

# Mental Illness, Health Care, and Assisted Death: Examining Parameters for Expanding or Restricting MAID under Canada's Charter and Federal System

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## ABSTRACT

In 2021, the federal government of Canada amended the *Criminal Code* to allow medical assistance in dying (MAID) for persons whose sole-underlying condition is a mental illness (MAID MI-SUMC), effective March 2024. Many, including the responsible Minister of Justice, have suggested that this expansion is, or inevitably will be, required by the courts. Part I of this article examines that claim and concludes that no Canadian court has recognized a Charter right to medical assistance in dying where mental illness is the sole underlying condition, nor is this necessarily a conclusion they will reach in the future, given the complex social, medical, ethical, and legal considerations engaged.

A number of those considerations have yet to be resolved in terms of health law and policy surrounding MAID MI-SUMC, including those which may fall to provincial jurisdiction. While the federal government is set to decriminalize access to MAID for mental illness, the Province of Quebec has expressly excluded it from eligibility through its own provincial statute. This, in turn, raises additional constitutional questions: to what extent can a provincial MAID scheme be constructed differently from that which the federal *Criminal Code* permits? Part II of this article explores these

jurisdictional considerations, drawing guidance from the Supreme Court of Canada’s recent decision *Murray-Hall v Quebec (Attorney General)*. The article concludes that there is significant constitutional room for the provinces to more actively regulate MAID, and considers the implications of these conclusions for legislation like Quebec’s.

KEYWORDS: medical assistance in dying, MAID, medical aid in dying, MAD, assisted death, mental illness, mental disorder, division of powers, constitutional jurisdiction over health, mental health law, criminal law, regulation of healthcare, Canadian Charter of Rights and Freedoms, Law & Disability

## A PRELIMINARY NOTE ON TERMINOLOGY

“*Medical assistance in dying*” or “MAID” is now widely-adopted in Canadian law and practice to describe both voluntary euthanasia (that is, the “administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death”) and assisted suicide (that is, “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”) [*Criminal Code*, s. 241.1, definitions]; in practice, however, 99.95% of all MAID deaths in Canada are by way of voluntary euthanasia<sup>1</sup>. The term has generated some criticism on the basis that it is confusing and obfuscating, especially as the practice expands into new contexts. One concern is that it can conflate the *termination* of life with conventional medical assistance provided throughout the dying process (i.e. palliative care). From a patient’s

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<sup>1</sup> Health Canada, Fourth Annual Report on Medical Assistance in Dying in Canada 2021, (Ottawa: Health Canada, October 2023) at 5 [*Fourth Annual Report*].

perspective, for example, being offered “medical assistance in dying” could potentially be mis-understood to mean medical treatment, symptom management, and personal support in the end-of-life process – not the ending of life itself. The Supreme Court of Canada declaration in *Carter* did not use the term “MAID”, instead adopting “physician-assisted death”. The term “*medical* assistance in dying” subsequently replaced *physician*-assisted death to encompass the involvement of both medical (i.e. physician) and nurse practitioners in the practice (nurse practitioners now perform 9.4% of all MAID procedures in Canada<sup>2</sup>). But while the word “medical” was ostensibly intended to describe the *person* performing the procedure, it has seemingly become a normative descriptor for the procedure itself – i.e. as “medical” in nature – again raising concerns about its potential conflation with medicinal and therapeutic treatment options such as palliative care (which is widely understood to be legally, clinically, and ethically distinct from MAID).<sup>3</sup> This dimension has raised particular concerns from disability perspectives, insofar as death may be increasingly understood as an intrinsically “medical” or “therapeutic” solution to suffering associated with disability. Finally, the accuracy of the term has been questioned – especially now that MAID is no longer limited to the end-of-life context – in describing the termination of life of a person who is *not* dying, and whose death is unforeseeable.<sup>4</sup> In using the terms “MAID” and “medical assistance in dying” throughout this paper, we do not intend to undermine these concerns in any way. We acknowledge these issues as beyond the scope of this paper, and use the term “MAID” because it is the legal terminology adopted in the *Criminal Code*.

“*Mental illness*” is the term used in Federal MAID legislation including Bill C-14, Bill C-7 and Bill C-39, *infra*, but has not yet been defined in such statutes. None use the term “mental disorder”, although this terminology is used elsewhere in the *Criminal Code* (where it is defined as “disease of the mind” and is largely used in relation to determining whether an accused is

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<sup>2</sup> *Ibid* at 6.

<sup>3</sup> See Mary J Shariff and Mark Gingerich, “Endgame: Philosophical, Clinical and Legal Distinctions between Palliative Care and Termination of Life” (2018), 85 *Supreme Court Law Review* (2d) 225.

<sup>4</sup> See K Sonu Gaiind et al, “Canada’s Medically Administered Death (MAD) Expansion for Mental Illness: Targeting the Most Vulnerable” (2022) 71:4 *World Medical Journal* 72 at 77-78, online: <papers.ssrn.com> [perma.cc/3LXK-Q2]6] [Gaiind et al, “Canada’s MAD Expansion”].

criminally responsible). The term “mental illness” was described by the Expert Panel on MAiD and Mental Illness as referring to “a subset of mental disorders, but lacks a standard clinical definition”. The term “mental disorder” appears to be favoured in the clinical context, and “is the term used in both major diagnostic classification schemes relied upon in Canadian psychiatric practice”.<sup>5</sup> It is also the term used in Quebec’s *Act respecting end-of-life care* (in French, “*trouble mental*”). The terms “mental illness” and “mental disorder” are often used interchangeably in discussions around MAiD policy. Because federal MAiD legislation has only used the former to date, we generally use the term “mental illness” throughout this paper, although “mental disorder” and “psychiatric disorder” are also used, particularly when describing cases, statutes, or sources which use those terms. Whether there is a substantive difference between the terms as a matter of statutory interpretation remains to be seen; we note, however, that even in legislation, the terms “mental illness” and “mental disorder” often appear to be interchangeable. Section 2 of the French version of *Criminal Code* (“definitions”), for example, simply uses the former term (“*maladie mentale*”) to define the latter term (“*trouble mental*”). Other statutes, such as the *Youth Criminal Justice Act*, SC 2002, c 1, employs them both (using the term “mental illness or disorder”).

## I. INTRODUCTION

In 2021, the federal government of Canada amended the *Criminal Code* to allow medical assistance in dying (MAiD) for persons whose sole underlying condition is a mental illness (MAiD MI-SUMC), a change scheduled to come into effect in March 2024.<sup>6</sup> This is further to the

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<sup>5</sup> See discussion in Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* (Ottawa: Health Canada, May 2022) at 6, 8-9, online (pdf): <[canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.pdf](https://canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.pdf)> [Health Canada, *Expert Panel 2022 Report*].

<sup>6</sup> Initially, this change was set to come into effect in March 2023, pursuant to amendments introduced in Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2021, cl 1(2.1) (assented to 17 March 2021), SC 2021 c 2 [Bill C-7]. In December 2022, the federal government announced that it would seek to delay the March 2023 start date, but stressed that it would only be *delaying* and not *cancelling* the implementation of MAiD MI-SUMC. On February 2, 2023, then-Minister

government's overall expansion of MAID in Bill C-7, which removed the eligibility requirement that a person's natural death be "reasonably foreseeable".<sup>7</sup>

The move to decriminalize MAID MISUMC has been controversial, insofar as MAID could potentially be offered as a publicly-funded medical treatment option for conditions such as clinical depression, chronic anxiety, eating disorders, obsessive compulsive behaviour, and post-traumatic stress disorder<sup>8</sup> – all of which can include amongst their symptoms, for example, hopelessness, despair, and suicidality (even if considered "rational").<sup>9</sup> It has

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of Justice David Lametti introduced Bill C-39 which was passed on March 9, 2023. Bill C-39 delays the repeal of the exclusion from eligibility for MAID MISUMC until March 17, 2024. For the text of bill see Bill C-39, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 44th Parl, 2023 (assented to 9 March 2023), SC 2023 c 1 [Bill C-39]. Bill C-314, a private Member's bill introduced by MP Ed Fast, proposed to halt this expansion; it was defeated on October 20, 2023 by a vote of 167-150. The NDP, Conservatives, and Greens all voted for the bill, along with one independent and eight Liberal MPs; the Bloc Québécois and most Liberal MPs voted against it, along with one independent MP. The close vote, and the broad cross-party support for the bill, seems to reveal a growing concern about MAID expansion in cases of mental illness. Immediately after the vote, Parliament referred the matter to a special joint committee to assess the degree to which Canada is prepared for this expansion, and to report back with a final recommendation by January 31, 2024. See Parliament of Canada, Bill C-314, online: <<https://www.parl.ca/legisinfo/en/bill/44-1/c-314>>.

<sup>7</sup> See Bill C-7, *supra* note 6 at cl 1(1).

<sup>8</sup> Depending on one's interpretation, all of these conditions could meet the statutory definition of a "grievous and irremediable medical condition", and thus give rise to MAID eligibility, if: (1) their manifestation is "serious and incurable"; (2) the patient is "in an advanced state of irreversible decline in capability"; and (3) the condition "causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable." See *Criminal Code*, RSC 1985, c C-46, s 241.2(2)(a-c) [*Criminal Code*]. Although the "irremediability" of a particular case of certain mental illness is a matter of debate and disagreement amongst many experts and specialists (discussed further below), according to the federal government, after Bill C-7's exclusion of mental illness expires, MAID will be available for those solely struggling with mental disorders including depression and personality disorders: see Department of Justice, "Canada's Medical Assistance in Dying (MAID) Law" (last modified 19 June 2023), online: <[justice.gc.ca](https://justice.gc.ca)> [perma.cc/B76D-CBZU].

<sup>9</sup> See Lars Mehlum et al, "Euthanasia and assisted suicide in patients with personality disorders: a review of current practice and challenges" (2020) 7:15 *Borderline Personality Disorder & Emotion Dysregulation*; see also Aiste Lengvenyte et al, "'Nothing Hurts Less Than Being Dead': Psychological Pain in Case Descriptions of Psychiatric Euthanasia and Assisted Suicide from the Netherlands: «Rien ne fait moins mal qu'être mort»: La douleur psychologique dans les descriptions de cas d'euthanasie

also been suggested that substance use disorders and addictive disorders may also give rise to MAID eligibility.<sup>10</sup> And though there is significant

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et de suicide assisté psychiatrique aux Pays-Bas” (2020) 65:9 Canadian Journal Psychiatry 612; see generally The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition, *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition* (Ottawa: Council of Canadian Academies, 2018) at ch 4, online (pdf): <cca-reports.ca> [perma.cc/HX8U-J548] [CCA Report]. For one discussion of distinguishing between the concepts of “rational “ or “understandable” suicide versus “true” suicide within the MAID context see Ellen R Wiebe et al, “Suicide vs medical assistance in dying (MAiD): A secondary qualitative analysis” (2020) 44:12 Death Studies 802. However, a clear distinction between “MAID” and “suicide” in our view remains implausible. For example, a report from the Canadian Association for Suicide Prevention states as follows: “when considering MAiD in the context of someone who is not dying as a result of their condition, such as a mental disorder alone, we are talking about suicide. By the very definition of suicide, which is the act of killing oneself, if the condition from which they are suffering is not killing them, then the act of providing medical assistance in dying is doctor-assisted suicide.” See Canadian Association for Suicide Prevention, “CASP Issues Statement About MAiD for Mental Illness” (14 December 2022), online: <suicideprevention.ca> [perma.cc/9DHY-AUMT]. On the other hand, the American Association of Suicidology (AAS) issued a statement in 2017 that “‘Suicide’ is not the same as ‘physician aid in dying’”, certain points of which were referenced as evidence in *Truchon v Attorney General of Canada*, 2019 QCCS 3792 at paras 358-364 [*Truchon*]. (The *Truchon* decision is discussed further below.) It is worth noting however, that the AAS statement appeared to discuss the distinction primarily in the context of the legalized practice in several US states which only allow patients with a short survival prognosis to request and self-administer a lethal prescription. The notion that there is a clear difference between MAID and suicide is arguably even harder to maintain when it involves patients who are not otherwise approaching death, and particularly when it involves MAiD solely for mental illness (on the latter, see Marie Nicolini, Chris Gastmans & Scott YH Kim, “Psychiatric euthanasia suicide, and the role of gender” (2021) 220(1) *British J. Psych.* 10). For an analysis and critique of the 2017 AAS statement, see Scott YH Kim, Yeates Conwell, & Eric D Caine, “Suicide and Physician-Assisted Death for Persons with Psychiatric Disorders: How Much Overlap?” (2018) 75:11 *JAMA Psychiatry* 1099. Interestingly, the AAS officially “retired” this statement on March 8, 2023, indicating that “a task force consisting of leaders within the industry from various disciplines across the globe will determine any future positions or statements on this subject matter”: American Association of Suicidology, “AAS Update on Physician Assisted Death Previous Statement” (8 March 2023), online: <suicidology.org> [perma.cc/ZFT3-UWQS].

<sup>10</sup> The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) includes alcohol use disorder, stimulant use disorder, and gambling disorder. See discussion in American Psychiatric Association, “Substance-Related and Addictive Disorders”, online: <[https://www.psychiatry.org/file%20library/psychiatrists/practice/dsm/apa\\_dsm-5-substance-use-disorder.pdf](https://www.psychiatry.org/file%20library/psychiatrists/practice/dsm/apa_dsm-5-substance-use-disorder.pdf)>. A recent conference on addiction medicine in Canada

controversy over whether such conditions are to be considered mental disorders, MAID MI-SUMC could arguably also include neurodevelopmental disorders, such as cognitive or intellectual disabilities and autism spectrum disorder.<sup>11</sup>

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featured a presentation on a MAID assessment framework for people with substance use disorders; a lead physician presenting the framework stated in a media interview that “it’s not fair to exclude people from eligibility purely because their mental disorder might either partly or in full be a substance use disorder. It has to do with treating people equally.” See Manisha Krishnan, “Canada Will Legalize Medically Assisted Dying for Eligible People Addicted to Drugs” (19 October 2023), Vice News, online: <<https://www.vice.com/en/article/4a3bdm/canada-will-legalize-medically-assisted-dying-for-people-addicted-to-drugs>>.

- <sup>11</sup> See discussion in the report of the Association des Spécialistes Psychiatres du Québec, *Accès à l’aide médicale à mourir pour les personnes atteintes de troubles mentaux : Document de réflexion* (2020) at 44-45, online (pdf): <[ampq.org](http://ampq.org)> [perma.cc/Y9S4-HJW8] [ASPQ]. In Belgium and the Netherlands (until recently the only other countries with a significant euthanasia practice for persons with mental illness), persons with such cognitive disabilities have been approved for and have had their life ended by euthanasia. For a discussion of this practice, see Irene Tuffrey-Wijne et al, “Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012-2016).” (2018) 19:1 *BMC Medical Ethics* at 17, online: <[bmcmethics.biomedcentral.com](http://bmcmethics.biomedcentral.com)> [perma.cc/MZ8D-49TV]; Irene Tuffrey-Wijne et al, “Euthanasia and physician-assisted suicide in people with intellectual disabilities and/or autism spectrum disorders: investigation of 39 Dutch case reports (2012-2021)” (2023) 9(3) *BJPsych Open*, online: <[cambridge.org](http://cambridge.org)> [perma.cc/FZ97-G2KA]. See also the detailed analysis of the controversial case in Belgium of Tine Nys (38), who had her life ended by euthanasia, four weeks after being diagnosed with autism spectrum disorder. It is the only case in Belgium where a euthanasia practice resulted in criminal prosecution, against the three physicians involved, which ended with a non-guilty jury verdict. The Court of Cassation remanded the case against one of the physicians back to a civil court because of insufficient justification for the not-guilty verdict (for a short explanation with links to the cases, see Trudo Lemmens, “What Counts as Evidence? A Uniquely Valuable Analysis of a Belgian Criminal Case Involving Euthanasia”, *JOTWELL* (4 May 2023), online: <[health.jotwell.com](http://health.jotwell.com)> [perma.cc/JDX9-H329] (reviewing Marc De Hert, Sien Loos, Sigrid Sterckx, Eric Thys & Kristoff Van Assche, “Improving Control Over Euthanasia of Persons With Psychiatric Illness: Lessons from the first Belgian Criminal Case Concerning Euthanasia”, 13 *Frontiers in Psychiatry* (2022)). The evidence presented in the trial arguably revealed serious concerns about lack of adequate care: Marc De Hert et al, “Improving Control Over Euthanasia of Persons with Psychiatric Illness: Lessons from the first Belgian Criminal Case Concerning Euthanasia” (2022) 13 *Frontiers in Psychiatry* 1.

All of this has raised a number of questions amongst medical professionals<sup>12</sup>, mental health specialists,<sup>13</sup> legal and human rights experts<sup>14</sup>, and disability scholars<sup>15</sup>, many of whom are particularly concerned about

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- <sup>12</sup> See Ramona Coelho et al, “Bill C-7, From MAiD to MAD: Medical Assistance in Dying becomes Medically Administered Death” (last modified 2022), online: <maid2mad.ca> [perma.cc/N2WX-U66J] [Coelho et al, “Bill C-7”]; Sonu Gaind, “Assisted suicide: We are poised to soon be ending lives of non-dying people”, *Toronto Star* (24 February 2020), online: <thestar.com> [perma.cc/TG8B-9M9W].
- <sup>13</sup> See the report of the Expert Advisory Group on MAiD: K Sonu Gaind et al, “Canada at a Crossroads: Recommendations on Medical Assistance in Dying and Persons with a Mental Disorder: An Evidence-Based Critique of the Halifax Group IRPP Report (26 March 2020) (Toronto, Expert Advisory Group on Medical Assistance in Dying, 2020), online: <eagmaid.org/report> [perma.cc/XXX3-SFLT]. [Gaind et al, “Canada at a Crossroads”]. See also the discussion in Gaind et al, “Canada’s MAD Expansion”, *supra* note 4 at 77-78.
- <sup>14</sup> See discussion in Letter from Gerard Quinn, Claudia Mahler & Olivier De Schutter to the Canadian Government (3 February 2021), online: <spcommreports.ohchr.org> [perma.cc/ER9E-3Z93.] [Quinn, Mahler & De Schutter]. See also Isabel Grant and Elizabeth Sheehy, “Focus on dignified lives, not facilitated deaths”, *Law360 Canada* (24 March 2021), online: <law360.ca> [perma.cc/6PS2-R2HA]; Trudo Lemmens & Laverne Jacobs, “The latest medical assistance in dying decision needs to be appealed: Here’s why”, *The Conversation* (9 October 2019), online: <theconversation.com> [perma.cc/MX6V-NECR] [Lemmens & Jacobs]; Jonas-Sébastien Beaudry, “The Way Forward for Medical Aid in Dying: Protecting Deliberative Autonomy is Not Enough” (2018) 85 SCLR (2d) 335 at 361.
- <sup>15</sup> See Catherine Frazee, “Assisted dying legislation puts equality for people with disabilities at risk”, *The Globe and Mail* (17 November, 2020), online: <theglobeandmail.com> [perma.cc/HW3D-XFKS]; Heidi Janz, “Opinion: We must ensure revised assisted dying law will not threaten lives of people with disabilities”, *Calgary Herald* (26 October 2020), online: <calgaryherald.com> [perma.cc/7PH5-KEY9]; Jonas-Sébastien Beaudry, “Somatic Oppression and Relational Autonomy: Revisiting Medical Aid in Dying through a Feminist Lens” (2020) 53:2 UBC L Rev 241 at 283-287 [Beaudry]. See also Jaro Kotalik & David W. Shannon, eds., *Medical Assistance in Dying (MAiD) in Canada: Key Multidisciplinary Perspectives* (Cham, Switzerland: Springer, 2023). Note that disability scholars and advocates have expressed serious concern about the overall expansion of MAiD outside the context of an approaching natural death, thus not just MAiD MI-SUMC. We share this broader concern as well.



the prospect of offering MAID in such contexts.<sup>16 17</sup> Some of these questions relate to the practice of evidence-informed medicine, for example: can mental illness be confidently predicted as being ‘irremediable’ in specific cases?<sup>18</sup> Several mental health experts and organizations have emphasized that there is no reliable scientific basis to determine, in advance, whether a

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<sup>16</sup> “Bill C-39, An Act to amend An Act to amend the Criminal Code (medical assistance in dying)”, 3rd reading, *Senate Debates*, 44-1, No 105 (9 March 2023) at 3088-3090 (Hon Fabian Manning) [Bill C-39 Senate Debates]; see also Parliament, Special Joint Committee on Medical Assistance in Dying, *Medical Assistance in Dying and Mental Disorder as the Sole Underlying Condition: An Interim Report* (June 2022) (Joint Chairs: Marc Garneau & Yonah Martin) at 35-42 [Interim Report].

<sup>17</sup> According to a recent poll conducted by the Angus Reid Institute, 51% of Canadians surveyed were opposed to allowing MAID M-SUMC, 31% were in favour, and 18% were unsure: Angus Reid Institute, “Mental Health and MAID: Canadians question looming changes to Canada’s assisted-death law” (13 February 2023), online: <angusreid.org> [perma.cc/A4CJ-KL55]. A September 2023 poll similarly found that, in every province, more Canadians are opposed to expansion than those who support it, and, further, that an overwhelming majority of Canadians (82%) “feel mental health care should be improved first before MAID eligibility is expanded to include those whose sole condition is a mental illness.” Angus Reid Institute, “Mental Health and MAID: Canadians who struggle to get help more likely to support expanding eligibility” (28 September 2023), <https://angusreid.org/mental-health-care-access-maid-mental-illness/#:~:text=Three%2Din%2Dten%20(28,access%2C%20there%20is%20elevated%20support>. [Angus Reid Institute]. See also discussion in Gaiind et al, “Canada’s MAD Expansion”, *supra* note 4 at 76.

<sup>18</sup> For discussion see Gaiind et al, “Canada at a Crossroads”, *supra* note 13 at 9-14; Sonu Gaiind, “What Does ‘Irremediability’ in Mental Illness Mean?” (2020) 65:9 *Can J of Psychiatry* 604 at 604-06, citing Sisco MP van Veen, Andrea M Ruissen & Guy AM Widdershoven, “Irremediable Psychiatric Suffering in the Context of Physician-assisted Death: A Scoping Review of Arguments” (2020) 65:9 *Can J of Psychiatry* 593 [Gaiind, “Irremediability in Mental Illness”]; see also The Centre for Addiction and Mental Health, “Medical Assistance in Dying (MAiD) and Mental Illness – FAQs” (February 2023), online: <camh.ca > [perma.cc/5HW4-EAEA] [Centre for Addiction and Mental Health]; Association des Médecins Psychiatres du Québec, “Access to medical assistance in dying for people with mental disorders: Discussion Paper” (November 2020), at 28-31, online (pdf): <campq.org > [perma.cc/9KRV-XGBE] [AMPQ]; compare to recommendations in Health Canada, *Expert Panel 2022 Report*, *supra* note 5 at 12-13, which differentiates between “irremediable” and “incurable” and describes that whether a psychiatric illness is ultimately “incurable” requires assessment on a case by case basis and furthermore, “cannot be established in the absence of multiple attempts at interventions with therapeutic aims” [emphasis added]. Note how this appears to run contrary to interpretations of “irremediability” that incorporate a patient’s refusal of evidence-based treatments. See also discussion in *Interim Report*, *supra* note 16 at 37-39.

person will be effectively treated or will sufficiently recover to cope with their illness.<sup>19</sup> Other concerns relate to systemic ableism, and the need to uphold equality rights as well as the right to life and security of the person for persons with disabilities (including mental illness) – especially in the Canadian context where many basic mental health supports and services are lacking. Charter concerns have been raised in connection with the government offering “death as a solution to the suffering of disability for those not at the end of life” in this context, as it perpetuates the “discriminatory premise that disability can be worse than death and therefore, death is a benefit for this group of Canadians”.<sup>20</sup>

There are also significant questions relating to broad social and public health policy goals. Is mental illness a context which points to a different “line in the sand” in relation to MAID?<sup>21</sup> For many, when it comes to MAID, mental illness is a paradigmatic example that more clearly reveals the problem of treating MAID as a medical treatment for various forms of suffering and symptoms associated with illness. Realistically, can MAID MD-SUMC actually be reconciled with the public health goal of suicide prevention?<sup>22</sup> How are we to approach the massive efforts many have

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<sup>19</sup> See *supra* note 18.

<sup>20</sup> Isabel Grant, “Legislated Ableism: Bill C-7 and the Rapid Expansion of MAiD in Canada” (unedited manuscript, McGill Journal of Law and Health, forthcoming), online: <[https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=4544454](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4544454)> [Grant, Legislated Ableism]. See also Heidi Janz, “MAID to Die by Medical and Systemic Ableism” in Jaro Kotalik & David W. Shannon, eds., *Medical Assistance in Dying (MAID) in Canada: Key Multidisciplinary Perspectives* (Cham, Switzerland: Springer, 2023).

<sup>21</sup> This is, in our view, an issue that arises broadly in the context of MAID, and particularly in situations where death is not approaching, and also in situations where mental illness and physical illness and disability intersect. But it is perhaps most starkly presented in situations of mental illness where suicidality is often a key component of the illness that underlies the request for MAID. We note that “No other country permits MAID MD-SUMC where one of the eligibility criteria is based on an individual’s personal assessment of what conditions for relief of their intolerable suffering they consider acceptable. If Canada were to expand MAID MD-SUMC using this criterion, it could become the most permissive jurisdiction in the world with respect to how relief of suffering is evaluated.” CCA Report, *supra* note 9; for discussion of disability being the ‘line in the sand’, ableism, and eugenics perspectives, see e.g. Ameil J Joseph, “Expanding MAiD could worsen discrimination against people with disabilities”, *iPolitics* (19 February 2021), online: <[ipolitics.ca](http://ipolitics.ca)> [perma.cc/S7F9-6GSB]; Shelley Tremain, “Disaster Ableism, Assisted Suicide, and Bioethics” (3 June 2022), online: <[biopoliticalphilosophy.com](http://biopoliticalphilosophy.com)> [perma.cc/X23U-8EKB].

<sup>22</sup> When Bill C-14, the federal government’s new MAID law, was introduced in 2016, the

undertaken to address stigmatization and structural vulnerability<sup>23</sup> to improve mental health and wellbeing and meaningful participation in Canadian life? And to what extent might extraneous factors such as systemic inequality, societal barriers, or unmet needs<sup>24</sup> be influencing a person's request to die in these contexts?<sup>25</sup> Would addressing these as a priority right after careful balancing and consideration of competing considerations be

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government emphasized that its restrictions on eligibility were needed, in part, to prevent MAiD from being used as a means for suicide more generally. For example, Justice Minister Wilson-Raybould testified before the Senate Standing Committee that “allowing assisted dying for persons solely on the basis of a diagnosis of mental illness could harm efforts to promote well-being and discourage suicide more generally”; she explained that “If mental illness is permitted as the sole basis for medical assistance in dying being provided, and if eligibility was not restricted to persons whose deaths have become reasonably foreseeable, it would be difficult to limit eligibility at all, on any principled basis” [emphasis added]. Senate, Standing Senate Committee on Legal and Constitutional Affairs, *Evidence*, 42-1, No 8 (4 May 2016) (Hon Jody Wilson-Raybould) online: <senCanada.ca> [perma.cc/J292-UUM5]. The Justice Department also emphasized that “restricting access to only those individuals whose death is reasonably foreseeable” was designed, in part, to further “the objective of suicide prevention”. See Department of Justice, *Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, online: <justice.gc.ca> [perma.cc/BM3X-CHN]. This was affirmed in the text of the final Bill; its preamble states that “suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities”: Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016, preamble para 5 (assented to 17 June 2016), SC 2016, c 3 [Bill C-14].

<sup>23</sup> “Structural vulnerability refers to the impacts of the interaction of demographic attributes (i.e., sex, gender, socioeconomic status, race/ethnicity), with assumed or attributed statuses related to one's position in prevailing social, cultural, and political hierarchies. Negative perceptions of these characteristics may lead to difficult social circumstances such as unstable housing and lack of employment opportunities. It can also affect self-perception and have an impact on how people interact with and are treated by health care systems. These types of circumstances can influence suffering and contribute to viewing death as one's only option”. Health Canada, *Expert Panel 2022 Report*, *supra* note 5 at 11.

<sup>24</sup> *Ibid* at 17: “Data related to specific topics (eligibility, supported decision-making, means available to relieve suffering, refusal of means available, and residence and legal status) should be collected in the MAiD monitoring system in addition to data already collected under the 2018 Regulations. These data can be used to assess whether key areas of concern raised about MAiD MISUMC and complex Track 2 cases discussed in this report are being addressed by the clinical practices recommended.”

<sup>25</sup> See CCA *Report*, *supra* note 9 at 148-49; see also Bill C-39 Senate Debates, *supra* note 16 at 3091 (Hon Julie Milville-Dechêne).

patently unconstitutional?<sup>26</sup> Would it be unreasonable to argue that MAID in these situations is ultimately irreconcilable with efforts to address these challenges?

Addressing such questions has, in the view of the authors, been largely side-stepped by lawmakers calling for urgent MAID expansion. Instead, they have suggested that legislators have no other choice, constitutionally speaking. For example, when asked to explain why Parliament was intent on moving forward with MAID for mental illness, then-Minister of Justice David Lametti stated: “We do have to respect decisions of the courts. They have said that medical assistance in dying is a right that Canadians have.”<sup>27</sup> When asked if there was a chance that Parliament would not proceed with allowing MAID for mental illness, the Minister replied, “I think that would run us afoul of the courts”.<sup>28</sup> Similarly, when asked, “How can you ethically, in good conscience, go ahead and provide this to people [MAID for mental illness] when you know that they may not have had the ability to get proper treatment?”, the Minister replied, “Well again, it is something that our courts, and the highest court in Canada, has said is a Charter right that Canadians have.”<sup>29</sup>

In fairness, Minister Lametti did not stand alone in asserting this view.<sup>30</sup> Several medical professionals and professional organizations appear to have embraced this argument as the primary reason to support its legalization.<sup>31</sup>

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<sup>26</sup> See CCA Report, *supra* note 9 at 148-49; see also Bill C-39 Senate Debates, *supra* note 16 at 3091 (Hon Julie Milville-Dechêne).

<sup>27</sup> Sidney Cohen, “NWT senator questions territory’s ability to offer medical assistance in dying”, *CBC News* (5 January 2023), online: <cbc.ca> [perma.cc/VAJ8-QCP7] [Cohen]; see also Stephanie Levitz, “Government seeks delay in expanding medical access in dying to those with mental illnesses”, *Toronto Star* (15 December 2022), online: <thestar.com> [perma.cc/CX5T-Q327].

<sup>28</sup> Cohen, *supra* note 27.

<sup>29</sup> The Fifth Estate, “Is it too easy to die in Canada? Surprising approvals for medically assisted death” (19 January 2023) at 00h:37m:02s, online (video): <youtu.be> [perma.cc/ZUN7-5XPG].

<sup>30</sup> See e.g. British Columbia Civil Liberties Association, “SENATE BRIEFING NOTE re Bill C-7”, (17 December 2020) at 2-4, online (pdf): <sencanada.ca> [perma.cc/ZBU2-8AV7].

<sup>31</sup> See e.g. ASPQ, *supra* note 11 at 26, 45, which discusses in detail the legal context, including the *Carter* and *Truchon* decisions, and emphasizes the need to avoid “discrimination” and to recognize “le même droit à l’autodétermination”. For a critical discussion of the Canadian Psychiatric Association position as arguably exclusively

However, based on our review of existing constitutional jurisprudence, the claim that the courts require a MAID MI-SUMC regime is not accurate. As examined in detail below, no court has stated that Canadians have a “Charter right” to medical assistance in dying where mental illness is the sole underlying condition.<sup>32</sup> Nor is this necessarily a conclusion that courts will automatically reach in the future. Whether s. 7 or s. 15 of the Charter can be interpreted to require the government to allow MAID for mental illness remains, at the very least, an unadjudicated question. So too is the question of whether the government could justify a legislative decision not to offer MAID MI-SUMC as a “reasonable limit” in a “free and democratic society” under section 1 of the Charter. No Canadian court has even *considered* the constitutionality of a regulatory regime which specifically excludes MAID for mental illness. And only one trial-level court has specifically opined on the constitutionality of limiting access to MAID outside the end-of-life context at all.<sup>33</sup>

It is also important to consider the compelling human rights arguments that might *restrict* the government from offering death as a medical solution for mental illness, as well as other conditions.<sup>34</sup> For example, multiple

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based on accepting legal claims related to the right to MAID, see Gaind et al, “Canada’s MAD Expansion”, *supra* note 4 at 74-75 and references therein. See e.g. also Dr. Derryck H. Smith’s statements in UTorontoLaw, “Canada’s Headlong Assisted Death Expansion” (22 February 2022) at 00h:34m:07sff, online (video): <youtube.com> [perma.cc/68NR-V73K].

<sup>32</sup> This conclusion was also reached by 31 law professors in a joint letter submitted to the federal government: “We disagree as law professors that providing access to MAiD for persons whose sole underlying medical condition is mental illness is constitutionally required, and that *Carter v Canada* AG created or confirmed a constitutional right to suicide, as Minister Lametti repeatedly stated. Our Supreme Court has never confirmed that there is a broad constitutional right to obtain help with suicide via health-care provider ending-of-life.” See Trudo Lemmens, “Parliament is not forced by the courts to legalize MAID for mental illness: Law Professors’ Letter to Cabinet” University of Toronto Faculty of Law Blog, (2 February 2023), online: <law.utoronto.ca> [perma.cc/T564-RVDR].

<sup>33</sup> *Truchon*, *supra* note 9. *Truchon* is discussed further below.

<sup>34</sup> See Grant, “Legislated Ableism”, *supra* note 20 and André Schutten, “Lethal Discrimination: A Case Against Legalizing Assisted Suicide in Canada” (2016) 73 SCLR (2d) 143 at paras 61-63; see also Beaudry, *supra* note 15 at 283-287. The argument here includes that by expanding MAID, while not adequately funding other options such as palliative care and disability support services, the government is actually undermining ‘genuine’ autonomy because the only ‘choice’ left to patients is really a choice of a premature death they may not actually want. See also discussion of assisted death,

United Nations experts have repeatedly warned that Canada’s existing MAiD regime undermines international human rights law obligations, including those Canada has committed to uphold such as Article 3 of the *Universal Declaration of Human Rights*, Article 6(1) of the *International Covenant on Civil and Political Rights*, and Article 10 of the *Convention on the Rights of Persons with Disabilities*.<sup>35</sup> UN experts have concluded that Bill C-7’s expansion of MAiD outside of the end-of-life context (i.e. for disability-related suffering, and *only* for disability-related suffering) is “contrary to Canada’s international obligations to respect, protect and fulfil the core right of equality and non-discrimination of persons with disabilities” as it creates and reinforces negative, ableist social assumptions - including that “it is better to be dead than to live with a disability”.<sup>36</sup> They have also expressed concern that Canada’s approach singles “out the suffering associated with disability as being of a different quality and kind than any other suffering”, and results “in a two-tiered system in which some would get suicide prevention and others suicide assistance, based on their disability status and specific vulnerabilities”.<sup>37</sup> These concerns apply equally in the context of advancing death as a solution for suffering experienced by Canadians with mental health disorders as for those with physical disabilities.<sup>38</sup>

With all of this said, the only two cases that have invalidated federal restrictions on MAiD - *Carter*<sup>39</sup> and *Truchon*<sup>40</sup> - considered just one legislative purpose in their deliberations: the protection of vulnerable persons from being induced to end their lives in a moment of weakness.<sup>41</sup>

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“meaningful choice” and the “right to highest attainable standard of health” in Mary J. Shariff, “Navigating assisted death and end-of-life care” (2011) 183(6) CMAJ 643-4, online: <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071380/>>.

<sup>35</sup> See Quinn, Mahler & De Schutter, *supra* note 14 at 4.

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid* at 7.

<sup>38</sup> *Ibid*; see also Catalina Devandas-Aguilar, “Visit to Canada: Report of the Special Rapporteur on the rights of persons with disabilities”, Human Rights Council, 43rd Sess, A/HRC/43/41/Add.2 (19 December 2019), online: <[ohchr.org](http://ohchr.org/)> [[perma.cc/GTA2-WCJJ](https://perma.cc/GTA2-WCJJ)].

<sup>39</sup> See *Carter v Canada*, 2015 SCC 5 [Carter 2015].

<sup>40</sup> See *Truchon*, *supra* note 9.

<sup>41</sup> The previous Supreme Court of Canada precedent on assisted suicide, *Rodriguez v British Columbia (Attorney General)*, 1993 CanLII 75 (SCC) at paras 140, 149, 162, 186

This narrow framing of the criminal law's objective drove the courts' constitutional analyses in both cases.<sup>42</sup> In the *Truchon* case, the court did so

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[*Rodriguez*], upheld the law on the basis that it had as one of its objectives the goal of “preserving life”, which was grounded in “the policy of the state that human life should not be depreciated by allowing life to be taken” as well as the conviction that “the active participation by one individual in the death of another is intrinsically morally and legally wrong”. The later 2015 Supreme Court of Canada decision, *Carter 2015*, *supra* note 39, agreed that “[t]he sanctity of life is one of our most fundamental societal values” (para 63). However, it articulated the law's object as having “the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness” (para 78). For a critique of *Carter's* narrow framing of the legislative purpose, and its departure from the *Rodriguez* precedent, see John Keown, “*Carter: A Stain on Canadian Jurisprudence*” in Derek B.M. Ross, ed., *Assisted Death: Legal, Social and Ethical Issues After Carter* (LexisNexis Canada, 2018) at 14-16, and John Sikkema, “The ‘Basic Bedford Rule’ and Substantive Review of Criminal Law Prohibitions Under Section 7 of the Charter” (2018) 85 SCLR (2d) 49 [Sikkema]. See also discussion in Mary J Shariff, “*Carter v Canada: Exploring the Ebb and Flow of “Competing” Societal Values through Section 7 and Section 1 of the Canadian Charter of Rights and Freedoms*” in Jaro Kotalik & David W. Shannon, eds., *Medical Assistance in Dying (MAID) in Canada: Key Multidisciplinary Perspectives* (Cham, Switzerland: Springer, 2023). In the 2019 decision of the Quebec Superior Court, *Truchon*, *supra* note 9 at paras 555-556, the Court rejected arguments that Bill C-14's “reasonably foreseeable natural death requirement” had the objective of affirming the inherent and equal value of every person's life and the importance of preventing suicide (despite clear language in the preamble of the law). Rather, the Court determined that the provision's sole purpose was to “protect vulnerable persons who might be induced to end their lives in a moment of weakness, by preventing errors when assessing requests for medical assistance in dying” [emphasis added]. For critiques of this analysis, see Grant, “Legislated Ableism”, *supra* note 20, and Derek Ross, “What's the Purpose of Canada's MAID Law?” (10 October 2019), online (blog): <[christianlegalfellowship.org](http://christianlegalfellowship.org)> [perma.cc/4G6Y-T229].

<sup>42</sup> See *Carter v Canada (Attorney General)*, 2012 BCSC 886 at para 16 [*Carter BCSC*]; *Carter 2015*, *supra* note 39 at para 78; *Truchon*, *supra* note 9 at para 556. In a judgment on a preliminary motion in *Truchon*, the court also refused to admit certain evidence on the competing interests considered by Parliament in drafting Bill C-14, and the objectives of the law. The court noted that its role was not to examine all of the criteria or objectives of the “*nouveau régime législatif*” – rather, its sole function was to decide whether the reasonably foreseeable death requirement is contrary to the Charter: see *Truchon c. Procureur général du Canada*, 2018 QCCS 317 at paras 19-26. As such, the Attorney General was restricted from bringing evidence on the general objectives of the law, and was instead limited to “la seule et unique question du critère de la mort devenue raisonnablement prévisible” (para 31). While the court was understandably concerned with admitting excessive evidence, this restrictive approach (combined with the court's ultimate dismissal of the preambular statements of purpose as mere “vehicles used to affirm social values or stakes”, *Truchon*, *supra* note 9 at para 556) seems difficult to reconcile with principles articulated by the Supreme Court of Canada: namely, that

even by rejecting very specific legislative objectives framed by Parliament only one year earlier.<sup>43</sup>

But the enactment of a new regime – for example, one that expressly excludes mental illness as a basis for MAID eligibility in furtherance of a distinct purpose or objectives – would require a fresh constitutional analysis and would not necessarily be governed by the reasoning employed in *Carter*. This was made clear in *Lamb v Canada*, where the B.C. Supreme Court rejected the argument that *Carter* was dispositive of Bill C-14, the government’s new MAID legislation enacted in response to *Carter*, because each law needs to be assessed based on its specific and unique legislative objectives.<sup>44</sup>

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“determining legislative purpose requires us to consider statements of legislative purpose together with the words of the provision, the legislative context, and other relevant factors,” and that an impugned provision “must also be read harmoniously with other provisions of the statute.” See *R v Appulonappa*, 2015 SCC 55 at paras 33, 46. See also *R v Moriarty*, 2015 SCC 55 at para 31 and *R v NS*, 2022 ONCA 160 at para 47 [emphasis added].

<sup>43</sup> See Lemmens & Jacobs, *supra* note 14. The legislative goals which were rejected by Justice Beaudouin as mere “vehicles used to affirm social values or stakes” included the affirmation of the inherent and equal value of every person’s life, combined with the prevention of negative perceptions of the quality of life of persons who are elderly, ill or disabled and the prevention of suicide.

<sup>44</sup> See *Lamb v Canada (Attorney General)*, 2017 BCSC 1802 at para 70 [*Lamb BCSC*]:  
I find that while medical assistance in dying is the general subject of both *Carter* and the present case, the constitutional issues in each case differ because the respective claims challenge two different pieces of legislation with arguably different objectives, purposes and effects. [...] These objectives, purposes and effects are consequential in determining the legislation’s constitutional validity in both the s. 7 Charter analysis and s. 1 Charter analysis. As a result, the constitutionality of the eligibility criteria in Canada’s newly permissive regime remains to be decided. [emphasis added]

This finding was endorsed by the B.C. Court of Appeal, which affirmed that “the assessment of the constitutionality of the new legislation should proceed ‘on relevant, current evidence that is specific to the objectives and effects of the legislation’”: *Lamb v Canada (Attorney General)*, 2018 BCCA 266 at para 100, citing Hinkson J. in *Lamb BCSC*, *supra* note 44, at para 107. The *Lamb* case was discontinued by the plaintiffs before proceeding to a hearing on its merits; thus, the B.C. courts never issued a decision on the constitutionality of Bill C-14. And although the Quebec Superior Court in *Truchon* did find Bill C-14 unconstitutional, its analysis was premised on its finding that the bill had essentially the same legislative purpose as the law impugned in *Carter*. Thus, nothing in *Truchon* challenges the principle in *Lamb* that the outcome *could* be different where a different law is found to further a *different* objective. See also Sikkema, *supra* note 41, at paras 1, 6, 70 [Sikkema]; see also discussion in *Truchon*, *supra* note 9 at



Similarly, it is far from a foregone conclusion that constitutional arguments against such an exclusion would be successful. As will be discussed further, comments from the courts intimate that, should Parliament after rigorous study of medical, social, ethical and human rights considerations decide to exclude MAID MI-SUMC through a “complex regulatory regime”, such a regime may be upheld.<sup>45</sup>

With the foregoing in mind, the cases that some have cited to support the assertion that the courts, including the Supreme Court of Canada, have identified a Charter right to MAID MI-SUMC are examined in detail in Part II below. Our main conclusion is this: no court has mandated Parliament to introduce a MAID MI-SUMC regime.<sup>46</sup>

Furthermore, while the federal government is nonetheless set to extend access to MAID for mental illness, the Province of Quebec has now expressly excluded it from eligibility through amendments (enacted via Bill 11)<sup>47</sup> to its own provincial “end-of-life care” statute, *Act respecting end-of-life care* (referred to below as the “Quebec EOL law”), which establishes the practice of “medical aid in dying” within the province.<sup>48</sup> The Quebec EOL law was

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paras 503-504.

<sup>45</sup> See e.g. *Carter 2015*, *supra* note 39 at para 125; See also Peter W Hogg & Ravi Amarnath, “Understanding Dialogue Theory” in Peter Oliver, Patrick Macklem & Nathalie Des Rosiers, eds, *The Oxford Handbook of the Canadian Constitution* (New York: Oxford University Press, 2017) 1053 at 1068-1069, describing how in the *Carter* case, “the Supreme Court recommended how the legislative scheme could be fixed, without compelling such a solution”, leaving the “ultimate modification of the legislation” to the legislature.

<sup>46</sup> Importantly also, it bears repeating that only one lower Quebec court has ruled that the reasonably foreseeable death safeguard, protecting the life of those not approaching their natural death, is unconstitutional, making it even questionable to defend, as the government has done, the main expansion under Bill C-7 as constitutionally required.

<sup>47</sup> See Bill 11, *An Act to amend the Act respecting end-of-life care and other legislative provisions*, 1st Sess, 43rd Leg, Quebec, 2023, cl 16(1), 20 (assented to 7 June 2023), CQLR 2023, c 15 [Bill 11]. The provision states that “a mental disorder other than a neurocognitive disorder cannot be an illness for which a person may make a request.”

<sup>48</sup> Quebec’s *Act respecting end-of-life care*, CQLR, c S-32.0001 was assented to June 10, 2014 and in effect since Dec 10, 2015 [Quebec EOL Law]. Medical aid in dying under the Quebec legislation is defined as: “care consisting in the administration by a competent professional of medications or substances to an end-of-life patient, at the patient’s request, in order to relieve their suffering by hastening death”. See Bill 11, *supra* note 47, cl 3(2). [emphasis added]. The term “MAID” will be used generally to refer to the practice of physician assisted death under both the federal *Criminal Code* and Quebec

adopted by Quebec in 2014 pursuant to its provincial jurisdiction over health care and approximately two years prior to Parliament decriminalizing MAID under the *Criminal Code*.<sup>49</sup> At the time, the Quebec EOL law was not challenged on the basis of it being, for example, *ultra vires* or conflicting with the federal prohibition. In fact, in *Carter*, the Supreme Court, though not providing any view on the validity of the Quebec EOL law, recognized that “aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation”.<sup>50</sup>

This, in turn, raises additional constitutional questions, including:

- which aspects of MAID practice fall within provincial health care jurisdiction; and
- to what extent can a provincial MAID scheme be constructed differently from that which the federal *Criminal Code* permits?

Given Quebec’s provincial EOL law (including Bill 11) and the opposition to federal MAID MI-SUMC expansion without provincial agreement recently voiced by Alberta’s premier,<sup>51</sup> along with questionable or minimal public support in favour of MAID MI-SUMC,<sup>52</sup> clarity around these questions is all the more critical. Part III thus attempts to frame some of the jurisdictional considerations, including where a line might be drawn as between the federal MAID framework and provincial zones of competence, drawing guidance from the Supreme Court of Canada’s recent decision in *Murray-Hall v. Quebec (Attorney General)*.<sup>53</sup>

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regimes, except where a distinction is required for purposes of legal clarity.

<sup>49</sup> See Bill C-14, *supra* note 22.

<sup>50</sup> *Carter 2015*, *supra* note 39 at para 53. Compare to *Carter v Canada (Attorney General)*, 2016 SCC 4 at para 4 [*Carter 2016*]; See also discussion in *Truchon*, *supra* note 9 at paras 691-733.

<sup>51</sup> See David Fraser, “Alberta Premier Danielle Smith opposes assisted-dying expansion as Ottawa seeks further delay”, *Canadian Press* (30 January 2023), online: <theglobeandmail.com> [perma.cc/GR2C-AT]8]; see also the reservations expressed by Senator Margaret Dawn Anderson of the Northwest Territories about whether MAID MI-SUMC can be provided in light “of the barriers residents face in accessing adequate, consistent and culturally-appropriate health care and mental health services”, reported in Cohen, *supra* note 27.

<sup>52</sup> See Angus Reid Institute, *supra* note 17.

<sup>53</sup> See *Murray-Hall v Quebec (Attorney General)*, 2023 SCC 10 [*Murray-Hall*].

The *Murray-Hall* decision indicates that when the federal criminal law permits an act, it does not create a positive right to that act and the provinces can potentially still, in certain contexts, regulate or even restrict it pursuant to their jurisdiction. Indeed, the Supreme Court of Canada affirmed, unanimously, that “the making of exceptions or exemptions under a criminal law scheme cannot serve to confer positive rights to engage in the activities covered by those exceptions or exemptions” and “provinces can legitimately undertake regulatory initiatives to provide a framework for decriminalized activities”.<sup>54</sup>

The use of Charter rights to argue for MAID decriminalization and access might legally justify the delivery of MAID through the healthcare system. But it does not automatically follow that MAID is a “medically necessary” or “medically required” healthcare service, *per se* – particularly when the acts which have been decriminalized stray from the current understandings of the medical ethics or standards of care. This, many maintain, is the situation for MAID-MI-SUMC, as it is in any situation where other medical or support options that preserve life or alleviate suffering are available, and is relevant in considering the question of provincial jurisdiction.<sup>55</sup>

We examine these questions in Parts II and III, below.

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<sup>54</sup> *Ibid* at para 97.

<sup>55</sup> See the discussion in Trudo Lemmens, Mary Shariff & Leonie Herx, “L’Aide Médicale à Mourir et le sacrifice de la norme de qualité de soins de la pratique médicale” in Nathalie Vézina, Pascal Fréchette & Louise Bernier, eds, *Mélanges Robert P Kouri – L’humain au cœur du droit* (Montreal: Éditions Yvons Blais, 2021) 621 [Lemmens, Shariff & Herx, “Sacrifice”]. For a shorter discussion, see Trudo Lemmens, Mary Shariff & Leonie Herx, “How Bill C-7 will sacrifice the medical profession’s Standard of Care”, *Policy Options* (11 February 2021), online: <policyoptions.irpp.org> [perma.cc/XA]3-2YQA].

## II. CANADIAN COURTS HAVE NOT RECOGNIZED A CONSTITUTIONAL RIGHT TO MAID FOR MENTAL ILLNESS

### A. *Carter v. Canada* (Supreme Court of Canada)

In *Carter v. Canada*<sup>56</sup> (*Carter* or *Carter 2015*), the Supreme Court was (exceptionally) presented with ‘fresh’ expert evidence and arguments.<sup>57</sup> This evidence and argument, based on the experience of permissive countries like Belgium,<sup>58</sup> examined how legalizing assisted suicide or euthanasia<sup>59</sup> for persons like the Claimant Gloria Taylor, who was suffering from ALS,<sup>60</sup> would inevitably lead to its expansion in other, more controversial contexts.<sup>61</sup> Concerns were specifically raised about “the potential for a slippery slope” leading to the legalization of assisted suicide or euthanasia for, among other conditions, mental illness.<sup>62</sup> The Supreme Court dismissed these concerns, specifically stating that “euthanasia for minors or

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<sup>56</sup> See *Carter 2015*, *supra* note 39.

<sup>57</sup> *Ibid* at para 110. Typically, appellate courts do not consider new evidence that was not before the lower courts whose decisions are being reviewed. In this case, the government was granted special permission to file “fresh evidence on developments in Belgium since the time of the trial”.

<sup>58</sup> *Ibid* at para 8. Assisted dying regimes reviewed by the court in *Carter* included models from The Netherlands, Belgium, Luxembourg, Switzerland, Oregon, Washington, Montana, and Colombia.

<sup>59</sup> Note that terms “physician-assisted dying” and “physician-assisted death” are used interchangeably throughout the *Carter* decision and were defined by the trial court to include both the acts of: “physician-assisted suicide” or PAS (whereby the patient intentionally kills themselves with assistance of a physician or someone acting under a physician’s direction); and “voluntary euthanasia” (whereby the patient’s life is intentionally terminated by a physician or someone acting under a physician’s direction). In its “declaration of invalidity” (discussed further below), the Supreme Court uses the term “termination of life”. See *Carter BCSC*, *supra* note 42 at paras 23, 37-39. See also *Carter 2015*, *supra* note 39 at paras 127, 147. Following the passage of Bill C-14, *supra* note 22, these terms were statutorily superseded by the term “Medical Assistance in Dying” or “MAID”. Bill C-14 received royal assent June 17, 2016.

<sup>60</sup> See *Carter 2015*, *supra* note 39 at paras 11-12.

<sup>61</sup> See e.g. discussion in *ibid* at paras 110-112.

<sup>62</sup> *Ibid*. For the trial court’s findings on fundamental distinctions between the reasoning of a terminally ill person (whose judgment is not impaired by mental illness) to end their life and that of decision-making about suicide by persons who are mentally ill, see *Carter BCSC*, *supra* note 42 at paras 812-814.

persons with psychiatric disorders” would “not fall within the parameters suggested in these reasons” (“paragraph 111”).<sup>63</sup>

The Supreme Court went on to strike down Canada’s ban of physician-assisted death housed within the *Criminal Code*,<sup>64</sup> but only to the extent that it prohibited physician-assisted death for:

a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.<sup>65</sup>  
[the “Declaration” or “Declaration of Invalidity”]

Although the Declaration itself did not explicitly include or exclude mental illness, it must be read in conjunction with the Court’s previous comments that euthanasia for persons with psychiatric disorders did not fall within the decision’s parameters.<sup>66</sup> And as many continue to also point out, the Declaration was also accompanied by these comments immediately following it:

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**.<sup>67</sup>

Indeed, it is a basic premise of Charter jurisprudence that cases cannot be decided in a factual vacuum and the “presentation of facts ... is essential”

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<sup>63</sup> *Carter 2015*, supra note 39 at para 111. See also discussion in Department of Justice, *Charter Statement, An Act to Amend the Criminal Code (medical assistance in dying) (C-7)*, tabled in the House of Commons, October 21, 2020, online: <justice.gc.ca/eng/csjsjc/pl/charter-charte/c7.html.> [*Charter Statement*]. A different interpretation of paragraph 111 in the subsequent case, *Canada (Attorney General) v EF*, 2016 ABCA 155 [EF] is discussed further below. See also the discussion of *Carter* in Trudo Lemmens, Heeso Kim & Elizabeth Kurz, “Why Canada’s Medical Assistance in Dying Legislation Should be C(h)arter Complaint and What it May Help to Avoid” *McGill JLH* (2018) 11(1) 61-148 at 100-119 [Lemmens, Kim & Kurz, “C(h)arter Complaint”]

<sup>64</sup> Specifically, ss 241(b) and 14. For full discussion of the Charter arguments see *Carter 2015*, supra note 39 at paras 54-92.

<sup>65</sup> *Carter 2015*, supra note 39 at para 127.

<sup>66</sup> Note that this particular point was emphasized by the Attorney General of Canada in support of its position that mental disorders fell outside the Declaration’s scope, but its argument was rejected by the Alberta Court of Appeal in *EF*, supra note 63. Respectfully, however, the ABCA’s reasons for doing so are contestable in our view, and in any event, have never been addressed by the Supreme Court. See further discussion below.

<sup>67</sup> *Carter 2015*, supra note 39 at para 127 [emphasis added].

to the Court's consideration of the constitutional issues.<sup>68</sup> Accordingly, the Supreme Court's clear boundary around the scope of the Declaration requires careful examination: exactly what were the "factual circumstances" of the *Carter* case?<sup>69</sup>

*Carter* involved the Claimant, Gloria Taylor who was terminally ill,<sup>70</sup> diagnosed with ALS (a fatal neurodegenerative disease<sup>71</sup>) and pro-actively seeking a physician-assisted death at a time of her own choosing.<sup>72</sup> The Court and the Claimant described how the unavailability of physician-assisted dying in light of the Claimant's deteriorating physical condition, along with her desire to obtain a physician-assisted death, presented her with "the 'cruel choice' between killing herself while she was still physically capable of doing so, or giving up the ability to exercise any control over the manner and timing of her death".<sup>73</sup> As succinctly put by the Court, whether it be in the context of "progression of degenerative illness" or a "gruesome death from advanced-stage cancer",

running through the evidence of all the witnesses is a constant theme – that they suffer from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing.<sup>74</sup>

The Court further emphasized that its conclusions were based on the circumstances of the plaintiff "and of persons in her position".<sup>75</sup> Even if "persons in her position" could be interpreted to include persons not yet in the terminal phase of the irremediable medical condition, it is clear that the factual circumstances in *Carter* pertain to medical conditions involving a progressive physical decline towards death, making that death potentially protracted and painful, and potentially rendering one incapable of ending their own life.<sup>76</sup>

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<sup>68</sup> *MacKay v Manitoba*, [1989] 2 SCR 357 at 361, 1989 CanLII 26 (SCC) [*MacKay*].

<sup>69</sup> Note that a different interpretation of these qualifying words is discussed below at Part II.c.

<sup>70</sup> See e.g. *Carter 2015*, *supra* note 39 at para 12. See also *Carter BCSC*, *supra* note 42 at para 14 and para 1414(b).

<sup>71</sup> See *Carter 2015*, *supra* note 39 at para 11.

<sup>72</sup> *Ibid* at paras 12-13.

<sup>73</sup> *Ibid* at paras 1, 13.

<sup>74</sup> *Ibid* at para 14 [emphasis added].

<sup>75</sup> *Ibid* at para 56 [emphasis added]; See also para 66: "people like Ms. Taylor".

<sup>76</sup> *Ibid* at paras 14-18, 57. We note that within the Charter analysis the SCC attached the

The *Carter* decision said nothing about physician-assisted dying for persons whose sole underlying condition was a mental illness, other than its express assurance in paragraph 111 that psychiatric disorders fell outside the decision's scope in response to "slippery slope" concerns and data from other jurisdictions.<sup>77</sup>

***1. Mental illness not a basis, nor automatic disqualifier, for MAID eligibility: Carter***

It should also be noted that while mental illness was not part of the applicants' claim, nor was it analysed in terms of providing a basis upon which to permit assisted death in Canada, mental illness was discussed in another context – namely, impact on capacity and capacity assessment.

In finding that the infringement of the Claimant's freedom to "seek" physician-assisted death pursuant to Section 7 of the Charter (life, liberty and security)<sup>78</sup> was not minimally impairing (and therefore could not be justified under Section 1),<sup>79</sup> the Court examined the concept of capacity and the argument that factors such as "cognitive impairment, depression or other mental illness" "could escape detection or give rise to errors in capacity assessment".<sup>80</sup> The Court, however, dismissed this argument, agreeing with the trial judge that it is "possible for physicians, with due care and attention to the seriousness of the decision involved, to adequately assess decisional capacity"<sup>81</sup> using the same "procedures" that they apply "in the context of medical decision-making more generally".<sup>82</sup>

The Court's conclusion that physicians are able to assess decisional capacity – even if other factors like depression or mental illness are present – thus pertains specifically to the feasibility and efficacy of safeguards<sup>83</sup> and

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inability to end one's life due to physical decline to the Section 7 right to life and attached the right to choose and exercise control over bodily integrity free from state interference to Section 7 rights to liberty and security of the person.

<sup>77</sup> *Ibid* at para 111. For discussion of interpretation in the Alberta case, *EF*, *supra* note 63, see below.

<sup>78</sup> See *Carter 2015*, *supra* note 39 at para 54ff.

<sup>79</sup> *Ibid* at para 121.

<sup>80</sup> *Ibid* at para 114.

<sup>81</sup> *Ibid* at para 116 [emphasis added].

<sup>82</sup> *Ibid* at para 115.

<sup>83</sup> *Ibid* at paras 114-117.

not the medical condition(s) that would qualify for access to assisted death. In other words, the Court maintained that the presence of a mental illness would not automatically *disqualify* an otherwise eligible application for assisted death – but it did not say that a mental illness as a sole condition would itself render someone *eligible for* assisted death. Rather, the qualifying medical condition(s) were constructed on the basis of Ms. Taylor’s specific claim, and turned on the case’s “factual circumstances”.<sup>84</sup>

To better understand those “factual circumstances” in *Carter*, it is helpful to study some additional aspects of the trial judge’s discussion of the evidence and facts, since the Supreme Court relied on and adopted much of her reasoning and conclusions.<sup>85</sup>

## 2. *The trial decision in Carter v Canada (B.C. Supreme Court)*

In delineating eligibility criteria for MAID, the trial judge in *Carter* (Justice Lynn Smith) rejected the Plaintiffs’ argument that “the term ‘grievously and irremediably ill persons’ should incorporate reference to ‘psychosocial suffering’.”<sup>86</sup> While Justice Smith did not define “psychosocial” factors, she did refer to expert evidence “that suicide related to mental illness [...] and other psychosocial factors is **different from end-of-life decision making** by grievously and irremediably ill individuals”.<sup>87</sup> Justice Smith further observed:

I accept [...] that it is problematic to conflate decision-making by grievously and irremediably ill persons about the timing of their deaths, with **decision-making about suicide** by persons who are **mentally ill**.<sup>88</sup>

When Justice Smith addressed concerns that the legalization of MAID would send the message that suicide is an answer to suffering, she repeated the Plaintiffs’ rejoinder that there is “a **difference between assisted death in response to intolerable suffering at the end of life**, and suicide arising out of mental illness”.<sup>89</sup> The *Carter* case was concerned with the former, as the Plaintiff also explicitly recognized, and not the latter.

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<sup>84</sup> For the importance of factual circumstances to Charter analyses, see *MacKay*, *supra* note 68; See also *Carter BCSC*, *supra* note 42 at para 1386.

<sup>85</sup> See e.g. *Carter 2015*, *supra* note 39 at paras 3, 66, 98, 117, 119.

<sup>86</sup> *Carter BCSC*, *supra* note 42 at para 1390.

<sup>87</sup> *Ibid* at para 813 [emphasis added].

<sup>88</sup> *Ibid* at para 814. [emphasis added].

<sup>89</sup> *Ibid* at para 1262 [emphasis added].



This is made clear in Justice Smith’s decision to limit the definition of “grievous and irremediable” “to those who are also in an advanced state of weakening capacities, with no chance of improvement”.<sup>90</sup> This limitation helps to underscore that access to physician-assisted death for psychiatric conditions was simply not part of the claim or judicial calculus in *Carter*. Again, the only thing the court was discerning in terms of mental illness was not the medical condition or grounds for *granting access* to physician-assisted suicide in Canada, but rather the extent to which mental illness could potentially impact *decisional capacity*; and the court appropriately concluded that it did not automatically or necessarily do so in every case.

### *3. Carter considered MAID only for “irremediable”/“incurable” cases*

While the Supreme Court of Canada (SCC) did not ultimately include the trial court’s specific limitation “in a state of advanced weakening capacities with no chance of improvement” in its Declaration of Invalidity, an exchange between Plaintiffs’ lead counsel and the SCC regarding the meaning of “irremediable” further accentuates the point that eligibility on the basis of psychiatric illness was not before the courts in *Carter*.

**MADAM JUSTICE ABELLA:** One of the qualities that you said we should look at in permitting assisted dying is irremediable medical conditions.

**MR. ARVAY, Q.C.:** Yes.

**MADAM JUSTICE ABELLA:** How is that consistent with your argument that an individual has the right to decide the quality of his or her life based on a dignity interest?

**MR. ARVAY, Q.C.:** Because our argument is founded on what Professor Battin sort of described as both principles of autonomy and the value of mercy. Because we are seeking to constitutionalize or to strike down the law that criminalizes assistance in suicide, we don’t rely on autonomy alone, we rely on autonomy and suffering.

**MADAM JUSTICE ABELLA:** But that can exist whether or not the medical condition is irremediable. I’m just asking why you think that has to be a condition that you impose in the decision to strike down when somebody wants the assistance of a doctor. Why can it not be a medical condition period? What is

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<sup>90</sup> *Ibid* at para 1391 [emphasis added]; see also para 1393; Note also how this limitation aligns with the statutory eligibility criterion “advanced state of irreversible decline in capability”. See Criminal Code, *supra* note 8 at s 241.2 (2)(b).

there about the ability of somebody to choose that should be restricted by the longevity or the fatality, the expected fatality of the illness?

MR. ARVAY, Q.C.: Well, first of all, we do not limit our claim to the terminally ill. People like Tony Nicklinson who had locked-in syndrome, which means he was going to live for 20 years.

MADAM JUSTICE ABELLA: So what do you mean by –

MR. ARVAY, Q.C.: So we had people like that in mind as to say that we are not limiting our case to the terminally ill, but we are limiting our case to people whose condition is irremediable or incurable, if you want to use that language, because assisted dying should only be allowed in the most serious cases and not just because somebody wants to, it's because their condition is not going to get any better.

MADAM JUSTICE ABELLA: Thank you.

MR. ARVAY, Q.C.: Okay.

MADAM JUSTICE ABELLA: That's what I wanted your clarification on.

MR. ARVAY, Q.C.: Yes. Thank you.<sup>91</sup>

Notwithstanding that “irremediable”, according to the SCC, “does not require a patient to undertake treatments that are not acceptable to the individual”,<sup>92</sup> the above exchange points to an objective evaluation of what an irremediable medical condition is for the purposes of physician-assisted death eligibility, namely that the condition is “incurable” and is “not going to get any better”, rather than eligibility hinging solely on whether or not individuals will accept evidence-based, recommended medical treatment(s).

As for Gloria Taylor, the Claimant in the *Carter* case, the trial court accepted, based on the attestation of her physician, that there was “no hope of her recovering”.<sup>93</sup> The same cannot be determinatively concluded in cases of mental illness.<sup>94</sup>

It is also noteworthy and bears repeating that the Supreme Court explicitly situated its Section 7 Charter analysis within a particular context:

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<sup>91</sup> Joseph J Arvay, QC, “Written Submissions to the Standing Senate Committee on Legal and Constitutional Affairs In view of its study on *Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*” (5 May 2016), at 5-6, online (pdf): <senCanada.ca> [\[perma.cc/Y9ZE-2QAJ\]](https://perma.cc/Y9ZE-2QAJ) [emphasis added] [Arvay].

<sup>92</sup> *Carter* 2015, *supra* note 39 at para 127.

<sup>93</sup> *Carter* BCSC, *supra* note 42 at para 1414(b).

<sup>94</sup> See Gaid, “Irremediability in Mental Illness”, *supra* note 18.

“during the passage to death” (as opposed to *any* stage of life), where, “in certain circumstances” (as opposed to *all* circumstances) “an individual’s choice about the *end of her life* is entitled to respect”.<sup>95</sup>

Ultimately, the trial court in *Carter* was satisfied that the risks associated with physician-assisted suicide and euthanasia could be limited by making physician-assisted death a “stringently-limited” exception, subject to “an almost-absolute prohibition”.<sup>96</sup> In support of this conclusion, the trial judge specifically pointed to “the low numbers of persons in Oregon who have availed themselves of physician-assisted suicide”.<sup>97</sup>

Oregon’s “death with dignity” (DWD) regime, both then and now, does not allow assisted death for mental illness or for that matter, any medical condition other than a “terminal disease” i.e. an incurable and irreversible disease that, as medically judged, “will produce death within six months”. (Note that Oregon also does not allow practitioner administered assisted death.)<sup>98</sup> The *Carter* trial judgment noted that in 2010, there were 65 assisted deaths in Oregon, amounting to 0.209% of deaths in that jurisdiction.<sup>99</sup> In 2022, Oregon’s DWD numbers rose to 278, amounting to an estimated 0.6% of total deaths in that state.<sup>100</sup> And since the Oregon DWD law was passed in 1997, the total number of DWD deaths in Oregon is 2,454.<sup>101</sup> In contrast, 13,241 people died by MAID in Canada in 2022 alone, amounting to 4.1% of total deaths that year.<sup>102</sup> This rate is 583% higher than the 2022 Oregon rates and 1860% higher than the 2010 per capita rates in Oregon that appeared to reassure the trial court in *Carter*.<sup>103</sup>

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<sup>95</sup> *Carter* 2015, *supra* note 39 at para 63.

<sup>96</sup> *Carter BCSC*, *supra* note 42 at paras 1283; See also *ibid* at paras 16, 1243, 1267.

<sup>97</sup> *Ibid* at para 1284.

<sup>98</sup> See *Death with Dignity Act*, ORS 127.800 § 101.12, 127.805 § 2.01.

<sup>99</sup> *Carter BCSC*, *supra* note 42 at paras 398-400.

<sup>100</sup> Oregon Health Authority, Public Health Division, *Oregon Death with Dignity Act 2022 Data Summary* (Portland: 8 March 2023), at page 6, online (pdf): <<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf>>.

<sup>101</sup> *Ibid*.

<sup>102</sup> *Fourth Annual Report*, *supra* note 1 at page 5. See also *ibid* at page 21.

<sup>103</sup> See *Carter BCSC*, *supra* note 42 at paras 398-400, 626. The large discrepancy in the utilization of MAID in Canada when compared with other jurisdictions such as Oregon can be explained in part by euthanasia (in which a physician administers lethal drugs to the patient) being permitted in Canada, whereas only assisted suicide (in which the

This single year total also amounts to 10,787 more deaths, nearly 440% higher, than the total DWD deaths in (2,454) over the span of 25 years.<sup>104</sup>

In the end, pursuant to the Section 7 infringement, Justice Smith issued a declaration allowing “physician-assisted suicide or consensual physician-assisted death”, but only for (among other criteria) “a fully-informed, non-ambivalent competent adult person who [...] is not clinically depressed”.<sup>105</sup> The court also required that Ms. Taylor’s physician attest that she was

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patient self-administers the lethal drugs) is permitted in Oregon. See Gian Domenico Borasio, Ralf J Jox & Claudia Gamondi, “Regulation of Assisted Suicide Limits the Number of Assisted Deaths” (2019) 393:10175 *Lancet* 982 at 982-983. In Canada, almost all MAID deaths are by euthanasia (administered by a health care practitioner), not self-administration; in 2022, of the 13,241 MAID deaths, “fewer than seven” were self-administered, “a trend consistent with previous years” (see *Fourth Annual Report*, *ibid* at 21). This distinction perhaps reflects another way in which Justice Smith may have had a much narrower regime in mind as a potential option, than the one Parliament ultimately implemented with Bill C-14. See also Daryl Pullman, “Slowing the Slide Down the Slippery Slope of Medical Assistance in Dying: Mutual Learnings for Canada and the US” (2023) *Am J Bioethics* online (pdf): <andfonline.com> [perma.cc/83C3-2Y98], where the author compares the numbers of Canada with the assisted suicide numbers in California and discusses the potential reasons.

<sup>104</sup> It might also be noted that Canada’s 10,064 MAID deaths in 2021 surpass Belgium’s euthanasia deaths for 2020-2021 combined (5,145: 2445 or approximately 1.93% of total recorded deaths in 2020 (126,850) and 2700 or approximately 2.4% of total recorded deaths (112,291) in 2021). See **Federal Commission for the Control and Evaluation of Euthanasia, *Euthanasia Report 2022 - 10th report to the Legislative Chambers- Figures for the years 2020-2021*, online (pdf): <organesdeconcertation.sante.belgique.be > [perma.cc/8F54-VWEM]; “112,291 inhabitants died in Belgium in 2021”, *Statbel* [Belgian Statistics Office] (16 June 2022), online: <statbel.fgov.be> [perma.cc/A6JC-DFNP]. Canada’s MAID numbers appear to be closer to the Netherlands’ where its euthanasia law came into force in 2002. In 2021, there were 7,666 euthanasia deaths representing approximately 4.5% of all deaths (170,839) in the Netherlands. See Netherlands, Regional Euthanasia Review Committees, *Annual Report 2021* (April 2022) at 4, online: <english.euthanasiacommissie.nl> [perma.cc/MCV4-TB8W]. The rapid expansion of MAID in Canada, with numbers equaling or bypassing in a short period of time the most liberal euthanasia regimes, is likely also related to the lack of explicit requirement in Canadian law that physicians need to agree that there are no other medical options left to address the patient’s suffering, which is a requirement under Belgian and Dutch law. See the discussion of this specific aspect in Lemmens, Shariff & Herx, “Sacrifice”, *supra* note 55; Coelho et al, “The Realities of Medical Assistance in Dying in Canada” (2023) *Palliative Supportive Care*, online: <pubmed.ncbi.nlm.nih.gov> [perma.cc/ZK6L-MC7U] [Coelho et al, “Realities”]**

<sup>105</sup> *Carter BCSC*, *supra* note 42 at para 1393(b).

“terminally ill and near death, and there is no hope of her recovering”.<sup>106</sup> It is difficult to see how these conditions (terminally ill, near death, no hope of recovery) could be met where the sole underlying condition is a mental disorder.

In sum, the trial court did not declare – or even suggest – that MAID should be offered as a medical treatment for mental illness. Quite the opposite, the court was explicitly concerned that a mental illness (specifically, clinical depression) should *not* be a factor driving the request for MAID. Based on the *Carter* cases, then, it is difficult to interpret the Supreme Court’s decision as in any way *mandating* Parliament to legally introduce the practice of termination of life for mental illness.

Two additional lower court cases, however, are relevant to this discussion as both have been referenced by MAID-MI-SUMC proponents as confirming or establishing the right to MAID for mental illness. These decisions are discussed below.

At the outset, however, it is important to note that neither of these decisions have been reviewed by the Supreme Court of Canada. The first case, *E.F.*, is a decision of the Alberta Court of Appeal, which explicitly stated that its opinion did *not* represent a constitutional analysis of any kind.<sup>107</sup> The second case, *Truchon*, is a decision of a single judge of the Quebec Superior Court, which was not appealed.<sup>108</sup> Neither decision is binding on the Supreme Court of Canada, and neither is binding outside of their respective provinces.<sup>109</sup>

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<sup>106</sup> *Ibid* at para 1414(b). Note also that in terms of the specific assisted death act or mechanism, the trial judge also imposed the following condition: “Unless Ms. Taylor has become physically incapable, the mechanism for the physician-assisted death shall be one that involves her own unassisted act and not that of any other person” (para 1414(f)).

<sup>107</sup> See *EF*, *supra* note 63.

<sup>108</sup> See *Truchon*, *supra* note 9.

<sup>109</sup> One other potentially relevant decision is *AB v Canada (Attorney General)*, 2017 ONSC 3759, which maintained, as did the Attorney General, that Bill C-14’s “reasonably foreseeable” death criterion did not “require that people be dying from a terminal illness, disease or disability” (para 82). However, that decision does not state that Parliament is constitutionally prohibited from introducing such a restriction, nor that Parliament must legalize MAID MI-SUMC – it simply concluded that, for the claimant in that case, their “natural death was reasonably foreseeable” and met the applicable legislative requirements.

## B. Canada (Attorney General) v. E.F. (Alberta Court of Appeal)

Pursuant to *Carter*, the Supreme Court's Declaration of Invalidity was suspended for 12 months (until February 6, 2016) to allow time for Parliament to respond,<sup>110</sup> meaning the absolute prohibition against physician-assisted death remained in place while awaiting new federal legislation.<sup>111</sup> Failing to pass legislation within that timeframe, Parliament received a 4-month extension from the Supreme Court (until June 6, 2016),<sup>112</sup> and eventually passed Bill C-14 on June 17, 2016. That bill amended the *Criminal Code* to allow the practice of "medical assistance in dying" or MAID.<sup>113</sup>

During the four-month extension period, however, individuals who wished to seek "termination of life" were granted an exemption which allowed them to "apply to the superior court of their jurisdiction for relief in accordance with the criteria set out in para. 127" of *Carter*.<sup>114</sup> Accordingly, the task of the judges hearing these applications was to determine whether applicants came "within the class of people" who had been granted a constitutional exemption during that four-month period.<sup>115</sup>

Approximately fifteen (15) applications for judicial authorization were brought before the provincial courts, only one of which involved a psychiatric illness as the underlying medical condition, namely, *E.F.*<sup>116</sup>

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<sup>110</sup> See *Carter 2015*, *supra* note 39 at para 128.

<sup>111</sup> Note that the trial judge had initially granted Gloria Taylor a constitutional exemption permitting her to obtain physician-assisted death under certain conditions, but she passed away before the Supreme Court's decision and thus the Court declined to "create a mechanism for exemptions during the period of suspended validity". See *Carter BCSC*, *supra* note 42 at para 1414; *Carter 2015*, *supra* note 39 at para 129.

<sup>112</sup> See *Carter 2016*, *supra* note 50; See also *EF*, *supra* note 63 at para 3.

<sup>113</sup> See Bill C-14, *supra* note 22.

<sup>114</sup> *Carter 2016*, *supra* note 50 at para 7 [emphasis added]. See also para 1; note that the SCC also granted Quebec an exemption from the extension, allowing the provincial MAID legislation to operate notwithstanding the ongoing *Criminal Code* prohibition, and making no pronouncement on the validity of the Quebec legislation. See para 4.

<sup>115</sup> *EF*, *supra* note 63 at para 5.

<sup>116</sup> These cases include: *HS(Re)*, 2016 ABQB 121; *AB v Canada (Attorney General)*, 2016 ONSC 1912; *Patient v Attorney General of Canada*, 2016 MBQB 63; *AB v Ontario (Attorney General)*, 2016 ONSC 2188; *AA (Re)*, 2016 BCSC 570; *WV v Canada (Attorney*

*E.F.* involved a patient suffering from “severe conversion disorder”, a psychogenic disorder causing physical symptoms. For *E.F.*, the disorder caused involuntary muscle spasms which, amongst other things, affected *E.F.*’s vision (her eyelid muscles spasmed shut) and digestive system, rendered her non-ambulatory and caused severe and constant pain.<sup>117</sup> Because the medical condition had “at its root a psychiatric condition”, the motions court’s decision authorizing *E.F.*’s application was challenged and the Alberta Court of Appeal (ABCA) was called on to determine *inter alia* whether “persons suffering psychiatric conditions and who otherwise comply with the criteria in *Carter 2015* [are] excluded from the ambit of the constitutional exemption”.<sup>118</sup>

Again, *E.F.* was not considering an individual constitutional challenge, nor the constitutionality of a legislative regime that explicitly excluded assisted death in cases where mental illness is the sole underlying medical disorder.<sup>119</sup> As put by the court in *E.F.*:

... the constitutional dimensions and debate inherent in the granting of a personal constitutional exemption do not form part of the inquiry in an application under *Carter 2016*. The authorization hearings are not intended as requests for exemptions. These are not individual constitutional challenges. The question the Supreme Court has directed the superior courts to answer in these applications is whether the applicant falls within the identified group. This limited inquiry is individual and fact-specific.<sup>120</sup>

Accordingly, the comments in *E.F.* regarding assisted death for psychiatric illness reflect an interpretation of the Supreme Court’s words in *Carter*. Furthermore, the court in *E.F.* was only tasked with determining the

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*General*), 2016 ONSC 2302; *CD v Canada (Attorney General)*, 2016 ONSC 2431; *EF v Canada (Attorney General)*, 2016 ONSC 2790; *EF*, *supra* note 63; *Patient 0518 v RHA 0518*, *Physician A0518 and Physician C0518*, 2016 SKGB 176; *MN v Canada (Attorney General)*, 2016 ONSC 3346; *IJ v Canada (Attorney General)*, 2016 ONSC 3380; *HH (Re)*, 2016 BCSC 971; *Tuckwell (Re)*, 2016 ABQB 302; *OP v Canada (Attorney General)*, 2016 ONSC 3956; See also discussion in Health Canada, *Expert Panel 2022 Report*, *supra* note 5 at 23.

<sup>117</sup> *EF*, *supra* note 63 at para 7.

<sup>118</sup> *Ibid* at para 11. A second and related issue in *EF* concerned whether the constitutional exemption only applied to terminal illness, which the ABCA concluded it did not. See paras 11, 27-42. This is discussed further below.

<sup>119</sup> See discussion in *ibid* at para 5.

<sup>120</sup> *Ibid* at para 24 [emphasis added].

scope of the Supreme Court's Declaration in *Carter* because Parliament had not yet passed a new law in response.<sup>121</sup> As the Quebec Superior Court later affirmed in the *Truchon* case (discussed further below), what *Carter* said and what the Charter ultimately requires in terms of curative legislation after a constitutional challenge are not necessarily equivalent.<sup>122</sup>

Keeping the foregoing in mind, the ABCA concluded *inter alia* that the Declaration in *Carter* did not exclude or preclude psychiatric conditions from MAID eligibility.

With respect to the Supreme Court's comment in *Carter* at paragraph 111 that high-profile cases of assisted dying in Belgium (i.e. psychiatric cases) "would not fall within the parameters suggested in [its] reasons", the ABCA asserted that it was made in the limited context of clarifying that "slippery slope" concerns arising out of Belgium were "addressed by the safeguards put in place in the court's description of the declaration of invalidity".<sup>123</sup>

However, this assertion overlooks the fact that MAID MI-SUMC (along with MAID for minor medical conditions or MAID for minor children), as earlier alluded to, was *itself* one of those substantive "slippery slope" concerns. In the expert evidence affidavit from Professor Etienne Montero (an expert on euthanasia practice in Belgium) – the evidence underlying the Supreme Court's paragraph 111 statement – Professor Montero described the difficulty in maintaining boundaries around the statutory conditions in Belgium and cited *inter alia*, examples of conditions that were "officially eligible" under the Belgian law due to "loose interpretation of the statutory conditions"<sup>124</sup> – namely:

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<sup>121</sup> *Ibid.*

<sup>122</sup> See e.g. *Truchon*, *supra* note 9 at paras 502-503 [emphasis added]:

[E]ven if they are inconsistent with the *Carter* parameters, are [legislative requirements] *de facto* unconstitutional, as the applicants submit? The Court does not think so. The mere fact that the federal statute includes additional requirements or conditions not found in *Carter* does not render it unconstitutional, as such. The applicants' burden of proving that their section 7 and 15 Charter rights have been infringed is not lesser simply because the impugned provisions are not in perfect harmony with *Carter*.

<sup>123</sup> *EF*, *supra* note 63 at para 49.

<sup>124</sup> *Carter v Canada (Attorney General)*, 2015 SCC 5 (Affidavit, Professor Etienne Montero, MAID in Belgium, sworn April 23, 2014 – English Translation) at para 30. [Montero Affidavit].



- euthanasia for psychological pain (e.g. an inmate with long-term incarceration, and a transgender individual with a “botched sex change surgery”);
- euthanasia in anticipation of future pain which is also a form of psychological pain (e.g. cancer diagnosis, Alzheimer’s, diagnosis of glaucoma and future blindness);
- euthanasia for psychiatric patients (e.g. Anorexia nervosa); and
- euthanasia for multiple but non-serious disorders (e.g. conditions that might arise in relation to older age).<sup>125</sup>

Professor Montero also described the more recent legislative developments in Belgium, such as euthanasia for children, as well as emerging developments such as euthanasia for persons with dementia and disabled newborns.<sup>126</sup> When describing euthanasia for psychiatric patients, Professor Montero also noted the confusion that exists between psychological pain and psychiatric illness.<sup>127</sup>

Again, the expert evidence at issue identified specific concerns about euthanasia for particular types of conditions or circumstances (e.g. psychiatric illness; non-terminal conditions, psychological pain) or particular classes of persons (e.g. minors). Equally important at this point in the Supreme Court’s analysis was the question of whether the absolute prohibition against MAID could be justified and thus retained (pursuant to Section 1) notwithstanding the limitation of the Claimant’s Section 7 rights.

With this added information, let’s look at SCC’s paragraph 111 in full, and in context:

[110] ... Canada says that Professor Montero’s evidence demonstrates that issues with compliance and with the expansion of the criteria granting access to assisted suicide inevitably arise, even in a system of ostensibly strict limits and safeguards. It argues that this “should give pause to those who feel very strict safeguards will provide adequate protection: paper safeguards are only as strong as the human hands that carry them out” (R.F., at para. 97).

[111] Professor Montero’s affidavit reviews a number of recent, controversial, and high-profile cases of assistance in dying in Belgium 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. Professor Montero suggests that these cases demonstrate that a slippery slope is at work in

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<sup>125</sup> *Ibid* at paras 30-43.

<sup>126</sup> *Ibid* at paras 79-88.

<sup>127</sup> *Ibid* at paras 32-34, 40ff.

Belgium. In his view, “[o]nce euthanasia is allowed, it becomes very difficult to maintain a strict interpretation of the statutory conditions.”

[112] We are not convinced that Professor Montero’s evidence undermines the trial judge’s findings of fact. First, the trial judge (rightly, in our view) noted that the permissive regime in Belgium is the product of a very different medico-legal culture. Practices of assisted death were “already prevalent and embedded in the medical culture” prior to legalization (para. 660). The regime simply regulates a common pre-existing practice. In the absence of a comparable history in Canada, the trial judge concluded that it was problematic to draw inferences about the level of physician compliance with legislated safeguards based on the Belgian evidence (para. 680). This distinction is relevant both in assessing the degree of physician compliance and in considering evidence with regards to the potential for a slippery slope.

[113] Second, 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.<sup>128</sup>

A plain reading of these paragraphs seems to point to the SCC generally rejecting Professor Montero’s evidence of slide or eligibility expansion into, for example, MAID for children, psychiatric disorders, or minor medical conditions, based on two main reasons/observations: (1) that these types of cases are simply not relevant to the scope of the decision at hand; and (2) that evidence of slide within the Belgian regime (due to a “different medico-legal culture”, interpretive discretion, non-compliance and so forth) provides little to no insight with respect to assessing Canadian physician compliance with eventual Canadian safeguards and criteria and how a Canadian regime might ultimately operate.

Implicit in both of these reasons/observations is an acknowledgment that the Charter question at hand does not concern assisted death for children, psychiatric disorders, or minor conditions. Even more explicitly, the Court makes clear, both here and in confining its scope to the “factual circumstances in the case”, that its Declaration clearly does not encompass such cases or circumstances.<sup>129</sup> The Supreme Court also suggests that, contrary to the Belgian legislature, Canada’s Parliament could enact stronger safeguards and restrictions, reducing the ‘discretion’ compared to

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<sup>128</sup> *Carter 2015*, *supra* note 39 at paras 110-113.

<sup>129</sup> *Carter 2015*, *supra* note 39 at para 127. See also note 66, *supra*, et seq and associated text.

that allowed under Belgian law.<sup>130</sup> It is therefore remarkable that the opposite appears to have occurred.<sup>131</sup>

But in *E.F.*, the ABCA (agreeing with the motion's judge interpretation) maintains that paragraph 111 "does not serve to exclude all psychiatric conditions from the court's declaration of invalidity".<sup>132</sup> According to the ABCA, the SCC rejected Professor Montero's concerns not on the basis of the irrelevance of the Belgian scheme and experience to Canada's eventual scheme, but on the basis that the SCC has identified specific "safeguards" - safeguards that the Supreme Court later articulates in the Declaration paragraph, namely:

- that a medical condition be "grievous and irremediable" and causing enduring and intolerable suffering (a requirement that excludes minor medical conditions and potentially also indicates "incurable");<sup>133</sup>
- that a person be an "adult" (a requirement to exclude *and* safeguard minors because of their "vulnerability"); and
- that a person be "competent" and "clearly consents" (requirements to safeguard the vulnerability of persons who have psychiatric disorders).

So instead of excluding MAID for psychiatric illness, the ABCA's interpretation of *Carter's* paragraph 111 is that concerning or problematic issues related to psychiatric disorders (such as "vulnerability" or lack of consent) are addressed by safeguards contained in paragraph 127.<sup>134</sup> In other words, the ABCA effectively reads language into paragraph 111 to say something like this:

controversial ... cases of assistance in dying... such as [assistance in dying] for ... persons with psychiatric disorders...would not fall within the parameters suggested

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<sup>130</sup> See *Carter 2015*, *supra* note 39 at para 113: "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."

<sup>131</sup> For a discussion regarding why the Canadian regime is providing broader access and contains weaker safeguards, see Lemmens, Shariff & Herx, "Sacrifice", *supra* note 55 at 621-644; Coelho et al, "Realities", *supra* note 104. See also *supra* note 104 and accompanying text data related to Canadian MAID numbers surpassing that of Belgium.

<sup>132</sup> *EF*, *supra* note 63 at para 49-50.

<sup>133</sup> See exchange between J. Arvay and Madame Justice Abella in *Carter: Arvay*, *supra* note 91 and accompanying text.

<sup>134</sup> *EF*, *supra* note 63 at para 49.

in these reasons *because* the “competent adult” and “clearly consents” safeguards exclude any *problematic* cases of mental illness; otherwise, euthanasia for persons with psychiatric disorders as the sole underlying medical condition fall within the parameters of the Declaration, so long as all the criteria are met.

This is one interpretation of the Supreme Court’s language, perhaps, but in our respectful view, it is a strained and implausible one – such an approach is hardly explicit in the reasons themselves, and the Supreme Court could have used much clearer language if that was its intent.

In *E.F.*, the ABCA was also presented with the federal government’s argument that psychiatric conditions were inferentially excluded from MAID by the Supreme Court’s statement that its Declaration was “intended to respond to the *factual circumstances* in this case”, and *Carter* did not involve a claimant with a psychiatric condition.<sup>135</sup> The ABCA also rejected this argument, stating that:

in *Carter 2015* the issue of whether psychiatric conditions should be excluded from the declaration of invalidity *was squarely before the court*; nevertheless the court *declined to make such an express exclusion* as part of its carefully crafted criteria.<sup>136</sup>

Again, this conclusion seems strained. One might ask: what is paragraph 111 of *Carter* if not an “express exclusion” of psychiatric conditions from the Court’s “carefully crafted criteria”? And regardless, why assume that psychiatric conditions are *included* unless they are “expressly excluded”? Why not conclude that they are *excluded* unless they are “expressly included”?<sup>137</sup>

Nevertheless, the ABCA concluded that persons “with a psychiatric illness are not explicitly or inferentially excluded if they fit the criteria.”<sup>138</sup> In doing so, the ABCA seemed to read *Carter*’s Declaration as restricting or colouring the scope of the clarifying statements surrounding it (including paragraph 111), rather than the other way around.

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<sup>135</sup> *Ibid* at para 29 [emphasis added]; see also *Carter 2015*, *supra* note 39 at para 127.

<sup>136</sup> *EF*, *supra* note 63 at para 57 [emphasis added].

<sup>137</sup> For further discussion see Dianne Pothier, “Doctor-Assisted Death Bill Falls Well Within Top Court’s Ruling”, *Policy Options* (29 April 2016), online: <policyoptions.irpp.org> [perma.cc/4PAC-XXXZ]. See also Dianne Pothier, “The Parameters of a Charter Compliant Response to *Carter v Canada* (Attorney General), 2015 SCC 5” (20 March 2016) [unpublished, archived at SSRN], online: <papers.ssrn.com> [perma.cc/7DXE-ECFZ]; See also discussion above regarding relevance of the facts to Charter analysis at *supra* note 68 and associated text.

<sup>138</sup> *EF*, *supra* note 63 at para 59.

In terms of psychiatric conditions being “squarely before the court” in *Carter*,<sup>139</sup> as discussed above, this is true only in respect of evidence and analysis regarding the potential impacts of mental illness or psychological suffering on *decision-making capacity to consent* to MAID, but not in respect of whether psychiatric disorders as the sole medical condition would qualify as a condition for MAID eligibility in Canada.

For these reasons, it appears that the court in *E.F.* was conflating (or collapsing the distinction between) criteria aimed at ruling out psychiatric disorders potentially affecting or likely to affect the decision-making process with the types of medical conditions that would qualify for MAID access.

Ultimately, however, the *E.F.* decision did not involve any interpretation of Charter rights, nor a declaration of the constitutionality of a specific legislative provision. It was simply an interpretation of the scope of *Carter’s* Declaration for the purpose of determining whether a specific applicant to the court met the criteria for a constitutional exemption for physician-assisted death during the interim period in which Parliament had not yet implemented a legislative response. The ABCA acknowledged this point, recognizing that there was no legislation before it that was the subject of constitutional review, stating: “Issues that might arise regarding the interpretation and constitutionality of eventual legislation should obviously wait until the legislation has been enacted.”<sup>140</sup>

*E.F.* therefore does not and cannot stand for the proposition that the Charter requires MAID for mental illness. As the Quebec Superior Court later affirmed in *Truchon*, even if legislative requirements are inconsistent with *Carter’s* parameters, they are not “*de facto* unconstitutional”.<sup>141</sup> The question is whether legislation complies with the Charter, which requires a case-specific, contextual analysis of the legislative regime in question.<sup>142</sup>

Moreover, *E.F.* does not speak to the legislature’s ability to introduce additional safeguards around MAID in connection with psychiatric conditions, such as (for example) the exclusion of cases in which a plaintiff is suicidal and/or clinically depressed. In fact, the ABCA emphasized

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<sup>139</sup> *Ibid* at para 54.

<sup>140</sup> *Ibid* at para 72. This point is also emphasized in Lemmens, Kim & Kurz, “C(h)arter Compliant”, *supra* note 63 at 105.

<sup>141</sup> *Truchon*, *supra* note 9 at para 502.

<sup>142</sup> *Ibid* at paras 502-508.

evidence before it that the plaintiff was not “depressed or suicidal”.<sup>143</sup> Like the trial decision in *Carter*, this points to the complexity of mental illnesses such as depression and how related symptoms may necessitate additional considerations.<sup>144</sup> Certainly, *E.F.* does not state or even suggest that MAID must be available where clinical depression is a patient’s sole underlying condition.

In short, while the *E.F.* case rejected the Government’s argument that *Carter* categorically excluded psychiatric conditions from its Declaration, it remains that *Carter* did not issue a specific legislative mandate to Parliament to decriminalize or offer MAID for mental illness, nor did it assert that the Charter prohibits a legislative response that might exclude it. The mere conclusion that the *Carter* Declaration did not specifically exclude mental illness does not mean that Parliament must include it.<sup>145</sup> And with respect to *E.F.*’s comments on *Carter*, they pertain to a limited factual and legal context and have not yet been addressed, let alone affirmed, by the Supreme Court of Canada.

### ***1. A word on “grievous and irremediable” criteria***

Though not related to the immediate question of whether the Canadian courts have established a Charter right to MAID MISUMC, and notwithstanding that *E.F.* was not considering legislated safeguards around MAID for psychiatric conditions,<sup>146</sup> it is noteworthy that the ABCA implicitly imposed its own procedural safeguard in respect of the applicant’s psychiatric illness being considered “irremediable”- one of the eligibility

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<sup>143</sup> *EF*, *supra* note 63 at para 7.

<sup>144</sup> See e.g. discussion in Gaind, “Irremediability in Mental Illness”, *supra* note 18; Centre for Addiction and Mental Health, *supra* note 13; AMPQ, *supra* note 18; Health Canada, *Expert Panel 2022 Report*, *supra* note 5 at 39-41. See also Lemmens, Kim & Kurz, “C(h)arter Compliant”, *supra* note 63 at 108 and associated references, discussing how complex clinical issues may not have been adequately dealt with in the *EF* case.

<sup>145</sup> During the oral hearing of *Carter 2016*, *supra* note 50 (in which the government sought an extension to introduce a new law to respond to *Carter*), Justice Moldaver acknowledged that Parliament “might want other conditions beyond what we talked about just the circumstances; they might want to put in measures that ensure so far as possible that we are not killing people who really ought not to be killed.” This statement was cited by the B.C. Supreme Court in *Lamb BCSC*, *supra* note 44 at para 27 in concluding that a fresh constitutional analysis was merited in assessing Parliament’s legislative response to *Carter*. See also note 44, *supra*, and surrounding discussion.

<sup>146</sup> See *EF*, *supra* note 63 at para 72.

requirements under the Declaration.<sup>147</sup> The ABCA explained that while some patients with conversion disorder might be “successfully treated”, others like the applicant might not respond to treatment even over a significant amount of time.<sup>148</sup> Here, the applicant had undergone both traditional and non-traditional treatments for over nine years, none of which had remedied the applicant’s condition which included physical symptoms that had resisted treatment and interfered with the applicant’s quality of life.<sup>149</sup> On this basis, the ABCA agreed with the conclusion of the motion’s court judge, that the applicant’s psychiatric condition met the grievous *and* irremediable criteria.<sup>150</sup>

It is further worth pointing out that psychiatric experts have criticized the evidentiary basis and procedures followed in *E.F.* to establish the claimant’s eligibility even according to the broad criteria the court set out. In an article in the *Journal of Ethics in Mental Health*, Dr. Hurwitz, one of Canada’s specialists on this rare disorder, expressed concern that *E.F.* was unlikely to have been assessed by someone with special expertise in the disorder, and that this was particularly problematic for a condition that is often misdiagnosed and confused with other neurological disorders, and for which more appropriate treatment may be available. He further pointed out that the court-appointed expert confirmed the diagnosis without meeting the patient in person. One could, therefore, invoke the *E.F.* decision to highlight the dangers of allowing MAID in complex situations like the *E.F.* case, and at least the need for additional safeguards, instead of as support for the existence of a constitutional right to MAID for mental illness.<sup>151</sup>

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<sup>147</sup> Note that the requirement that a condition be “irremediable” in addition to “grievous” is an eligibility criterion that continued into the current legislated MAID law. See *Criminal Code*, *supra* note 8, s 241.2(1)(c); note that whether a psychiatric illness can actually be considered “irremediable” continues to be a source of major controversy and debate. For further discussion see references at note 83.

<sup>148</sup> *EF*, *supra* note 63 at para 64.

<sup>149</sup> *Ibid* at para 65.

<sup>150</sup> *Ibid* at para 66.

<sup>151</sup> See Trevor A. Hurwitz, “Euthanasia and Mental Illness: A Four Part Series. Part 1: The Case of *EF*” (2018) 10 *J Ethics Mental Health*, online: <jemh.ca> [perma.cc/YZL7-RVLE].

### C. *Truchon* (Quebec Superior Court)

As earlier described, in June 2016, federal Bill C-14 amended the *Criminal Code* to permit the practice of MAID<sup>152</sup> and Quebec's EOL law was already in effect as of December 2015.<sup>153</sup> The 2019 Quebec Superior Court's decision in *Truchon*<sup>154</sup> struck down Bill C-14's eligibility requirement that in order to access MAID, a person's natural death must be "reasonably foreseeable" (RFND)<sup>155</sup> as well as a similar end-of-life (EOL) provision contained in the Quebec EOL law.<sup>156</sup>

The *Truchon* case involved applicants Jean Truchon and Nicole Gladu, both of whom were seeking access to MAID but were considered ineligible because their respective physical medical conditions did not meet the RFND/EOL criteria.<sup>157</sup> The applicants successfully challenged the federal RFND criterion on the basis of the Section 7 Charter right to life, liberty and security of the person<sup>158</sup> and the Section 15 Charter right to equality, as well as the Quebec EOL criterion on the basis of Section 15 only.<sup>159</sup>

Although a closer examination of MAID jurisdictional issues is the subject of Part III below, it should be pointed out here that the distinction with respect to the Section 7 and Section 15 Charter arguments in *Truchon* relates in part to the different objectives of the statutory provisions at issue (as identified by the Quebec court). The court (Justice Baudouin) observed that while the federal MAID law under the *Criminal Code* was a response to a court decision (i.e. *Carter 2015*), the Quebec EOL legislation was enacted

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<sup>152</sup> See *Bill C-14*, *supra* note 22.

<sup>153</sup> See Quebec EOL Law, *supra* note 48.

<sup>154</sup> See *Truchon*, *supra* note 9.

<sup>155</sup> *Ibid* at para 12; see also *Bill C-14*, *supra* note 22 at cl 3.

<sup>156</sup> See *Truchon*, *supra* note 9 at para 12; see also Quebec EOL Law, *supra* note 48 at s 26(3).

<sup>157</sup> See *Truchon*, *supra* note 9 at paras 5, 35, 69-70. Mr. Truchon suffered from "spastic cerebral palsy with tripareisis since birth" and later also diagnosed with "severe spinal stenosis (narrowing of the spinal canal) as well as myelomalacia (spinal cord necrosis)" - causing constant physical pain and psychological pain due to complete dependency for daily activities; see paras 17-50. Ms. Gladu contracted polio at aged 4, and later diagnosed with "degenerative muscular post-polio syndrome" as well as osteoporosis and pulmonary disease - causing constant physical pain and discomfort, psychological suffering due to loss of functional autonomy and a fear of complete dependency; see paras 51-73.

<sup>158</sup> *Ibid* at paras 12-14.

<sup>159</sup> *Ibid*.



pursuant to provincial jurisdiction over health as a “social response” and “paradigm shift” based on Quebec medical community initiatives which desired a “holistic approach” to appropriate “end-of-life” care.<sup>160</sup> Therefore, the court identified the objective of the federal legislation and RFND criterion as the protection of “vulnerable persons who might be induced to end their lives in a moment of weakness, by preventing errors when assessing requests for medical assistance in dying”.<sup>161</sup> Note here that the object of the federal law (as identified by the Quebec Court) is no longer in relation to the absolute prohibition of assisted suicide (the issue in *Carter*), but rather in relation to Bill C-14’s new MAID scheme pursuant to the *Criminal Code*. Thus, as later stated by the Quebec court,

... the object of the legislation is precisely to allow people who meet the state-imposed conditions to request medical assistance in dying. It is admitted that the applicants, having been examined and assessed by several experts, meet every legal requirement except for the one regarding end of life. There is no question of a potential error regarding their eligibility or of protecting them as vulnerable persons due to their medical condition.<sup>162</sup>

On the other hand, the court identified the purpose of the Quebec legislation with its EOL requirement as having a “twofold” purpose, namely,

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<sup>160</sup> *Ibid* at para 120.

<sup>161</sup> *Ibid* at para 556 [emphasis added]. Note however the broader objectives of the new MAID legislation as described in the House of Commons during debate over amending the Bill C-14: “to recognize the significant and continuing public health issue of suicide, to guard against death being seen as a solution to all forms of suffering, and to counter negative perceptions about the quality of life of persons who are elderly, ill or disabled ... C-14 strikes the right balance for Canadians between protection of vulnerable individuals and choice for those whose medical circumstances cause enduring and intolerable suffering as they approach death”. See discussion at para 118; see also para 244 where Canada describes the objective in relation to vulnerability: “affirming the inherent and equal value of vulnerable persons’ lives and of addressing and preventing suicide and would put vulnerable individuals at risk,” and compare to para 252 where the court rejects the concept of “collective vulnerability”; see also para 551 where Canada formulates the objective of the legislative regime including the RFND provision into three categories: 1) to affirm inherent and equal value of every life and avoid encouragement of negative perceptions of quality of life for persons who are elderly, ill, and disabled; 2) to address suicide, a significant public health issue which has lasting, harmful effects on individuals, families and communities; and 3) to protect vulnerable persons from being induced to end their lives in moments of weakness.

<sup>162</sup> *Ibid* at para 576 [emphasis added].

end-of-life care and the “recognition of dignity and autonomy”.<sup>163</sup> The court also stated that in terms of purpose, medical aid in dying under the Quebec EOL law was considered appropriate care not because of it being provided at end of life, but because it related to suffering and decision-making autonomy.<sup>164</sup> Consequently, the court focused on the effects of the EOL provision on the applicants in relation to their Section 15 equality rights.<sup>165</sup>

The main point here is that in *Truchon* the court was tasked with determining whether the RFND and EOL criteria were constitutionally valid. And again, MAID MI-SUMC was not part of this question. Justice Baudouin did recognize early in the judgment that despite decriminalization, MAID continued to prompt concerns and raise questions that remained unanswered including, for example, MAID in respect of minor children and incapable persons.<sup>166</sup> However, Justice Baudouin clarified that the sole question before the court was to “determine the constitutional validity” of the RFND and EOL requirements and that this was “the only question that it will answer”.<sup>167</sup>

The court agreed to hear some expert evidence concerning MAID-MI-SUMC in connection with “the impact that the removal of the reasonably foreseeable natural death requirement would have on the vulnerable persons that the government wants to protect”.<sup>168</sup> Ultimately, however, the court stressed that, because neither of the plaintiffs in that case had “a psychiatric illness that could be related to their request for medical assistance in dying”,<sup>169</sup> the “relevance of any evidence adduced by the Attorney General of Canada on the subject of people who might avail themselves of medical assistance in dying based solely on a psychiatric illness

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<sup>163</sup> *Ibid* at para 725.

<sup>164</sup> *Ibid* at paras 724-725. Compare to discussion of the purpose of the Quebec EOL Law in parliamentary discussion. See e.g. discussion in “Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)”, 2nd reading, *Senate Debates*, 42-1, No 41 (1 June 2016).

<sup>165</sup> See *Truchon*, *supra* note 9 at paras 691-704.

<sup>166</sup> *Ibid* at para 16.

<sup>167</sup> *Ibid* [emphasis added].

<sup>168</sup> See discussion in *ibid* at paras 230-232.

<sup>169</sup> *Ibid* at para 386; see also para 232: “the issue of psychiatric illness as the only underlying medical condition for a request for medical assistance in dying, concern neither Mr. Truchon nor Ms. Gladu, who are not suicidal and do not suffer from any psychiatric condition.”

is doubtful, to say the least.”<sup>170</sup> With this caveat, *Truchon*’s limited discussion of MAID MI-SUMC, summarized below, should be considered *obiter*.

### ***1. Truchon’s limited discussion of MAID MI-SUMC***

Because the Charter analysis in *Truchon* involved consideration of the “vulnerable person”, as well as physicians’ ability to assess the capacity of patients,<sup>171</sup> the court allowed and considered, to a limited extent, evidence regarding “Vulnerable persons whose psychiatric illness is the only medical condition underlying their request for medical assistance in dying”.<sup>172</sup> Specifically, the court contemplated evidence and arguments led by Canada in relation to the “the danger of extending access to medical assistance in dying to patients suffering from a psychiatric condition”.<sup>173</sup> For the court, the only relevance of this evidence boiled down to the issue of whether a person could have the capacity to consent in “the presence of any illness” including a “psychiatric illness”, whatever the legislative provisions in force.<sup>174</sup> The court concluded that, whether or not a patient is suffering from a psychiatric or physical condition, the question of capacity and vulnerability can and must be assessed on an individual, case-by-case basis. Justice Baudouin was satisfied on the evidence before her that the process for assessing capacity in Canada by health care professionals was sufficient.<sup>175</sup>

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<sup>170</sup> *Ibid* at para 387.

<sup>171</sup> *Ibid* at para 239.

<sup>172</sup> *Ibid* at para 237 [emphasis original].

<sup>173</sup> *Ibid* at para 388.

<sup>174</sup> *Ibid* at para 406: “The Attorney General is mistaken on the importance to be assigned to the issue of the presence of psychiatric illnesses under the legislative provisions currently in force, because the Attorney General confuses the person’s capacity to consent with the presence of a diagnosed mental illness. The only thing that is relevant for the Court’s purposes is the determination of capacity taking into consideration the presence of any illness. Once again, the overwhelming evidence, on a balance of probabilities, does not at this time raise any doubt as to the quality of the process for assessing the capacity of a patient who has requested medical assistance in dying in Canada, whether or not the patient is suffering from a psychiatric condition” [emphasis added].

<sup>175</sup> See e.g. *ibid* at paras 420-422. It is worth noting here how Justice Beaudouin discounts the testimony of two expert witnesses for the Attorney General, Drs. Scott Kim and K. Sonu Gaidn, and in particular Dr. Kim’s testimony, which she entirely dismisses (at

The court's observations around capacity in the potential presence of mental illness or psychological suffering say nothing about whether MAID-MI-SUMC is *required* by the Charter. The court made no such declaration.<sup>176</sup> The court was not asked to opine on whether Parliament could specifically exclude psychiatric conditions from the MAID regime based on a variety of other factors. Rather, Justice Baudouin concluded that, for the purposes of determining eligibility, patients who *otherwise meet the statute's requirements* cannot be presumed to be ineligible based solely on collective assumptions related to mental illness or psychiatric conditions. In the view of the authors, Justice Baudouin's discussion is best understood as dealing with safeguards and whether mental illness or psychiatric condition precludes an *otherwise eligible person* from receiving MAID, not whether the Charter requires Parliament to include psychiatric conditions within the eligibility criteria for granting MAID in the first place.

Again, it is important here not to conflate *eligibility* for MAID solely on the basis of a psychiatric illness with how the court tackled issues of *decisional capacity* and *vulnerability* when a person has psychological pain or suffering associated with the somatic medical condition, or if psychiatric illness is concurrently present. For example, although the applicants' respective somatic medical conditions caused them psychological suffering in various forms including in relation to dependency, fear of dependency, being bedridden, loss of autonomy and loss of meaning in life,<sup>177</sup> neither had any

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paras 388-422). She does so in part because, so she emphasizes, they have no specific experience with MAID capacity assessments in Canada. She contrasts this with other expert witnesses who were at that time directly involved in MAID capacity assessments in Canada. Yet, Dr. Gaiind and Dr. Kim's testimony addressed particularly the potential *additional* challenges with MAID assessments *outside* the end-of-life context, which no Canadian expert was supposed to have had experience with, since it was still prohibited. The court's outright rejection of Dr. Kim's testimony in relation to Belgian and Dutch experience with MAID for mental illness particularly stands out. Dr. Kim (an international expert on, among other issues, capacity in medical decision-making) and colleagues have been among the first to analyze in leading peer-reviewed publications the practice of MAID for mental illness in the Netherlands, one of the only jurisdictions with at that time relevant evidence for the practice of euthanasia outside the end-of-life context.

<sup>176</sup> Ibid, at para 16.

<sup>177</sup> See e.g. *ibid* at paras 25, 39, 42, 45, 47, 58, 67 and 68.

psychiatric illness affecting capacity to consent<sup>178</sup> nor in relation to their respective requests for medical assistance in dying.<sup>179</sup>

It should, however, also be pointed out that the court's analysis seemed to assume that, other than the "reasonably foreseeable death" qualifier, MAID for certain "mental" conditions (for example, intellectual disability) might already be included in Parliament's existing legislative regime.<sup>180</sup>

For its part, the federal government (which chose not to appeal *Truchon*, despite calls from numerous commentators and disability rights organizations to do so)<sup>181</sup> evidently did not interpret *Truchon* as requiring MAID for mental illness,<sup>182</sup> as its initial legislative response to *Truchon* (i.e. Bill C-7 as introduced) specifically excluded mental illness as a sole underlying condition from MAID's eligibility criteria.<sup>183</sup> Furthermore, no court has considered the constitutionality of the government's initial legislative proposal to exclude mental illness in Bill C-7, nor, for that matter, the amended version that followed, which removes the mental illness exclusion through a sunset clause.<sup>184</sup>

## D. Summary of Part II and introduction to Part III

Despite suggestions to the contrary:

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<sup>178</sup> See e.g. *ibid* at paras 39, 42, 45, 66, 68 and 69.

<sup>179</sup> *Ibid* at para 387.

<sup>180</sup> See e.g. *ibid* at paras 304–306, noting that, under the existing regime, a "mental condition might possibly, in some cases, correspond to the legislative requirement of a grievous and irremediable medical condition", but that this is only one of the regime's statutory conditions. See also *ibid* at paras 406, 421.

<sup>181</sup> See e.g. Council of Canadians with Disabilities et al, "Advocates Call for Disability-Rights Based Appeal of the Quebec Superior Court's Decision in *Truchon & Gladu*" (4 October 2019), online: <inclusioncanada.ca> [perma.cc/83P5-XL5N]; Lemmens & Jacobs, *supra* note 14; see also discussion in Tim Stainton, "Disability, vulnerability and assisted death: commentary on Tuffrey-Wijne, Curfs, Finlay and Hollins" (2019) 20:89 *BMC Medical Ethics*, online: <bmcmedethics.biomedcentral.com> [perma.cc/UK8P-82E3]; see also discussion in Department of Justice, *What We Heard Report: A Public Consultation on Medical Assistance in Dying (MAID)*, (Ottawa, March 2020), online (pdf): <justice.gc.ca> [perma.cc/J3GU-GTXW].

<sup>182</sup> See discussion in *Charter Statement*, *supra* note 63, at "Excluding eligibility for MAID where mental illness is the sole underlying medical condition".

<sup>183</sup> See Bill C-7, *supra* note 6; see also *ibid*.

<sup>184</sup> See Bill C-7, *supra* note 6, cl 6.

- 1) no Canadian court has stated that Parliament must make MAID available for individuals whose sole underlying condition is a mental illness, nor is there clear indication that such a conclusion will necessarily be reached in the future as a jurisprudential “*fait accompli*”; and
- 2) no court has considered the constitutionality of a legislative regime that explicitly excludes mental illness as a sole basis for MAID eligibility, nor the range of policy, legal, medical, and other considerations which might lead Parliament to do so.

Separate from the constitutional compliance issue, Parliament has nonetheless decided that the practice of MAID MI-SUMC is to be made permissible under the *Criminal Code* as of March 17, 2024.<sup>185</sup> As earlier mentioned, Alberta’s premier recently voiced opposition to the federal government proceeding with MAID MI-SUMC without provincial agreement, and Quebec, in recent amendments to its provincial EOL legislation, has expressly excluded mental disorders (other than neurocognitive disorders) from eligibility.<sup>186</sup>

Quebec’s ability to create its own assisted death scheme pursuant to provincial jurisdiction has not, to date, been challenged by the federal government.<sup>187</sup> And furthermore, much of the MAID jurisdiction dialogue has predominantly focused on establishing uniformity across Canadian provinces.

Given the controversial nature of MAID MI-SUMC<sup>188</sup> along with at least two provinces having already signalled a jurisdictional “line in the sand”, it is critical to achieve some clarity as to what “compelling interest” each level of government has when it comes to legislating MAID, and the extent to which provinces can regulate MAID in a manner distinct from (and potentially more restrictive than) the federal MAID standards established pursuant to the criminal law.

The goal of the next section is not necessarily to definitively answer these questions but rather to provide information that might assist in better understanding the

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<sup>185</sup> See Bill C-39, *supra* note 6.

<sup>186</sup> See Bill 11, *supra* note 47, cl 16(1), 20.

<sup>187</sup> See e.g. discussion in *Carter 2016*, *supra* note 50 at paras 3-4.

<sup>188</sup> See Cohen, *supra* note 27; see also Bill C-39 Senate Debates, *supra* note 16 at 3091 (Hon Julie Miville-Dechéne): “Let me remind you that Quebec is a pioneer in medical assistance in dying, yet Quebec’s elected officials decided not to rush into the specific issue of eligibility where mental illness is the sole underlying condition, because there are too many differences of opinion.”

legal construction of MAID in relation to the constitutional division of powers between the federal and provincial governments. Included in this discussion is review of the recent Supreme Court of Canada decision, *Murray-Hall v. Quebec*, which held that **notwithstanding permissive federal law, the Quebec legislature had jurisdiction to completely prohibit the possession and self-cultivation of cannabis plants in a dwelling house.**<sup>189</sup> As will be discussed, while provinces may not permit actions that are expressly prohibited by the federal Criminal law, they can have jurisdiction to create further policies and standards in respect of a permissible act.<sup>190</sup>

### III. CONSTITUTIONAL JURISDICTION

#### A. MAID as a medicalized act - preliminary considerations

In Canada, national MAID law reform was advanced on the basis of a Charter challenge to the criminal law in relation to a practice framed as a medical act<sup>191</sup> and thus from the outset has involved consideration of the intersection between federal (criminal) and provincial (health) law. As the Supreme Court of Canada observed in *Carter*:

Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic ... This suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation.<sup>192</sup>

Following that Charter challenge, Parliament created an exemption in the *Criminal Code* to permit medical personnel to practice MAID and pursuant to that exemption, the delivery and further regulation of MAID fell to provincial health jurisdiction.<sup>193</sup>

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<sup>189</sup> See *Murray-Hall*, supra note 53.

<sup>190</sup> See also discussion at Government of Canada, “Medical Assistance in Dying: Implementing the framework” (7 February 2023), online: <<https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying/implementing-framework.html>>.

<sup>191</sup> See e.g. *Carter* 2015, supra note 39 at paras 10, 23, 30, 66-67.

<sup>192</sup> *Ibid* at para 53, citing *RJR-MacDonald Inc v Canada (Attorney General)*, 1995 CanLII 64 (SCC) at para 32 [RJR]; *Schneider v The Queen*, 1982 CanLII 26 (SCC) at 142 [Schneider], [emphasis added]. The Court made this comment in the context of rejecting the Claimant’s claim of a core provincial jurisdictional power over health on the grounds of interjurisdictional immunity.

<sup>193</sup> See e.g. the preamble of Bill C-14, supra note 22: “Whereas it is desirable to have a consistent approach to medical assistance in dying across Canada, while recognizing the provinces’ jurisdiction over various matters related to medical assistance in dying,

To date, however, with the exception of Quebec, provinces generally have not enacted legislation substantively regulating medical assistance in dying. Pursuant to the *Criminal Code* MAID exemption, provincial MAID law and policy has been predominantly implementation and regulatory in focus,<sup>194</sup> addressing for example matters related to the regulation of health professions;<sup>195</sup> insurance;<sup>196</sup> access and delivery;<sup>197</sup> notice, reporting, registering and monitoring MAID deaths;<sup>198</sup> limitation of liability;<sup>199</sup> vital statistics and investigation;<sup>200</sup> and codes of medical ethics and practice

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including the delivery of health care services and the regulation of health care professionals, as well as insurance contracts and coroners and medical examiners”.

<sup>194</sup> Note that the federal government introduced reporting obligations (including reporting obligations for physicians, nurse practitioners, preliminary assessors, pharmacists and pharmacy technicians) to which provincial regulatory bodies or health authorities may add. See *Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying*, SOR 2022-222, s 10(1).

<sup>195</sup> See e.g. Council of the College of Physicians & Surgeons of Nova Scotia, “Professional Standard Regarding Medical Assistance in Dying” (5 May 2021), online (pdf): <cpsns.ns.ca/wp-content/uploads/2021/04/Professional-Standard-Regarding-Medical-Assistance-in-Dying-April-26-2021-amended-May-5-2021.pdf>; regarding effective referrals for physicians who object to MAID, see e.g. College of Physicians and Surgeons of Ontario, “Professional Obligations and Human Rights” (March 2015), online: <cpsno.on.ca> [perma.cc/3USV-LN6G] [Ontario Professional Obligations]; regarding nurses, see e.g. College of Registered Nurses of Manitoba, “Medical Assistance in Dying: Guidelines for Manitoba Nurses” (July 2021), online (pdf): <crnm.mb.ca> [perma.cc/7FPM-N6MH]; See also for example, Pharmacists Regulation, BC Reg 417/2008, s 4.1(2).

<sup>196</sup> See e.g. *The Insurance Act*, SS 2015, c I-9.11, s 8-118.1(4), which states that a medically assisted death, provided it was administered lawfully, is not to be considered a suicide under a life insurance policy; See also *Workplace Safety and Insurance Act, 1997*, SO 1997, c 16, Sch A.

<sup>197</sup> See e.g. Ontario Professional Obligations, *supra* note 195 at ss 12-16; compare to Manitoba’s *The Medical Assistance in Dying (Protection for Health Professionals and Others) Act*, CCSM c M92.

<sup>198</sup> See e.g. Medical Assistance in Dying Statute Law Amendment Act, 2017, SO 2017, c 7; see also The Fatality Inquiries Amendment and Vital Statistics Amendment Act, SM 2016, c 21 [The Fatality Inquiries Act]; The Coroners Amendment Act, 2020, SS 2020, c 21.

<sup>199</sup> See e.g. Excellent Care for All Act, 2010, SO 2010, c 14.4.

<sup>200</sup> See e.g. Vital Statistics Act, RSO 1990, c V.4, s 21(7); See also The Fatality Inquiries Act, *supra* note 198.



directions.<sup>201</sup> Indeed, following the *Carter* decision and in light of federal government limitations with respect to regulating health care, a conversation regarding achieving a “pan-Canadian” approach to MAID to avoid a “patchwork” of MAID regimes across the provinces and territories was prompted and cooperation between federal and provincial/territorial governments was encouraged.<sup>202</sup>

Nevertheless, there appears to be significant constitutional room for the provinces to more actively legislate matters regarding MAID within the provincial zone of competence in respect of health, notwithstanding an early argument by some that “[p]rovinces and territories cannot ... restrict the circumstances in which physician-assisted dying is permitted beyond those validly provided for by Parliament”.<sup>203</sup> But to what degree and for what purposes? If provincial regulations do take a more restrictive approach to MAID based on legitimate provincial considerations, would they frustrate the purpose of the federal law and be struck down? When might provincial legislation in this area create conflict or inconsistency with federal law such that it might be deemed “inoperative”? To try to find answers to these types of questions, it is helpful to review the Constitution’s division of powers between the provincial and federal governments in relation to matters of health care, and the Supreme Court of Canada’s interpretation of same.

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<sup>201</sup> See e.g. College of Physicians & Surgeons of Nova Scotia, “Professional Standard Regarding Medical Assistance in Dying” (April 26, 2021), online (pdf): <cpsns.ns.ca/wp-content/uploads/2021/04/Professional-Standard-Regarding-Medical-Assistance-in-Dying.pdf>; see also College of Physicians and Surgeons of British Columbia, “Practice Standard Medical Assistance in Dying” (10 May 2022), online: <cpsbc.ca> [perma.cc/9BXK-M98H]; The College of Physicians & Surgeons of Manitoba, “Standard of Practice Medical Assistance in Dying (MAiD)” (9 June 2021), online (pdf): <cpsm.mb.ca> [perma.cc/CJZ8-G7QU].

<sup>202</sup> See e.g. External Panel on Options for a Legislative Response to *Carter v. Canada*, Consultations on Physician-Assisted Dying, Summary of Results and Key Findings (15 December 2015) at iv-vii, 18-19, online (pdf): <justice.gc.ca> [perma.cc/4NDB-ZFFW]; see also Provincial-territorial Expert Advisory Group on Physician-Assisted Dying, Final Report (November 30, 2015) at 2-4, 19, online (pdf): <novascotia.ca> [perma.cc/GXU5-2KE3] [Provincial-Territorial Report]; see also Canada, Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centered Approach* (Ottawa: Special Joint Committee, 2016), at 2, 6, 58, online (pdf): <parl.ca> [perma.cc/7ZH5-GLKJ] [Patient-Centred Approach]; See also Bill C-14, *supra* note 22 at preamble.

<sup>203</sup> See Provincial-Territorial Report, *ibid* at 16 [emphasis added].

## B. Jurisdiction over “health”

### 1. *Concurrent, overlapping and ‘amorphous’*

Not only is health an area of *concurrent* jurisdiction (whereby both Parliament and the provinces may validly legislate on the topic),<sup>204</sup> the Supreme Court of Canada has recently reiterated in *Murray-Hall v. Quebec (Attorney General)* (discussed further below) that “health, as a matter not assigned in the *Constitution Act, 1867*, is an area of *overlapping* jurisdiction”.<sup>205</sup> The Court, quoting Justice Karakatsanis’ decision in the *2020 Reference re Genetic Non-Discrimination Act*,<sup>206</sup> further described this jurisdiction as *amorphous*:

Health is an ‘amorphous’ field of jurisdiction, featuring overlap between valid exercises of the provinces’ general power to regulate health and Parliament’s criminal law power to respond to threats to health ...<sup>207</sup>

### 2. *Federal jurisdiction – a prohibition, a legitimate “evil” and establishing a “baseline”*

The federal government has legislative competence in the area of health pursuant to its criminal (s. 91(27)) powers as well as its federal spending power which has been said to be inferred from its jurisdiction over public debt and property (section 91(1A)) and its general taxing power (section 91(3)).<sup>208</sup>

With respect to its criminal law jurisdiction, the federal power to legislate must be in the form of a prohibition and directed at legitimate criminal law purpose. Thus, as stated by the Supreme Court in the 1995 decision *RJR-MacDonald*:

The scope of the federal power to create criminal legislation with respect to health matters is broad, and is circumscribed only by the requirements that the legislation must contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil.<sup>209</sup>

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<sup>204</sup> *Carter 2015*, *supra* note 39 at para 53.

<sup>205</sup> *Murray-Hall*, *supra* note 53 at para 73 [emphasis added].

<sup>206</sup> See *Reference re Genetic Non-Discrimination Act*, 2020 SCC 17 at para 93.

<sup>207</sup> *Murray-Hall*, *supra* note 53 at para 73 [emphasis added]. See also *Chaoulli v. Quebec (Attorney General)* [2005] S.C.J. No. 33, [2005] 1 S.C.R. 791, 2005 SCC 35, at para 16 [Chaoulli].

<sup>208</sup> For discussion see e.g. *Patient-Centred Approach*, *supra* note 202 at 4.

<sup>209</sup> *RJR*, *supra* note 192 at para 32 [emphasis added].

And as further explained by the Supreme Court in 2011 in the later *PHS* decision (and reiterated in *Carter*):

Parliament has power to legislate with respect to federal matters, notably criminal law, that touch on health. For instance, it has historic jurisdiction to prohibit medical treatments that are dangerous, or that it perceives as ‘socially undesirable’ behaviour.<sup>210</sup>

In the context of assisted death, MAID can thus be validly regulated by the federal government because it involves activities that would otherwise be considered culpable homicide,<sup>211</sup> aiding suicide<sup>212</sup> or administering a noxious thing<sup>213</sup> under the *Criminal Code* – practices that are not only inherently dangerous in that they involve the intentional ending of life (or the intentional endangerment to life) but also practices historically perceived as, in the words of Justice Sopinka in *Rodriguez*, “intrinsicly morally and legally wrong”.<sup>214</sup> Notwithstanding that there are different views on the morality and ethics of MAID, it is for these kinds of reasons – i.e. threats to health, morality, public safety and security – that the acts of administering or providing a substance to a person to intentionally cause that person’s death are legitimate subjects for criminal prohibition. Accordingly, the federal *Criminal Code* continues to prohibit the offences of aiding suicide as well as culpable homicide and administering a noxious thing but carves out an exemption from these offences for physicians and nurse practitioners (and individuals assisting them) who actively and knowingly cause a patient’s death, with their consent, in accordance with the specific requirements set out in the *Criminal Code* MAID provisions.<sup>215</sup>

In short, pursuant to its criminal law jurisdiction, the federal government sets out the criminal law framework and “legal conditions

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<sup>210</sup> *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 at para 68, citing *R v Morgentaler*, 1988 CanLII 90 (SCC); *Morgentaler v The Queen*, 1975 CanLII 8 (SCC); *R v Morgentaler*, 1993 CanLII 74 (SCC) [*Morgentaler 1993*]. This passage was quoted by the Court in *Carter 2015*, *supra* note 39 at para 51 [emphasis added].

<sup>211</sup> See *Criminal Code*, *supra* note 8, ss 222(4), 229.

<sup>212</sup> *Ibid* at ss 241(2)(7), 241.1, 241.2, 241.3.

<sup>213</sup> *Ibid* at ss 245(1)(3).

<sup>214</sup> *Rodriguez*, *supra* note 41 at para 162.

<sup>215</sup> See discussion and comments in “Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)”, 2nd reading, *House of Commons Debates*, 42-1, No 62 (31 May 2016) at 3797 (Hon Jody Wilson-Raybould).

under which MAID can be provided”.<sup>216</sup> Thus as put by one Senator during the Bill C-14 Parliamentary debates:

Essentially, what we as federal lawmakers can do is say, “Yes, you can be exempt from our law, but only if you do it according to our framework.” ... We are not imposing how the provinces will regulate their health care service delivery. We are sending them the message that if you want to break our federal law, you have to meet a minimum standard.<sup>217</sup>

And as explained by then-Minister of Justice Jody Wilson-Raybould when describing the interface between the federal MAID provisions pursuant to the criminal law and provincial jurisdiction over MAID as a form of health care:

The views of the provinces and territories, the attorneys general and the health ministers across the country and the view of our government is that there should be and needs to be a uniform criminal law across the country. That’s what we have sought to do in terms of Bill C-14, to ensure that there is a baseline of safeguards which exist, to ensure there is consistency in terms of eligibility.<sup>218</sup>

### ***3. Provincial jurisdiction – health care, flexibility and local considerations***

Generally speaking, the provinces have broad jurisdiction over matters of health care, “grounded primarily in broad and plenary jurisdiction over property and civil rights (s. 92(13)) and residual jurisdiction over matters of a merely local or private nature in the province (s. 92(16))”.<sup>219</sup> In addition, s. 92(7) expressly grants the provinces jurisdiction over the “Establishment, Maintenance, and Management of Hospitals, Asylums, Charities and Eleemosynary Institutions”.<sup>220</sup>

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<sup>216</sup> CCA Report, *supra* note 9 at 54.

<sup>217</sup> “Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)”, 2nd reading, *Senate Debates*, 42-1, vol 150 No 46 (9 June 2016) at 1016 (Hon Tobias C Enverga Jr).

<sup>218</sup> “Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)”, 2nd reading, *Senate Debates (in Committee of the Whole)*, 42-1, vol 150 No 41 (1 June 2016) at 750 (Ms Wilson-Raybould) [C-14 Committee of the Whole] [emphasis added].

<sup>219</sup> Murray-Hall, *supra* note 47 at para 71, citing Chaoulli, *supra* note 207 at para 18.

<sup>220</sup> Constitution Act, 1867 (UK), 30 & 31 Vict, c 3, s 92(7), reprinted in RSC 1985, Appendix II, No 5.

Accordingly, when it comes to matters of health care policy, administration and delivery of medicine or health care services, and the regulation of the health care profession, it is generally agreed that the provinces have been constitutionally endowed with primary jurisdiction.<sup>221</sup> So, while the federal government has decriminalized MAID as a matter of criminal law policy and established specific “baseline” standards to render health care professionals exempt from criminal liability in certain circumstances, it is the provinces who ultimately decide on MAID implementation and the extent to which it is to be incorporated into the provincial health care system as a *medical* treatment option.<sup>222</sup>

Thus in 2016, when asked during the Bill C-14 parliamentary debates whether Quebec’s EOL law was potentially in conflict with the forthcoming federal MAID law (the latter which was understood to be more permissive

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<sup>221</sup> *Ibid* at ss 92(7), 92(13), and 92(16). See *Eldridge v. British Columbia (Attorney General)*, 1997 CanLII 327 (SCC) at para 24: “the hospital insurance and medicare programs in force in this country come within the exclusive jurisdiction of the provinces under ss. 92(7) (hospitals), 92(13) (property and civil rights) and 92(16) (matters of a merely local or private nature)”. See also Canada, Commission on the Future of Health Care in Canada, *Constitutional Jurisdiction Over Health and Health Care Services in Canada*, by Howard Leeson, Discussion Paper No 12 (Ottawa: 2002) at v.

<sup>222</sup> A basic example of this is that while the *Criminal Code* MAID provisions permit both physician and nurse administration as well as patient self-administered MAID, the Quebec EOL law for example, only permits physician administration. See *Criminal Code*, *supra* note 8 at Section 241.1(a) and (b) and compare to Quebec EOL Law, *supra* note 48 at s 3(6). Furthermore, Quebec’s medical regulator while providing a protocol for physician administration has not provided one for self-administration as of 2019. See Collège des médecins du Québec Ordre des pharmaciens du Québec Ordre des infirmières et infirmiers du Québec Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec Barreau du Québec Chambre des notaires du Québec, *L’aide Médicale à Mourir, Mise à Jour 11/2019 Guide D’exercice et Lignes Directrices Pharmacologiques* (November 2019) at 5.1, online (pdf): <extranet.ciissca.com> [perma.cc/X4GY-GFG8]; see also discussion in C. Harty et al, “The Oral MAiD Option in Canada, Part 1: Medication Protocols, Review and Recommendations” (18 April 2018) at 21, online (pdf): <camapcanada.ca> [perma.cc/Q5ER-S9M4]; C Harty et al, “The Oral MaiD Option in Canada Part 2: Process for Providing Review and Recommendations” (18 April 2018) at 5, online (pdf): <camapcanada.ca> [perma.cc/SYT4-QKG4]; Stukalin et al, “Medications and dosages used in medical assistance in dying: a cross-sectional study” (2022) 10:1 CMAJ Open E19 at E19; *Cameron v Nova Scotia (Attorney General)*, 1999 NSCA 14 (CanLII), leave to appeal to dismissed, [1999] S.C.C.A. No. 531 (QL) [*Cameron*], discussed *infra*.

in scope than the former<sup>223</sup>), Minister of Justice Jody Wilson-Raybould again explained as follows:

There are some differences between what is in place in the Province of Quebec and what is being put forward within Bill C-14. As you rightly point out, senator, the Quebec legislation is around end of life and care at the end of life by medical practitioners.

... We have purposefully – and this is where there is a distinction between the Quebec law and Bill C-14 – put in place reasonable foreseeability in terms of “death has become reasonably foreseeable,” to inject the flexibility to enable medical practitioners, based on the close relationship they have with their patients, to determine whether or not their patient is eligible to receive medical assistance in dying. I have been in close contact with the Province of Quebec and the Attorney General, and what we’re doing in terms of Bill C-14 is exercising the criminal law power.

The legislation in place in the Province of Quebec is under the health jurisdiction of the province, and we do not see a conflict necessarily between those two laws.  
... there is no conflict in terms of the laws.

...

So there are standards of safeguards and eligibility which exist in the criminal law context. The provinces and territories, including as I said with respect to Quebec, have the ability to work with the federal Minister of Health, but working within their own jurisdictions to put in place other regulatory provisions they deem appropriate in terms of medically assisted dying.<sup>224</sup>

In other words, the Quebec law did not conflict with the federal provisions in that the narrower provincial criteria (end of life) fit within the broader and more permissive federal standard (reasonably foreseeable natural death), and this was also not contested in *Truchon*.<sup>225</sup> Additionally,

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<sup>223</sup> I.e. “reasonably foreseeable natural death” under Federal Bill C-14, *supra* note 22 versus “end of life” under the Quebec EOL Law, *supra* note 48, ss 3(3), 3(6).

<sup>224</sup> *C-14 Committee of the Whole*, *supra* note 211 at 749 (Hon Jody Wilson-Raybould).

<sup>225</sup> It is interesting to point out here how this makes it all the more remarkable that the *Truchon* decision was not appealed by the federal Attorney General. As others have pointed out (Thomas McMorrow et al, “Interpreting Eligibility Under the Medical Assistance in Dying Law: The Experiences of Physicians and Nurse Practitioners” (2020) 14:1 McGill JL & Health 51 at 57), the plaintiffs in *Truchon* would have had immediate access to MAID in other provinces. Indeed, the reason that the plaintiff in *Lamb* abandoned her challenge to the MAID law was precisely because an expert witness for the AG testified that she (Ms. Lamb) would likely qualify under a broad interpretation of ‘reasonable foreseeable natural death.’ Arguably, the plaintiffs in *Truchon* did not qualify for MAID in Quebec due to the more narrow Quebec law criterion of ‘end of life’, which resulted in a more narrow application of the federal RFND requirement. A declaration of unconstitutionality of the Quebec law could thus arguably have sufficed

the quote above reflects the recognition that the goal of uniformity in terms of the criminal law must be balanced with facilitating flexibility and respecting the provinces' ability to tailor their laws to address local needs and concerns. As described in the 2022 Final Report of the Expert Panel on MAID and Mental Illness:

A major advantage of federal legislation for MAiD is uniformity across the country, which ensures important measures, like safeguards, are implemented everywhere and in all cases. However, some desirable measures might fall within the provincial rather than federal legislative powers. An advantage of provincial legislation is that it can be tailored to reflect local needs and concerns. Variation in the organization and delivery of MAiD between provinces and territories may in certain cases, reflect appropriate responses to needs of patients, families and practitioners. Legislative uniformity, particularly in health care organization and delivery, may constrain appropriate flexibility in frontline care. Other matters may be better left to regulatory authorities to develop and enforce through self-regulatory processes.<sup>226</sup>

Furthermore, in terms of the legitimate scope of provincial regulation pursuant to the federal exemption, the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying had previously acknowledged in 2015 post-Carter:

Provided that provincial/territorial laws were not inconsistent with valid federal legislation or with the Charter, provinces and territories could regulate aspects of physician-assisted dying not prohibited by federal law. For example, provinces and territories could enact legislation to regulate in relation to at least: eligibility (including rules regarding who may determine eligibility);

- determining competency and obtaining consent;
- safeguards to protect the vulnerable;
- settings in which physician-assisted dying is permitted;
- provider participation, including health institutions and both physicians and non-physician health professionals;
- means of delivery of physician-assisted dying;
- insurance (life and professional liability);
- certification of death; and
- reporting requirements and quality review.<sup>227</sup>

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to provide the plaintiffs access to MAID.

<sup>226</sup> Health Canada, *Expert Panel 2022 Report*, *supra* note 5 at 32-33.

<sup>227</sup> *Provincial-Territorial Report*, *supra* note 202 at 16-17 [emphasis added].

#### 4. *The Canada Health Act, Insured Services and “Medically Necessary”*

There appear to be three (3) principal lines of reasoning behind arguments that provinces do not have the ability to narrow or restrict the circumstances in which MAID is permitted: The first is that to do so would be contrary to Charter rights (but as discussed above, there is no recognized Charter right to MAID-MI-SUMC); the second is that it could “frustrate” or intrude on valid federal law (discussed further in section c below); and the third relates to federal cash transfers pursuant to the *Canada Health Act* (CHA), the federal legislation for publicly funded health care insurance.<sup>228</sup>

This third argument is fairly straightforward: MAID’s classification as a “medically necessary” and thus “insured health service” makes provinces accountable to the principles of the CHA, including satisfying the five criteria of: public administration, comprehensiveness, universality, portability and accessibility.<sup>229</sup>

Accordingly, as the argument goes, if provinces deviate from the federal MAID framework – for example, by narrowing eligibility or increasing safeguards – this would fall afoul of CHA requirements, in particular by creating barriers to access. This argument may also be shored up by reference to the preamble of Bill C-14 which describes the new MAID law in the context of the Government of Canada’s commitment to uphold the principles set out in the CHA.<sup>230</sup>

With all of this said, however, it may be relevant to first note that the main statutory consequence of provincial non-compliance with the criteria and conditions of the CHA is that the federal government can withhold a portion of its federal cash contribution to the province(s) at issue.<sup>231</sup> The CHA is not a constitutional statute that can enforce practical conformity

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<sup>228</sup> See *Canada Health Act*, RSC 1985, c C-6 [CHA].

<sup>229</sup> *Ibid*, ss 2, 7.

<sup>230</sup> See Bill C-14, *supra* note 22 at preamble.

<sup>231</sup> See CHA, *supra* note 221 at ss 15-17. For further discussion see Colleen M Flood & Bryan Thomas, “Modernizing the *Canada Health Act*” (2016) 39:2 Dal LJ 397 at 399 [Flood & Thomas]. See also Cameron, *supra* note 215 at para 97 [emphasis added]:

If, without deciding that the Act fails to meet the standards or objectives of the *Canada Health Act*, it does not follow that the appellants would be entitled to relief in this Court. Jurisdiction over health care is exclusively a provincial matter. Failure of a province to comply with the *Canada Health Act* may result in the Government of Canada imposing a financial penalty on the province. It raises a political, not a justiciable issue. **It does not render the provincial legislation unconstitutional.**



on the part of the provinces. It is simply a federal law that governs federal transfer payments.

Perhaps of more significance is that while the CHA requires provinces to provide insured health services (in order to receive federal transfers), the term “insured health services” is quite fluid being described as “medically necessary” hospital services<sup>232</sup> or “medically required” physician services.<sup>233</sup> In turn, the terms “medically necessary” and “medically required” are not defined in the CHA, meaning the CHA has “left it open to the provinces and territories to interpret and determine what services are medically necessary or medically required. As a result, the list of insured services varies from one jurisdiction to another across Canada.”<sup>234</sup>

Accordingly, a province may decide not to sponsor a particular service at all, on the basis that it is not considered medically necessary or required.<sup>235</sup> This was affirmed by the Nova Scotia Court of Appeal, which noted:

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<sup>232</sup> CHA, *supra* note 221, s 2. See also Flood & Thomas, *supra* note 224 at 403.

<sup>233</sup> CHA, *supra* note 221.

<sup>234</sup> See Library of Parliament, *The Canada Health Act: An Overview*, by Marlisa Tiedemann, Publication No 2019-54-E (Ottawa: Library of Parliament, 2020) at 3, online (pdf): <lop.parl.ca> [perma.cc/CR3M-S9YH], citing J C Herbert Emery & Ronald Kneebone, “The Challenge of Defining Medicare Coverage in Canada” (2013) 6:32 *SPP Research Papers*; see also Commission on the Future of Health Care in Canada, *Medically Necessary: What is it, and who decides?*, (Ottawa: Commission on the Future of Health Care in Canada, 2002) and Timothy A Caulfield, “Wishful Thinking: Defining ‘Medically Necessary’ in Canada” (1996) 4 *Health LJ* 63 at 63-85. See also Flood & Thomas, *supra* note 224 at 403: “The main stricture here is that physicians require a fee code when billing medicare for a specific service, and the menu of fee codes is renegotiated annually between provincial medical associations and provincial health insurers.”

<sup>235</sup> See Brian Bird, “The provinces could pass on expanding assisted death—regardless of the federal government’s wishes”, *The Hub* (7 March 2023), online: <thehub.ca> [perma.cc/TK2D-DA4C] [Bird]:

regardless of whether the Charter is said to require the decriminalization of assisted death, provinces are not necessarily obliged to integrate assisted death into their health-care systems. Provinces cannot criminalize assisted death, as criminal law is federal jurisdiction. But pursuant to their jurisdiction over the delivery of health care, provinces could have potentially declined to sponsor assisted death as health care and could potentially decline to sponsor other forms or features of assisted death that may be decriminalized in the future.

A very important limitation in the policy [of the *Canada Health Act*] is that insured services be medically necessary or medically required. Of necessity, what is or is not medically required must be judged by those placed in charge of the administration of the policy. The judgment call requires an appreciation not only of medical procedures, but the availability of funds to finance them. The exercise of such judgment is not a function of this Court. Our role is limited to requiring that those who make and administer the policy follow their own rules - in particular, the Act and the Regulations - in doing so. We are not accountable for the raising and expenditure of public monies. The persons who make these decisions under the policy are persons who are directly or indirectly so accountable. Charter considerations aside, as long as their decisions are reached in good faith and are not shown to be clearly wrong, we have no power to overturn them.<sup>236</sup>

This is not to say that we are asserting a position on whether MAID or only certain categories of MAID should be an insured health service or not. Rather, we simply point out that what is ultimately deemed medically necessary or required and in turn an insured health service is a determination largely left to the provinces, as a matter of health care policy.

##### ***5. Preliminary summary re: jurisdiction***

Both the federal and provincial governments have constitutional authority to legislate matters related to assisted death. The federal government can, subject to the Charter, prohibit or restrict the practice in connection with its criminal law authority to “suppress some evil or injurious or undesirable effect upon the public”, while the provinces may also regulate assisted death “in order to protect the health and security of the public” from harm pursuant to its jurisdiction over health care.<sup>237</sup>

While it may be less contentious to assert that provinces pursuant to their health jurisdiction cannot permit that which is prohibited by the criminal law,<sup>238</sup> it is not a foregone conclusion that provinces could not legitimately restrict or limit the circumstances in which MAID is permitted pursuant to specific provincial objectives including those responsive to local needs and concerns. In short, and in the view of the authors, “Parliament

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<sup>236</sup> Cameron, *supra* note 215 at para 101. See also *ibid* at paras 93-97; See also discussion in John J Morris and Cynthia D Clarke, *Law for Canadian Health Care Administrators*, 2<sup>nd</sup> ed, (Toronto: LexisNexis Canada, 2011) at 32-33.

<sup>237</sup> Murray-Hall, *supra* note 47 at paras 77, 80.

<sup>238</sup> But note that Quebec proceeded with regulating assisted death prior to federal decriminalization (see note 40).

can create a regulatory baseline but not a ceiling for how activities that are approved by the provinces as health care are delivered.”<sup>239</sup>

As previously noted, the provinces have generally not exercised their jurisdiction to regulate MAID beyond the baseline regime set out in the *Criminal Code*. As described by legal scholar Brian Bird, “the prevailing view on how the provinces should handle assisted death seems to be that they must robotically and robustly integrate into their health-care systems whatever Parliament decriminalizes in this area”.<sup>240</sup> As discussed above, however, it is the authors’ opinion that this view is simply not accurate – an opinion shared by Bird,<sup>241</sup> and which finds support in the recent decision of the Supreme Court of Canada, *Murray-Hall v. Quebec (Attorney General)*. This decision offers helpful guidance on the contours of the provincial and federal governments respective zones of competence. Most significantly, it affirms that the provinces can not only *regulate* certain practices or treatment options, but could potentially even *restrict* or *prohibit* them in furtherance of public health and security purposes, even when the practices at issue have been decriminalized by Parliament. A close examination of that case is therefore merited.

### **C. *Murray-Hall*: Provinces can restrict what Parliament permits ... in certain circumstances**

*Murray-Hall* involved a constitutional challenge to a Quebec law that completely prohibited the possession and cultivation of cannabis plants at home. The claimants argued that this law conflicted with federal law, which permitted an individual to possess or cultivate up to four cannabis plants in their home. The question for the Court was whether “the more ‘permissive’ federal approach and the more ‘restrictive’ Quebec approach [could] coexist from a legal standpoint within the Canadian federation”.<sup>242</sup> The Court unanimously answered this question in the affirmative.

The Court noted that merely prohibiting a practice does not necessarily constitute an intrusion into the federal government’s criminal law power.<sup>243</sup>

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<sup>239</sup> Bird, *supra* note 228.

<sup>240</sup> *Ibid.*

<sup>241</sup> *Ibid.*

<sup>242</sup> *Murray-Hall*, *supra* note 53 at para 2.

<sup>243</sup> *Ibid* at para 68. The Court also cited *Siemens v Manitoba (Attorney General)*, 2003 SCC 3 at para 25, Major J: “[t]he mere presence of a prohibition and a penalty

According to the Court, in characterizing the impugned provisions, the Court must read the impugned provisions in the context of the scheme; meaning that the Court must not look just at the fact that a prohibition exists, but rather at the *purpose* of the prohibition as distinct from the *means* for achieving that purpose.<sup>244</sup> The driving question is: what are the *ends* or *purposes* which the *means* (i.e. the restrictions) seek to achieve? In the present case, the Court found that the purpose of the impugned provisions was to establish a provincial scheme to “protect the health and security of the public, and of young persons in particular, from cannabis harm”.<sup>245</sup> This was a proper legislative purpose related to public health, grounded in the provincial heads of power in ss. 92(13) and (16).

Part of the claimant’s argument was that the province was effectively recriminalizing what Parliament sought to decriminalize,<sup>246</sup> in part evidenced by comments made by members of the Quebec legislature which, according to the claimant, demonstrated intent to thwart Parliament.<sup>247</sup> This argument was rejected by the Court. Although the Court reiterated “[t]he guiding principle . . . that the provinces may not invade the criminal field by attempting to stiffen, supplement or replace the criminal law . . . or to fill perceived defects or gaps therein”, there was no evidence that Quebec had attempted to do so in this case.<sup>248</sup> The Quebec government was not seeking to condemn or eliminate an act deemed morally reprehensible or a “public evil” (such would be a matter for exclusive federal jurisdiction); rather, it was concerned “about the risks arising from cannabis consumption, particularly for younger individuals”.<sup>249</sup> Furthermore, ministerial statements expressing uneasiness or concerns were not taken by the Court as demonstrating any intention to re-criminalize but rather were statements that simply showed “that concerns about the harmful effects of cannabis on health did not disappear merely because this substance was decriminalized”.<sup>250</sup> The Court thus determined that:

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does not invalidate an otherwise acceptable use of provincial legislative power”.

<sup>244</sup> See *Murray-Hall*, *supra* note 53 at para 33.

<sup>245</sup> *Ibid* at para 28 [emphasis added]; see also para 60.

<sup>246</sup> *Ibid* at para 54.

<sup>247</sup> *Ibid* at para 51.

<sup>248</sup> *Ibid* at para 55, citing *Morgentaler 1993*, *supra* note 203 at 498.

<sup>249</sup> *Murray-Hall*, *supra* note 53 at para 54 [emphasis added].

<sup>250</sup> *Ibid*.

The impugned provisions do not represent a colourable attempt to re-enact the criminal law prohibitions repealed by Parliament...

... [W]hile the impugned provisions do bring otherwise decriminalized conduct into the sphere of penal law, the consequences flowing from a contravention are very different from those arising under the provisions of the [federal law]...

Prohibiting the possession and cultivation of cannabis plants is not in itself the *purpose* of the impugned provisions, but rather a *means* of steering consumers to the only source of supply considered to be reliable and safe.<sup>251</sup>

Thus, because the prohibitions were an integral part of a larger scheme anchored in an area of legitimate provincial competence, the purpose of which was to protect the public from harm for health and security reasons rather than to suppress an act (solely for the sake of suppressing it), they were deemed an acceptable use of the provincial legislative power, and not a “colourable attempt to re-enact the criminal law prohibitions repealed by Parliament.”<sup>252</sup>

With respect to classifying the law, (i.e. whether the impugned provisions fell under the federal criminal law power or within the powers conferred on the provinces),<sup>253</sup> the Court first explained the space for provincial regulation with respect to conduct decriminalized by Parliament:

Parliament’s decision to decriminalize conduct leaves the field clear for the provinces to enact their own prohibitions accompanied by penalties in relation to that conduct, as long as the prohibitions serve to enforce laws relating to matters within provincial jurisdiction. ... It follows that penal regulatory measures adopted by the provinces with regard to decriminalized activities are not necessarily attempts to legislate in criminal matters.<sup>254</sup>

Second, the Court clarified that that the provinces do have “jurisdiction to make laws in relation to several matters that touch on purposes that otherwise constitute valid criminal law purposes” including touching on “moral aspects” and the consideration of risk [cannabis consumption poses] to certain vulnerable populations.<sup>255</sup> The provincial scheme at issue was advancing the objectives of public health and security, which are clearly

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<sup>251</sup> *Ibid* at paras 57-64 [emphasis original].

<sup>252</sup> *Ibid* at para 57.

<sup>253</sup> *Ibid* at para 65.

<sup>254</sup> *Ibid* at para 68 [emphasis added].

<sup>255</sup> *Ibid* at para 69.

related to provincial heads of power: property and civil rights (s. 92(13)) and residual jurisdiction over matters of a merely local or private nature (s. 92(16)).<sup>256</sup>

Third, it was also significant that, in the Court's view, the impugned prohibitions ultimately did not have a punitive purpose:

... the Quebec legislature saw the possession and personal cultivation of cannabis not as a social evil to be suppressed, but rather as a practice that should be prohibited in order to steer consumers to a controlled source of supply...the purpose of the legislation was not to punish persons with a drug addiction, but **rather to regulate their medical treatment and ensure their safety** ...In the instant case, the prohibitions ... do not have punitive purposes as such, but instead reflect an approach based on regulating and supervising access to the substance.<sup>257</sup>

### *1. Applying the Murray-Hall analysis to Quebec's EOL law*

Applying this analysis to Quebec's EOL law, we can see how it contains similar elements to the legislation upheld in *Murray-Hall*. Bill 11 does not restrict MAID MISUMC to punish those who participate in it, nor because the provincial government deems it to be a social or public "evil" to be suppressed. Rather, it excludes mental disorders as a basis for MAID eligibility in the context of a larger statutory regime regulating "end-of-life care", which has a broader *medical* purpose including:

- ensuring "patients are provided care that is respectful of their dignity and their autonomy" and
- establishing "the rights of such patients as well as the organization of and a framework for end-of-life care, including medical aid in dying, so

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<sup>256</sup> *Ibid* at paras 71-72. *Murray-Hall* was recently followed in a Manitoba case (the only other province, along with Quebec, to completely prohibit home cultivation of cannabis). The Manitoba Court of King's Bench affirmed the constitutionality of Manitoba's prohibition, noting that, although its legislation differed from the Quebec regime upheld in *Murray-Hall* (it did not create a provincial monopoly on cannabis and did not explicitly mention "health and safety"), it was within the jurisdiction of the province to enact. The court was satisfied, following *Murray-Hall*, that the statute's purposes were valid, as it was intended to advance the objectives of public health and safety by "protect[ing] against access to cannabis by children in the home, and to prevent excess product from finding its way into the unregulated market"; the dominant purpose was not "to suppress a social evil or condemn an activity to which the legislature generally disapproved" but rather to "*Lavoie v. The Government of Manitoba*, 2023 MBKB 146 at paras 74-76.

<sup>257</sup> *Ibid* at para 74, citing *Schneider*, *supra* note 185 at 132-33 [emphasis added].

that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.”<sup>258</sup>

The Quebec government’s recent express exclusion of MAID for mental disorders is rooted in a legislative committee’s extensive study of various clinical and medical-ethical considerations.<sup>259</sup> That committee identified the difficulties associated with determining whether mental disorders are incurable and irreversible, distinguishing between suicidal ideation and a desire to obtain MAID, balancing the right to self-determination with the protection of vulnerable persons, and the adverse impacts that MAID MI-SUMC would have on suicide prevention and therapeutic relationships.<sup>260</sup> All of these considerations are directly related to public health and security. At the conclusion of this study, Quebec’s Select Committee on the Evolution of the *Act respecting end-of-life care* expressed concern about the “differences of opinion that persist within the medical profession about the incurability of mental disorders and the irreversible decline in capability that may be associated with them” and “therefore recommended that access to medical aid in dying not be made available to persons whose only medical condition is a mental disorder.”<sup>261</sup>

This exclusion, like the impugned provisions in *Murray-Hall*, is part of a larger legislative scheme within the province’s constitutional competence. And like the impugned provisions in *Murray-Hall*, it reflects health and safety concerns about an act (MAID MI-SUMC) that do not disappear with its decriminalization.

It should be noted here that when the Quebec Superior court in *Truchon* found the Quebec EOL law’s “end-of-life” restriction unconstitutional, it was *not* on the basis that the Quebec law deviated from or was narrower than the federal MAID law (which the Court also found unconstitutional).<sup>262</sup> Additionally, it is worth recalling that the Court

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<sup>258</sup> *Quebec EOL Law*, *supra* note 48, s 1. Note that, following Bill 11, *supra* note 47, “medical aid in dying” was expressly added to the purpose text.

<sup>259</sup> See Quebec, National Assembly, Select Committee on the Evolution of the Act respecting end-of-life care, *The report of the Select Committee on the Evolution of the Act respecting end-of-life care* (December 2021) (Chair: Nancy Guillemette) online: <assnat.qc.ca> [perma.cc/678F-CHUD].

<sup>260</sup> *Ibid* at 47, 49-50, 54-55.

<sup>261</sup> *Ibid* at 61.

<sup>262</sup> That said, the Court did consider the distinction between the two laws as part of the

identified that the respective laws had different objectives. That is, according to the Quebec Superior Court, the objective of the federal MAID law was the protection of “vulnerable persons who might be induced to end their lives in a moment of weakness, by preventing errors when assessing requests for medical assistance in dying;<sup>263</sup> whereas the provincial EOL legislation was identified as having a twofold purpose: end-of-life care (because it relieves suffering at end of life) and the “recognition of dignity and autonomy”.<sup>264</sup> Although the court ultimately struck down certain provisions contained in that law for Charter reasons (pertaining to the EOL criterion), the constitutional validity of these provincial *objectives* were never questioned.

One can see how Quebec’s exclusion of mental disorders from MAID eligibility would actually *further* these valid provincial objectives. It would be reasonable to conclude, for example, that the purpose of the exclusion is not the prohibition itself, but a *means* of steering patients towards health care that the province has deemed medically efficacious and clinically appropriate in relieving suffering and affirming the dignity and autonomy of patients, in a way that also supports provincial suicide prevention efforts and the prevention of harm to patients’ health and security. In other words, the legislature, after a careful study of complex policy considerations, may choose to prioritize life-affirming mental health care and supports – not death – as the best model and therapeutic medical response to suffering associated with mental disorders.

Depending on the evidence and context, it would be open to a court to conclude that a legislative exclusion of mental illness for MAID eligibility is not punitive, nor aimed at “morally suppressing [it] as such”.<sup>265</sup> Rather, a court could find the provincial regulatory scheme to be, like the law upheld in *Murray-Hall*, concerned with protecting the health and security of the public – including vulnerable persons – from harm, and of advancing the legitimate legislative purposes recognized in *Truchon*: relieving suffering (in

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legal context for the purposes of the Section 15 analysis in respect of the Quebec EOL law. See *Truchon*, *supra* note 9 at para 703. See also discussion above at *supra* note 153 et seq and accompanying text as well as *supra* notes 210, 216 and accompanying text.

<sup>263</sup> *Truchon*, *supra* note 9 at para 556 [emphasis added]. See also note 154, *supra*.

<sup>264</sup> *Ibid* at paras 724-725.

<sup>265</sup> *Murray-Hall*, *supra* note 53 at para 15.



this case, by means *other* than by their premature death) and the recognition of dignity and autonomy.

## 2. *When does a provincial law “frustrate” a federal law?*

But even if a provincial law restricting MAID is grounded in a legitimate provincial head of power, another question remains: by restricting MAID or introducing additional safeguards that have the effect of making it less immediately accessible than it otherwise would be, are the provinces unconstitutionally frustrating the *Criminal Code*’s more permissive approach? It has been argued that the provinces cannot “restrict the circumstances in which physician-assisted dying is permitted beyond those validly provided for by Parliament”.<sup>266</sup> Is this accurate?

The Supreme Court’s analysis in *Murray-Hall* indicates that the answer to this question is “no”, at least in appropriate circumstances. The provinces have a clear constitutional basis for legislative action in the field of public health, even where such matters “touch on purposes that otherwise constitute valid criminal law purposes”.<sup>267</sup> As earlier described, when Parliament partially decriminalizes a practice – be it the cultivation of cannabis plants or physician-assisted suicide – it “open[s] the door to provincial legislative action” and “leaves the field clear for the provinces to enact their own prohibitions”, as long as they “serve to enforce laws relating to matters within provincial jurisdiction”.<sup>268</sup> Under the “double aspect doctrine”, provincial legislation may apply and operate concurrently with federal legislation, because there are a number of matters – including MAID – that “by their very nature, have both a federal aspect and a provincial aspect”.<sup>269</sup>

This doctrine has application even where a provincial law is more restrictive than an overlapping federal criminal law. This is because the criminal law power has an “essentially prohibitory nature” and it cannot create positive rights immune from any and all provincial limits.<sup>270</sup> As the

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<sup>266</sup> *Provincial-Territorial Report*, *supra* note 202 at 16.

<sup>267</sup> *Murray-Hall*, *supra* note 53 at para 69.

<sup>268</sup> *Ibid* at paras 68 and 71.

<sup>269</sup> *Ibid* at para 76, (references omitted), citing *Desgagnés Transport Inc v Wärtsilä Canada Inc.*, 2019 SCC 58 at paras 84-85; *Reference re Securities Act*, 2011 SCC 66 at para 66.

<sup>270</sup> *Murray-Hall*, *supra* note 53 at para 83.

Supreme Court explains, “when exceptions are carved out for practices that Parliament does not wish to prohibit, this ‘only means that a particular practice is not prohibited, not that the practice is positively allowed by the federal law’...the creation of positive rights is not a valid exercise of the criminal law power”.<sup>271</sup>

The Supreme Court’s thorough analysis on this point in *Murray-Hall* is worth reproducing at length:

The purpose of the federal Act’s provisions is not to create a positive right to self-cultivate cannabis as part of a broader objective of limiting the influence of organized crime. Such a purpose would be inconsistent with the fact that “the criminal law power is essentially prohibitory in character” (*Rothmans*, at para. 19), a fact that has been recognized in Canadian law since the leading case of *Proprietary Articles Trade Association v. Attorney General for Canada*, [1931] A.C. 310 (P.C.). As McLachlin C.J. noted in *Reference re AHRA*, “[t]he federal criminal law power may only be used to prohibit conduct” (para. 38). [...]

The guidance provided in *Rothmans* is relevant for the purposes of this appeal. In my view, the principles arising from that case are determinative of the issue of the operability of the impugned provisions. The question in *Rothmans* was whether provincial legislation that prohibited the promotion of tobacco products in any place accessible to young persons frustrated the purpose of federal legislation that prohibited the promotion of tobacco products except in retail businesses. The Saskatchewan Court of Appeal had found that the provincial legislation negated the authorization otherwise afforded by the federal legislation for the promotion of tobacco in retail businesses. This Court came to a different conclusion, stating that “Parliament did not grant, and could not have granted, retailers a positive entitlement to display tobacco products” (para. 18 (emphasis added)). In addition, statutes enacted pursuant to the criminal law power “do not ordinarily create freestanding rights that limit the ability of the provinces to legislate in the area more strictly than Parliament” (para. 19 (emphasis added)).

The principle to be drawn from these excerpts is that the making of exceptions or exemptions under a criminal law scheme cannot serve to confer positive rights to engage in the activities covered by those exceptions or exemptions. This is an important point in a case like the one before us. The provinces can legitimately undertake regulatory initiatives to provide a framework for decriminalized activities without thereby frustrating a purpose — the creation of positive rights — that by definition is outside the scope of the federal criminal law power.

... I cannot accept that exceptions or exemptions made under a scheme of criminal offences may give rise to positive rights, even where the exceptions or

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<sup>271</sup> *Ibid* at paras 90, 95, quoting *Reference re Assisted Human Reproduction Act*, 2010 SCC 61 at para 38.

exemptions are closely related to the achievement of criminal law purposes. [...] The recognition of positive rights created out of exceptions or exemptions closely related to a valid criminal law purpose would improperly extend the scope of the federal criminal law power.<sup>272</sup>

The Supreme Court's analysis here is noteworthy for a few reasons. First, it articulates an important principle: the removal of a criminal prohibition does not establish a positive right. This must be borne in mind when contextualizing various elements of the "rights rhetoric" surrounding MAID.<sup>273</sup> To the extent that a legal "right" to access a decriminalized service exists – including MAID – it is not as a freestanding, positive right. In other words, there is no automatic corollary right to demand that a third party, or the state, provide it. The *Criminal Code* only regulates criminal liability, and in this regard, its MAID provisions simply specify the circumstances in which a willing medical or nurse practitioner can voluntarily participate in the termination of another person's life, at their request and with their consent, without risk of criminal sanction. The criminal law does not – and can not – mandate any practitioner to terminate a patient's life, nor does it – or can it – require provinces to implement and incorporate such a procedure as part of its provincial health care program. To the extent that the *Charter* is engaged, it is only as a shield against unconstitutional state restrictions on a practitioner's voluntary participation in MAID in certain circumstances, not as a sword to *compel* medical or nurse practitioners, hospitals, or provincial health care systems to actively provide and finance it. As the Supreme Court of Canada has emphasized, "[t]he Charter does not confer a freestanding constitutional right to health care" – even for procedures that aren't criminally regulated like MAID.<sup>274</sup> The *Criminal Code* is also explicit that nothing in its provisions "compels an individual to provide or assist in providing medical assistance in dying".<sup>275</sup> Similarly, it

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<sup>272</sup> *Murray-Hall*, *supra* note 53 at paras 90, 96-97, 99 [emphasis added].

<sup>273</sup> For further discussion on "rights rhetoric" surrounding MAID, see Trudo Lemmens, "When Death Becomes Therapy: Canada's Troubling Normalization of Health Care Provider Ending of Life", (2023) 23(11) *The American Journal of Bioethics* 79-84 [Lemmens, "Death as Therapy"].

<sup>274</sup> Chaoulli, *supra* note 207 at para. 104 (S.C.C.). See also *Auton* (Guardian ad litem of v. British Columbia (Attorney General), [2004] S.C.J. No. 71, [2004] 3 S.C.R. 657, 2004 SCC 78 (S.C.C.), *Flora v. Ontario* (Health Insurance Plan, General Manager), [2008] O.J. No. 2627, 91 O.R. (3d) 412, 2008 ONCA 538, at para. 108 (Ont. C.A.).

<sup>275</sup> *Criminal Code*, s. 241.1(9). Some provincial physicians' colleges have, however, introduced policies requiring health care professionals to participate through the

has “never been the case that all hospitals must provide all health services.”<sup>276</sup> Contrary to popular rhetoric, then, there is no positive “right” to MAID – or any other procedure – at least not as a publicly-funded health care service.

Second, *Murray-Hall* does not attach any exceptions to the basic rule that the criminal law cannot create a *positive* right to an activity or service. This principle is not limited to certain *kinds* of criminal law provisions, nor to the specific facts of *Murray-Hall* (unlike the Declaration in *Carter*).<sup>277</sup> Thus, while one might point to certain differences between the impugned law in *Murray-Hall* and Quebec’s Bill 11, for example, the legal principles enunciated by the Court are what must govern the analysis. Those legal principles make clear that decriminalizing an act or service does not, in itself, prevent a province from regulating or even potentially restricting it, provided it is doing so for a constitutionally legitimate purpose.

Third, nowhere in *Murray-Hall* does the Supreme Court suggest that a province can only regulate a decriminalized service so long as it does not ultimately restrict *access* to it. Quebec was found constitutionally competent to completely prohibit an act that Parliament had decriminalized (self-cultivation of marijuana). In affirming this, the Supreme Court cited another case where Saskatchewan was also found constitutionally

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provision of “effective referrals”. For discussion on these types of policies and concerns about their impact on medical conscience and independent clinical and ethical decision-making, see: Derek Ross and Deina Warren, “The Importance of Conscience as an Independent Protection” in Jaro Kotalik & David W. Shannon, eds., *Medical Assistance in Dying (MAID) in Canada: Key Multidisciplinary Perspectives* (Cham, Switzerland: Springer, 2023); Mary Ann Waldron, “Conscientious Objections to Medical Aid in Dying: Considering How to Manage Claims of Conscience in a Pluralistic Society” (2018) 85 SCLR (2d); Brian Bird, “The Call in *Carter* to Interpret Freedom of Conscience” (2018) 85 SCLR (2d), 107-141.

<sup>276</sup> John J Morris, Cynthia Clarke & Anna Marrison, “The Canadian Charter of Rights and Freedoms: Legal Rights: Section 7 – Right to Life, Liberty and Security of the Person” in *Law for Canadian Health Care Administrators*, 3rd ed (Toronto: LexisNexis Canada, 2021).

<sup>277</sup> Indeed, as Jesse Hartery observes, even prior to *Murray-Hall*, the Supreme Court unanimously held that that the criminal law power “does not allow Parliament to create positive entitlements. Rather, it is properly limited to the suppression of an ‘evil or injurious or undesirable effect upon the public,’ and is not a license to regulate intra-provincial trade and health.” See Jesse Hartery, “Federalism and the Paramountcy Doctrine”, 2023 32-1 Constitutional Forum 9, 2023 CanLIIDocs 1261, <<https://canlii.ca/t/7n4jz>> (references omitted).

competent to completely prohibit an act that Parliament had decriminalized (promotion of tobacco in retail businesses accessible to young persons).<sup>278</sup>

If it were otherwise – if the federal government’s decriminalization of a procedure *required* provinces to provide it – this would undercut the provinces’ jurisdiction and autonomy to, for example, regulate health care in a manner consistent with local needs. This point was made by Chief Justice McLachlin in the *Assisted Human Reproduction Act Reference*:

In my view, the requirement that a criminal law contain a prohibition prevents Parliament from undermining the provincial competence in health. The **federal criminal law power may only be used to prohibit conduct, and may not be employed to promote beneficial medical practices.** Federal laws (such as the one in this case) may involve large carve-outs for practices that Parliament does not wish to prohibit. However, **the use of a carve-out only means that a particular practice is *not* prohibited, not that the practice is positively allowed by the federal law.** This has important implications for the doctrine of federal paramountcy. **If a province enacted stricter regulations than the federal government, there would be no conflict in operation between the two sets of provisions since it would be possible to comply with both.** Further, there would be no frustrations of the federal legislative purpose since federal criminal laws are only intended to prohibit practices. **A stricter provincial scheme would complement the federal criminal law.**<sup>279</sup>

Therefore, provincial regulation or restriction of MAID will not be deemed inoperative for conflicting with the *Criminal Code* simply because they have the *effect* of limiting access to MAID that might otherwise be more accessible pursuant to permissive criminal law. There must be a conflict of *purposes*. The purpose of a criminal law exception can never be to create a *positive entitlement* to something, but simply to *allow* it, subject to limits which other levels of government are constitutionally authorized to impose and maintain.

#### D. Application to MAID

The above principles as discussed in *Murray-Hall* demonstrate how a province may, as Quebec has done, exclude assisted death for mental disorders from its health care regime. Whether such an exclusion will unconstitutionally conflict with federal law will depend on its *purpose*, which courts will assess based on “the actual text of the law, including its preamble

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<sup>278</sup> See *Rothmans, Benson & Hedges Inc v Saskatchewan*, 2005 SCC 13.

<sup>279</sup> Reference re *Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 S.C.R. 457 at para. 38. Emphasis added.

and purpose clauses, as well as extrinsic evidence, such as parliamentary debates and minutes of parliamentary committees”.<sup>280</sup>

If the purpose of the provincial law is to protect health and security as part of a larger health care regime (one aimed at suicide prevention and life-affirming care and supports, for example), it will very likely not be seen as conflicting with federal purposes. On the other hand, if the purpose were, by contrast, to condemn or suppress an act as a public or social “evil”, it would likely be seen as conflicting with the federal criminal power.<sup>281</sup>

To summarize, the Supreme Court has made it clear that the decriminalization of an act – in this case, MAID – does not, in itself, create a positive right to it. The criminal law may only *prohibit* conduct – it cannot *compel* provinces to allow or facilitate it. Furthermore, provinces may potentially restrict activities which Parliament has decriminalized, provided they do so for purposes clearly grounded in their heads of power set out in s. 92 of the *Constitution Act, 1867*. Regulating health care services and protecting the health and security of the public are clear examples of such purposes within provincial zones of competence.

All of this supports the conclusion that provinces may restrict the circumstances in which MAID is performed as a publicly funded health care service. In the authors’ view, this authority potentially allows provinces to exclude, as a matter of public health policy, MAID MI-SUMC from their respective health care systems.

Excluding MAID MI-SUMC is still subject to the Charter, of course, and would likely face future arguments that such an exclusion infringes Section 7 right to life and/or Section 15 equality rights. However, as discussed in Part II, no Canadian court has yet ruled on this question. There is no court ruling dictating that Parliament must decriminalize assisted death for mental illness as a sole underlying condition, much less that provinces must offer it as a publicly funded health care service. Additionally,

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<sup>280</sup> *Murray-Hall*, *supra* note 53 at para 25.

<sup>281</sup> Provinces may also want to regulate where and how MAID could be offered. For example, private funeral homes have started to offer MAID in Ontario and Quebec, and the Quebec legislature debated whether this should be permitted. Conflict of interest concerns may arise in the context of funeral homes renting out space for MAID, which the provinces can legitimately regulate. There has also been discussion about offering MAID in public spaces, for example in public parks. Rules about use of such property and public spaces fall under provincial jurisdiction, even if some of the rules may touch on issues of public morality.

there is no guarantee that such challenges would be successful. And even short of a complete exclusion from their health care systems, as discussed above, provinces nonetheless have wide constitutional authority to regulate MAID MI-SUMC including adding additional substantive eligibility criteria and procedural safeguards as a matter of health care policy.

It is important to note that, to date, the federal government has opted not to introduce any additional requirements to the *Criminal Code* MAID provisions if and when MAID MI-SUMC becomes permitted,<sup>282</sup> despite concerns and calls to the contrary.<sup>283</sup> To borrow from the words of *Murray-Hall*, concerns about MAID MI-SUMC simply do not disappear merely because it has been decriminalized.

### ***1. Future considerations***

The above discussion has focused on MAID MI-SUMC as a case study, but the reasoning discussed herein may also apply to other contexts where provinces wish to prioritize medical supports other than termination of life in furtherance of their larger health care schemes. The effect of doing so may be to more strictly regulate MAID than the federal law, but that would not necessarily be fatal to the provincial regime in question.

For example, in the same way that Quebec has excluded mental disorders (again, with the exception of neurocognitive disorders) as a basis for MAID eligibility, another province might decide to exclude MAID for non-terminal illnesses from its provincially-sponsored health care system, and adopt something similar to Bill C-14's "reasonably foreseeable death" safeguard. While that safeguard was invalidated by a single judge in Quebec, that decision (*Truchon*) is not binding on other provinces, and because the federal government declined to appeal it, its reasoning has yet to be reviewed by the Supreme Court of Canada (or any appellate court, for that matter). And, as mentioned, several have put forward in the very opposite direction, reasonable arguments in support of the claim that the expansion outside of the end-of-life context itself is open to a Charter challenge.

Furthermore, the purpose of new provincial legislation in respect of MAID would be different from that of the federal MAID provisions and as such, with the exception of Quebec's specific provisions reviewed in *Truchon*, has not been judicially examined. Similarly, as Parliament

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<sup>282</sup> The repeal of the exclusion from eligibility for MAID MI-SUMC is to take place on March 17, 2024. See *Bill C-39*, *supra* note 6.

<sup>283</sup> See *supra* notes 11-14.

considers expanding MAID in cases of diminished capacity (i.e. via “advance request”), or for mature minors,<sup>284</sup> provinces might also decide to adopt a

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<sup>284</sup> See Special Joint Committee on Medical Assistance in Dying, *Medical Assistance in Dying in Canada: Choices for Canadians* (February 2023) at 61, 73 (Chairs: Marc Garneau & Yonah Martin), which recommended that the federal government “amend the eligibility criteria for MAID set out in the *Criminal Code* to include minors deemed to have the requisite decision-making capacity upon assessment” and to also “to allow for advance requests following a diagnosis of a serious and incurable medical condition disease, or disorder leading to incapacity.” But see the federal government’s response to the report, which noted that these proposals “require further consideration, consultation, and study” and that any specific reform “would require a significant amount of work with provinces and territories to implement.” The Government Response also acknowledged that “MAID crosses federal, provincial, and territorial jurisdictions. Certain aspects of MAID fall under federal jurisdiction, such as the criminal law dimensions, whereas others fall under provincial and territorial jurisdiction, such as health care delivery”: Hon Jean-Yves Duclos, “Government Response to the Second Report of the Special Joint Committee on Medical Assistance in Dying” (13 June 2023) at 1, 7, online (pdf): <parl.ca.> [perma.cc/QFY5-4ZBJ]. Note that Quebec, while excluding mental disorders from assisted death eligibility, expanded its EOL law to permit assisted death pursuant to advance request. See Quebec EOL law, *supra* note 48 at Chapter IV, Division II, §3. We note, however, that to the extent that Quebec’s law is more *permissive* than the federal *Criminal Code*’s prohibitions, it would likely be rendered inoperative for offending the constitutional doctrine of paramourty. See, e.g. *Québec (Procureur général) c. D’Amico*, 2015 QCCA 2138 [“*Saba*”]. There, although the Quebec Court of Appeal upheld Quebec’s more permissive EOL law in the face of a total criminal prohibition on MAID, it did so because the federal law had recently been found unconstitutional in *Carter*, and therefore, in the court’s view, there was no conflict with a “valid” federal law. This decision generated some criticism as the federal law was technically still in effect at the time (*Carter*’s declaration of invalidity had been suspended for one year). That dimension of the decision aside, we note that *Saba* did state that “[i]f Parliament eventually enacts valid federal legislation with respect to medical aid in dying that applies to Quebec, the provisions of the *Act respecting End-of-Life Care* that concern medical aid in dying will need to be re-examined to determine whether they are in conflict with that legislative framework” (at para. 44, emphasis added). This comment was made in the context of conflicts created by a more *permissive* Quebec regime. In the case of a more *restrictive* provincial regime, as discussed in this paper, there may not be any conflict of purposes, since the purpose of the criminal law cannot be to create positive rights. It is also noteworthy that the Court of Appeal in *Saba* emphasized the provinces’ jurisdiction to legislate around MAID (at para. 41) and described Quebec’s EOL Law as “legislation with respect to health which falls within Quebec’s legislative jurisdiction” (see para. 42). Thus there is support, from at least one appellate court, for provincial jurisdiction to implement its own “strong framework for controlling medical aid in dying, thereby limiting the risks involved” (at para. 42).



more restrictive approach, based on medical, public health, and security considerations.<sup>285</sup>

We would also observe that the analysis in *Murray-Hall* could also support new possibilities for *federal* regulation. The Court confirmed that a federal law may have, as its legitimate constitutional objective under s. 91(27), the prohibition of an act *for the purpose of prohibiting it* – be it as an “evil” or an act having an “injurious or undesirable effect on the public”.<sup>286</sup> Thus, it potentially remains open for Parliament to re-enact a restriction on MAID for individuals who are not dying, not only for “the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness”,<sup>287</sup> but to suppress consensual homicide in such contexts because it has been deemed inherently “injurious or undesirable” for individuals and for society. Such a conclusion may, for example, be informed by the concerns of disability advocates, human rights experts, and

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<sup>285</sup> Similar to MAID in cases of mental illness, we note that there is no court directive compelling Parliament to introduce MAID for mature minors or through advance requests. *Carter’s* Paragraph 111, discussed in detail above, stated that “euthanasia for minors” would “not fall within the parameters suggested in these reasons”, and the Court referred only to “adults” throughout the decision, including the final Declaration. Similarly, the Court’s reasons only discussed MAID in cases where a *competent* adult “clearly consents” (present-tense) to the termination of life. The Court made no reference to the possibility of MAID for patients who have lost competence (and therefore can’t provide contemporaneous consent), based on a prior request. No subsequent court decision has suggested that safeguards which limit MAID eligibility to competent, contemporaneously consenting adults are unconstitutional. The BC Court of Appeal interpreted *Carter* to require that “when assisted suicide is legalized, it must be conditional on the on the ‘clear consent’ of the patient”, and noted that courts should be “assiduous in seeking to ascertain and give effect to the wishes of the patient in the ‘here and now’, even in the face of prior directives” (*Bentley v. Maplewood Seniors Care Society*, 2015 BCCA 91 para 18). In *Truchon*, the court emphasized that the questions of whether MAID should be made available for minors, or for incapable persons based on prior requests, were “not at issue” in the case (para 16). A full discussion of potential Charter issues in these areas is beyond the scope of this paper, but we would note that much of the discussion herein with respect to MAID for mental illness has equal relevance to the matters of MAID for minors or for advance requests. Subject to Charter considerations, these practices are within the jurisdictional scope of Parliament to criminally prohibit, and, even if decriminalized, would be within the power of the provinces to restrict or further regulate in accordance with their jurisdiction over health care.

<sup>286</sup> *Murray-Hall*, *supra* note 53 at para 77.

<sup>287</sup> *Carter 2015*, *supra* note 39 at para 78.

health care professionals, who have pointed to the harms of offering death as a “solution” for – and only for – disability-related suffering<sup>288</sup> as well as current data indicating that “[t]he Canadian MAiD regime is lacking the safeguards, data collection, and oversight necessary to protect Canadians against premature death”.<sup>289</sup> It could also be supported by international human rights instruments Canada has signed, including the *Convention on the Rights of Persons with Disabilities*, as discussed above.

One can see how the suppression of an injurious act is the purpose of existing *Criminal Code* provisions like s. 14 (which states that no person can “consent to have death inflicted on them”) - a provision which was partially invalidated by the Supreme Court *Carter* decision without any discussion as to its purpose in that case. Why does the *Criminal Code* prohibit inflicting death upon another person, even with their consent, if not to suppress it as an inherently injurious act?

Of course, if such a prohibition were federally re-enacted with a clearly stated purpose of suppressing MAiD in cases where a patient is not already dying, it could still be challenged under the Charter. But a fresh analysis would be required to determine whether it is overbroad, arbitrary, or grossly disproportionate contrary to Section 7. And unlike the purpose examined in *Carter* - “the protection of vulnerable persons from being induced to commit suicide at a time of weakness” - it is difficult to see how a prohibition of termination of life outside the end-of-life context goes further than necessary to achieve its purpose, namely, *suppressing it as such* as a public or social harm.<sup>290</sup> There may be other grounds to challenge such a law - under Section 15, for example - and a full discussion of its constitutionality is beyond the scope of this paper. But it is worth noting that this too is an area in which Parliament may have more room to legitimately legislate than some might suggest.

## IV. CONCLUSION

Contrary to what some have argued, the courts have not clearly directed legislatures to allow MAiD for mental illness. Instead, they have expressed some caution and an inclination to defer to legislative deliberations on this

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<sup>288</sup> See *supra* notes 12-15, 38.

<sup>289</sup> Coelho et al, “Realities”, *supra* note 104.

<sup>290</sup> For further discussion, see Sikkema, *supra* note 41.

issue. Canadian courts *have* declined to allow MAID for patients who are clinically depressed and/or suicidal, by ruling out the presence of certain psychiatric conditions and/or suicidality.<sup>291</sup> And courts *have* stated that MAID should be subject to an “almost-absolute prohibition”.<sup>292</sup> They have also affirmed that a high degree of deference is owed to legislators regarding MAID, especially in the context of a “complex regulatory response”, which is better created by the legislature than by the courts.<sup>293</sup> In our view, a degree of deference which the *Carter* decision recognized should already have been a reason to defend the original end-of-life focused MAID law (Bill C-14). This call for deference would certainly need to be taken into account if Parliament or the provinces were to decide to prohibit or restrict MAID for mental illness based on complex medical, clinical, ethical, and social considerations, including those related to provincial jurisdiction over health care.<sup>294</sup>

Thus far, the federal government has ignored calls to seek a reference to the Supreme Court of Canada for its opinion with respect to some of these issues. Similarly, the Attorney General refused to appeal the *Truchon* decision, which would have permitted the Supreme Court to opine on whether a safeguard of reasonably foreseeable death was indeed unconstitutional and irreconcilable with the parameters it issued in *Carter*. Expanding MAID now further, shouldering the “obviously irreversible and heavy”<sup>295</sup> consequences of a MAID MI-SUMC regime on the basis that advocates have simply *argued* that the *Charter* requires it, is in our view an abdication of the constitutional role bestowed upon legislators: to wrestle with “complex issues of social policy and a number of competing societal

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<sup>291</sup> See e.g. *Truchon*, *supra* note 9 at paras 232 and EF *supra* note 52 at para 7.

<sup>292</sup> *Carter BCSC*, *supra* note 42 at para 1283.

<sup>293</sup> *Ibid* at para 1174, citing *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at para 37.

<sup>294</sup> For a survey of some of these considerations, see, K Sonu Gaiind, et al, “Normalizing Death as ‘Treatment’ in Canada: Whose Suicides do we Prevent, and Whose do we Abet” (2022) 68:3 World Medical J; See also Alexander Simpson, Jason Tran & Roland Jones, “Ethical considerations regarding mental disorder and medical assistance in dying (MAiD) in the prison population” (2023) 63:1 Medicine, Science & L 3.

<sup>295</sup> This was the language used by the Quebec Superior Court to describe medical assistance in dying in *Truchon*, *supra* note 9 at para. 156.

values” to determine the appropriate boundaries of *everyone’s* rights in accordance with the principles of a free and democratic society.<sup>296</sup>

Simply asserting that the Charter requires Canada to offer MAID for mental illness, when, in fact, no court has stated so, and with the arguments remaining untested, not only risks misleading the public – it pre-empts their opportunity to contribute, through the democratic process, to the determination of what justice actually requires in this context. Similarly, it suppresses meaningful medical and ethical discourse on what constitutes appropriate health care and what services are – and are *not* – clinically appropriate medical solutions to mental disorders.

The determination of what is “clinically appropriate” should not be dictated by what is purportedly “constitutionally required”. In fact, it is the other way around: clinical experience and medical expertise must help *inform* the analysis of what constitutes a reasonable legislative regime in a free and democratic society under section 1 of the Charter. As the trial judge noted in *Carter*, ethical principles appropriately help shape the law and enter into constitutional analysis,<sup>297</sup> and “both legal and constitutional principles are derived from and shaped by societal values.”<sup>298</sup>

Thus, health care professionals and their organizations should not feel pressured to embrace certain practices as “good medicine” simply because some have asserted that the constitution “requires” it.<sup>299</sup> What the

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<sup>296</sup> Carter 2015, *supra* note 39 at para 98; see also Canadian Charter of Rights and Freedoms, s 1, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.

<sup>297</sup> See Carter BCSC, *supra* note 42 at para 165.

<sup>298</sup> *Ibid* at para 317.

<sup>299</sup> This point was also made in Scott Kim, “In Canada, MAID Has Become a Matter of Ideology”, *The Globe and Mail* (25 February 2023), online: <[theglobeandmail.com](https://www.theglobeandmail.com/perma.cc/H3BT-N3L7)> [perma.cc/H3BT-N3L7]. The fact that professional organizations, political decision makers, and even individual practitioners, are seemingly uncritically accepting this claim, is in our view a serious issue. It raises fundamental questions about how expert evidence should inform policy making, and about inherent limitations of judge-made law in relation to complex policy and medical questions. It also seems to us difficult to reconcile an arguably all-too-easy invocation of ‘the courts require us to do so’ with the doctrine of ‘constitutional dialogue’ which has been firmly embraced in Canadian constitutional law (see Peter W Hogg & Allison A Bushell, “The Charter Dialogue between Courts and Legislators (Or perhaps the Charter of Rights Isn’t Such a Bad Thing After All)” (1997) 35 *Osgoode Hall LJ* 75.) This is particularly so when a single lower court decision is used to shape such an important area of new social policy making for the entire country. For further discussion see Paul Yowell, *Constitutional Rights*

constitution actually requires is that decision-makers carefully consider all of the evidence, including the insights and recommendations of health care professionals with clinical experience and expertise in supporting those with disabilities and mental disorders, in determining what is “reasonable” in a “free and democratic society”.<sup>300</sup>

The Constitution is not a governmental tool for political expedience. It does not excuse governments from justifying contentious policies nor is it a political shortcut to bypass challenging work – it is a mandate requiring legislators to meaningfully engage in it.

For the Constitution to work effectively, it requires courage: courage from professionals and their organizations to challenge prevailing narratives where necessary – even where doing so is unpopular – and to offer decision-makers, the courts, and society insights based on their special knowledge, experience, and expertise. It also requires courage from political decision-makers to wrestle with that evidence, and to develop legislative and regulatory regimes that offer adequate protection, within the context of constitutional constraints. It sets a precarious precedent when policy changes with major societal implications are pushed through on the basis of self-imposed, fictitious, or even prematurely perceived judicial constraints.

Certain assumptions appear to be driving current Canadian law and policy as it relates to MAID. This paper has sought to identify and challenge some of these assumptions with the hopes of providing increased clarity with respect to the constitutional parameters surrounding MAID. In so doing, it is hoped that this work might help to ensure that further dialogue and decision-making concerning MAID is more fully informed.

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and *Constitutional Design: Moral and Empirical Reasoning in Judicial Review*. (Oxford: Hart Publishing, 2018). As one of us formulated it elsewhere: “Proportionality review embedded in constitutional or human rights-analysis must be informed by evidence-informed clinical, policy and ethical arguments. Yet, in Canada, rights rhetoric largely replaced evidence-informed debate.” Lemmens, “Death as Therapy”, *supra* note 273 at 80. We cannot discuss these questions here in detail, but our analysis could also inform further debate about these broader questions.

<sup>300</sup> As discussed above, many mental health experts maintain that it is impossible to predict irremediability confidently in individual cases. The claim of the ‘right to access MAID’ is thus invoked in the context of the ongoing debate between psychiatric experts. The explicit authorization embedded in the legislation to allow MAID for mental illness seemingly also includes an acceptance of the argument that its “irremediability” can be assessed. This makes it so much more important to critically examine the claim that ‘the courts oblige us to’.