan and MRI done. From these tests he told me that I had an ongoing, slow deterioration of the nerves that would never kill me but eventually would reduce me to lie flat in a bed and never move. This thought horrified me.”

Kay Carter had spinal stenosis, which is not a life-limiting or terminal condition.

*(b) The government’s position on Kay Carter, mental illness/major physical disability, and Bill C-14 is incoherent*

The government has no evidence upon which to conclude that Kay Carter’s death was “not too remote” apart from the fact that she was old. On the logic of this, if someone has a non-life-threatening mental illness or major physical disability as their sole condition, as long as they are old, they will be eligible. Yet this is precisely what the government is trying to prevent by s.241.2(d). So either Kay Carter didn’t meet s.241.2(d) or Bill C-14 allows access to medical assistance in dying for individuals whose sole condition is a non-life-threatening mental illness or major physical disability. They cannot have it both ways.

(c) *The phrase “reasonably foreseeable” is untenable as a criterion for access*

“Reasonably foreseeable” is impermissibly vague. The debate about whether Kay Carter herself would meet this criterion makes this point crystal clear.

The government’s suggestion that “reasonably foreseeable” be interpreted as “in the not too distant future” or “not too remote” flies in the face of common usage, where it means predictability, not temporal proximity.

Contrary to the claims made by the government, the meaning proposed for “reasonably foreseeable” in the government’s glossary and public remarks is not consistent with the meaning of “reasonably foreseeable” in either the criminal law or tort law (where it means predictability rather than temporal proximity – i.e., it means you can foresee “that” rather than foresee “when”).

(d) *The word “incurable” is not found in Carter and the Bill does not limit “incurable”*

It might be suggested that “incurable” does the same work as “grievous.” But then the criteria would be “incurable and irremediable condition,” which is nonsensical. Alternatively, it might be suggested that “incurable” does the same work as “irremediable.” However, “incurable” is not limited in the Bill in the way that the SCC limited “irremediable.”

## **Proposed Change #2<sup>1</sup>**

Delete the Preamble’s reference to a commitment (with no deadline) for an exploration of the contested issues of mature minors, advance requests, and requests where mental illness is the sole underlying medical condition. Add a *statutory mandate* (i.e., in the body of the Act) for *independent expert* studies of the contested issues with a *prescribed and limited deadline* (18 months) for reporting back to Parliament.

### ***Reasons for proposed change***

The government provided a “Legislative Background” document to explain why it has concluded that Bill C-14 is consistent with the *Charter*. However, this document’s justifications for limiting the *Charter* rights are grossly inadequate. The government has not given parliamentarians a persuasive justification for the exclusions, and the document’s weaknesses establish the necessity of *independent expert* advice before parliamentarians can reasonably conclude that the exclusions do not violate the *Charter*. The document’s weaknesses include the following:

- 1) Misrepresentation of legislation in permissive jurisdictions.<sup>2</sup>

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<sup>1</sup> I believe Bill C-14 should be amended to include mature minors, mental illness, and advance requests. However, others will make the arguments in support of this position.

- 2) Misrepresentation of data from permissive jurisdictions.<sup>3</sup>
- 3) Reliance on unreliable sources of evidence for claims about permissive jurisdictions.<sup>4</sup>
- 4) Reliance on an ethical distinction explicitly rejected by Justice Smith in *Carter*.<sup>5</sup>
- 5) Reliance on assumptions that are fundamentally inconsistent with the advance directives legislation in place in provinces and territories across Canada.<sup>6</sup>
- 6) Reliance on a staggeringly unbalanced set of experts.<sup>7</sup>

A mere Preamble reference to a commitment to do the reports is too weak when *Charter* rights are being limited and the only question is whether the limits can be justified. The commitment for further study must be given the force of *statutory mandate*.

Furthermore, there must be a *prescribed, short timeline*. Real people, suffering in agony, will have their *Charter* rights limited every day until the government commissions studies and then reports back to Parliament.

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<sup>2</sup> “Amendments to Belgian law in 2014 extended eligibility to all minors but on narrower grounds of eligibility than exist for adults and emancipated minors: they must be in constant and unbearable physical (but not psychological) pain, and they must be likely to die in the short term. Parental consent and other additional safeguards are also required in these circumstances.” (16) Belgium did not extend assisted dying to all minors – only to mature minors (they must have the “capacity of discernment”).

<sup>3</sup> “[M]ental illness cases increased from zero in 2003 to 4% in 2013 of all medical assistance in dying reporting [in Belgium.]” (16) The category they reference is not limited to mental illness but rather includes, for example, Huntington’s Disease, Alzheimer’s Disease, and vascular dementia which are not mental illnesses.

<sup>4</sup> The cases that supposedly support their argument for limiting access to those who are “nearing death” are sourced to a series of websites for news media (endnote 39 – e.g., a Belgian case sourced to the Daily Mail Australia). The Supreme Court of Canada rejected this approach to evidence: “Anecdotal examples of controversial cases abroad were cited in support of this argument, only to be countered by anecdotal examples of systems that work well. The resolution of the issue before us falls to be resolved not by competing anecdotes, but by the evidence.” (para 120)

<sup>5</sup> “Respecting a mature minor’s refusal of further unwanted medical treatment is not the same as acquiescing to a request for active measures to cause death.” (21) This claim rests on a distinction explicitly rejected by Justice Smith in *Carter*: “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. I find the arguments put forward by those ethicists, such as Professor Battin, Dr. Angell and Professor Sumner, to be persuasive.” (para 335) The government’s “rationale” re: advance requests also rests on the active/passive distinction. (20-21)

<sup>6</sup> “Advance directives generally do not provide reliable evidence of a person’s consent at the time that medical assistance would be provided.” (20) All provincial/territorial legislation on advance directives is premised on the exact opposite assumption.

<sup>7</sup> Every source listed in the category “Canadian academics and experts” in the Bibliography is either authored or co-authored by M. Somerville, H. Chochinov, M. Heisel, or B. Mishara. The last three were experts for the Crown in *Carter*, and M. Somerville is one of Canada’s most well-known opponents of assisted dying.