



LEGISLATIVE SUMMARY



Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)

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Legislative Summary of Bill C-14
(Legislative Summary)

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APPENDIX – MEDICAL ASSISTANCE IN DYING

LEGISLATIVE SUMMARY OF BILL C-14: AN ACT TO AMEND THE CRIMINAL CODE AND TO MAKE RELATED AMENDMENTS TO OTHER ACTS (MEDICAL ASSISTANCE IN DYING)

1 BACKGROUND

Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)¹ was introduced in the House of Commons on 14 April 2016 by the Honourable Jody Wilson-Raybould, Minister of Justice. **It passed second reading on 4 May and was referred to the House of Commons Standing Committee on Justice and Human Rights. The committee reported the bill back with amendments on 12 May, and the bill was passed by the House of Commons on 31 May.**

The bill received first reading in the Senate the same day and was referred to the Standing Senate Committee on Legal and Constitutional Affairs on 3 June 2016. That committee had done a subject matter study of the bill in May 2016. The committee reported the bill back without amendments on 7 June. The bill was amended in the Senate and was passed on 15 June, and a message was sent to the House of Commons.

The House of Commons considered the Senate amendments and sent a message back to the Senate on 16 June agreeing with some of the amendments, modifying some, and disagreeing with others. The Senate concurred with the House of Commons amendments on 17 June 2016, and the bill received Royal Assent that same day.

The bill sets out the requirements for the provision of medical assistance in dying (MAID) and establishes exemptions to various *Criminal Code*² offences for physicians, nurse practitioners, pharmacists and certain other persons who provide or assist in the provision of MAID.

The bill was developed in response to the Supreme Court of Canada's unanimous decision in *Carter v. Canada (Attorney General)*³ (the *Carter* decision), in which the Court declared that sections 241(b) and 14 of the *Criminal Code*,⁴ which prohibit assistance in terminating life, infringe upon the right to life, liberty and security of the person for individuals who want access to MAID.

To give governments time to respond with legislative changes, the Court suspended its 6 February 2015 declaration so that it would not come into effect for 12 months.⁵ On 15 January 2016, the Supreme Court of Canada granted a motion to extend the suspension of its declaration of invalidity for four additional months. The declaration of invalidity was therefore to come into effect on 6 June 2016.⁶

The issue of MAID (see discussion of terminology below) has been debated in Canada for decades. Before the release of the *Carter* decision, the issue was addressed in:

- various court cases, including the unsuccessful challenge to the *Criminal Code*'s prohibition on assisted suicide in *Rodriguez v. British Columbia (Attorney General)* in 1993;⁷
- private members' bills;
- a number of extensive studies, including a Senate study on euthanasia and assisted suicide in 1995;⁸ and
- a Royal Society of Canada report on the issue.⁹

And as *Carter* was making its way through the courts, Quebec's legislature and government were engaged in detailed study of end-of-life care, including consideration of whether to legalize MAID, which culminated in the introduction of the *Act respecting end-of-life care* in 2014.¹⁰

In response to the *Carter* decision, the federal government established the External Panel on Options for a Legislative Response to *Carter v. Canada* (the External Panel) in the summer of 2015, which provided a report in December 2015 summarizing the consultations it held on the issue.

A Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (the P-T Advisory Group) was established in August 2015 and also reported in December 2015, making a number of recommendations relating to MAID.

Finally, in December 2015, a Special Joint Committee on Physician-Assisted Dying (Special Joint Committee) was established by motions in the House of Commons and in the Senate.¹¹ That committee tabled its report on 25 February 2016.

Quebec's *Act respecting end-of-life care*, the *Carter* decision, the External Panel report, the P-T Advisory Group report and the Special Joint Committee report are summarized briefly below, following an explanation of terminology used with respect to MAID.

1.1 TERMINOLOGY

A number of terms are used in relation to a patient's express wish to end his or her life. The terms "physician-assisted dying" and "physician-assisted death" were used in the *Carter* decision and were subsequently used by the External Panel and the P-T Advisory Group. At the trial level in *Carter*, the plaintiffs submitted that physician-assisted death includes both "physician-assisted suicide," which they defined as

an assisted suicide where assistance to obtain or administer medication or other treatment that intentionally brings about the patient's own death is provided by a medical practitioner ... or by a person acting under the general supervision of a medical practitioner, to a grievously and irremediably ill patient in the context of a patient-physician relationship¹²

and "consensual physician-assisted death," which they defined as

the administration of medication or other treatment that intentionally brings about a patient's death by the act of a medical practitioner ... or by the act of a person acting under the general supervision of a medical practitioner, at the request of a grievously and irremediably ill patient in the context of a patient-physician relationship.¹³

In addition to "assisted suicide," the term "euthanasia" is often used in relation to persons who wish to end their lives. There are different forms of euthanasia:

- As described by the trial judge in *Carter*, "euthanasia" is the "intentional termination of the life of a person, by another person, in order to relieve the first person's suffering."
- "Voluntary euthanasia" is euthanasia performed in accordance with the wishes of a competent person, expressed personally or by advance directive.
- "Non-voluntary euthanasia" refers to euthanasia performed when the wishes of the person are not known.
- "Involuntary euthanasia" is euthanasia performed against the wishes of the person in question.
- "Assisted suicide" is "the act of intentionally killing oneself with the assistance of another person who provides the knowledge, means or both" of doing so.¹⁴

"Euthanasia" as it is used in discussions relating to MAID is normally understood to refer to "voluntary euthanasia" only. In Quebec's *Act respecting end-of-life care*, the term used is "medical aid in dying," which is defined as "care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death."¹⁵ This definition means that voluntary euthanasia, but not assisted suicide, is permitted under its law.

The adoption of the term “medical assistance in dying” was recommended for use in legislation by the Special Joint Committee:

The Committee prefers the term “medical assistance in dying” to “physician-assisted dying,” as it reflects the reality that health care teams, consisting of nurses, pharmacists, and other health care professionals, are also involved in the process of assisted dying.¹⁶

1.2 QUEBEC’S ACT RESPECTING END-OF-LIFE CARE

The introduction in the Quebec legislature of Bill 52, An Act respecting end-of-life care, on 12 June 2013, followed an examination of the issue of MAID by the legislature and the provincial government lasting several years. The Act, which received Royal Assent on 5 June 2014, establishes, among other things,

- rights with respect to end-of-life care;
- rules for those who provide end-of-life care;
- rules relating to continuous palliative sedation;
- powers of the Minister of Health and Social Services;
- rules relating to advance medical directives; and
- rules relating to “medical aid in dying.”

1.3 CARTER V. CANADA (ATTORNEY GENERAL)

In 2012, Gloria Taylor, who had amyotrophic lateral sclerosis (ALS), and the British Columbia Civil Liberties Association challenged the laws prohibiting assisted dying in the courts. They were joined by William Shoichet, a physician willing to provide MAID if it were no longer prohibited by law, as well as by Lee Carter and Hollis Johnson, who had travelled with Ms. Carter’s mother, Kay (who had spinal stenosis), to an assisted suicide clinic in Switzerland where she ended her life.

The trial judge found that the relevant *Criminal Code* provisions (primarily section 241(b) and related sections 14, 21, 22 and 222) violated their rights under sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*. Section 7 of the Charter states that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” Section 15 of the Charter states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The British Columbia Court of Appeal overturned the trial decision on 10 October 2013 in a 2-to-1 decision.¹⁷ This decision was appealed, and on 6 February 2015, the Supreme Court of Canada concluded that sections 14 and 241(b), which prohibit the provision of assistance in terminating life, violated section 7 of the Charter, and declared that those sections

are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.¹⁸

As noted above, the Supreme Court of Canada initially suspended the declaration of invalidity for one year, and then for an additional four months, in response to an application made by the Attorney General of Canada. When the extension of the suspension of the declaration of invalidity was granted in January 2016, certain sections of Quebec's *Act respecting end-of-life care* were exempted, meaning that those provisions were not prevented from taking effect. In addition, when the Court granted the extension of the suspension, it nevertheless allowed a limited form of access to MAID:

We would ... grant the request for an exemption so that those who wish to seek assistance from a physician in accordance with the criteria set out in para. 127 of our reasons in *Carter*, may apply to the superior court of their jurisdiction for relief during the extended period of suspension. Requiring judicial authorization during that interim period ensures compliance with the rule of law and provides an effective safeguard against potential risks to vulnerable people.¹⁹

1.4 THE EXTERNAL PANEL ON OPTIONS FOR A LEGISLATIVE RESPONSE TO *CARTER V. CANADA*

On 17 July 2015, the federal government established the External Panel, which was mandated to carry out consultations and make recommendations for a legislative response to *Carter*. After the federal election in October, the External Panel's deadline to report was extended by the federal Minister of Justice and the federal Minister of Health on the grounds of "limitations posed by the ... election period,"²⁰ and the Panel's mandate was modified to enable them to meet the new deadline. Instead of providing legislative options, the External Panel was asked to provide a summary of its key findings.

In its report, the External Panel summarized consultations relating to the following issues:

- forms of assisted dying and the terminology of assisted dying;
- eligibility criteria;
- how the request for MAID should be made;
- how to assess requests for MAID;
- participation in MAID; and
- system oversight.²¹

1.5 THE PROVINCIAL-TERRITORIAL EXPERT ADVISORY GROUP ON PHYSICIAN-ASSISTED DYING

In August 2015, the P-T Advisory Group was established. Quebec did not participate, and British Columbia had observer status. The P-T Advisory Group's report, released in December 2015, contained 43 recommendations, most of which related to aspects of MAID that would likely fall within provincial jurisdiction. The P-T Advisory Group's key recommendations included:

- establishing a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying;
- establishing a program within the publicly funded health care system to link patients seeking MAID with an appropriate provider;
- amending the *Criminal Code* to allow assisted dying by regulated health professionals acting under the direction of a physician or a nurse practitioner, and to protect health professionals who participate in physician-assisted dying;
- amending the *Criminal Code* to ensure that eligibility for physician-assisted dying is based on competence rather than age;
- having medical regulatory authorities develop guidance and tools for physicians to assist them in making deliberations on a case-by-case basis;
- not requiring a mandatory waiting period between a request and provision of assistance in dying;
- requiring “conscientiously objecting” health care providers to inform patients of all end-of-life options, including physician-assisted dying, and requiring providers to give a referral or direct transfer of care or to contact a third party and transfer the patient's records;
- having provincial and territorial governments establish review committee systems to review compliance in all cases of physician-assisted dying;
- establishing a pan-Canadian Commission on End-of-Life Care (preferably in collaboration with the federal government); and
- providing public education about physician-assisted dying and engaging the public so that it can inform future developments of related law, policies and practices.²²

1.6 THE SPECIAL JOINT COMMITTEE ON PHYSICIAN-ASSISTED DYING

On 11 December 2015, motions were passed in the House of Commons and the Senate to establish the Special Joint Committee

to review the report of the External Panel on Options for a Legislative Response to *Carter v. Canada* and other recent relevant consultation activities and studies, to consult with Canadians, experts and stakeholders, and make recommendations on the framework of a federal response on physician-assisted dying that respects the Constitution, the [Canadian] Charter of Rights and Freedoms, and the priorities of Canadians.²³

The motions directed the committee “to consult broadly, take into consideration consultations that have been undertaken on this issue, examine relevant research studies and literature and review models being used or developed in other jurisdictions.”²⁴ The Special Joint Committee was required to report back to Parliament by 26 February 2016. The committee was made up of five senators and 10 MPs.

It held meetings in January and February 2016, and issued its final report, *Medical Assistance in Dying: A Patient-Centred Approach*, on 25 February 2016.²⁵ The report adopted by the majority contained 21 recommendations comprising a legislative approach to be adopted by Parliament. Throughout the report and its recommendations, the Special Joint Committee emphasized the need for the federal government to work collaboratively with the provinces to ensure consistency among jurisdictions. Among other things, the Special Joint Committee recommended that:

- MAID be available “to individuals with terminal and non-terminal grievous and irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition” (recommendation 2);
- a psychiatric condition should not be a bar to eligibility (recommendation 3);
- the capacity of a person requesting MAID to provide informed consent should be assessed using existing medical practices (recommendation 5);
- competent mature minors should have access to MAID within three years of the coming into force of the provisions relating to MAID for competent adults (and that during that three-year period, the issue of competent mature minors and MAID be examined) (recommendation 6);
- advance requests for MAID should be permitted in certain circumstances (recommendation 7);
- the request for MAID be made in writing and in the presence of two witnesses (recommendation 9);
- the federal government work with the provinces and territories and their medical regulatory authorities to establish a process that respects the freedom of conscience of health care practitioners while respecting the needs of patients, and that objecting health care practitioners should be required to provide an effective referral for a patient (recommendation 10);
- all publicly funded health care institutions provide MAID (recommendation 11);
- MAID be carried out only if two physicians who are independent of one another have determined that the eligibility criteria are met (recommendation 12);
- physicians, nurse practitioners and registered nurses working under the direction of a physician to provide MAID be exempted from sections 14 and 241(b) of the *Criminal Code* (recommendation 13); and
- Health Canada re-establish a Secretariat on Palliative and End-of-Life Care (recommendation 19).

Some of the Conservative MPs who participated in the Special Joint Committee presented a dissenting opinion, stating that:

- allowing future access to MAID for competent mature minors was contrary to *Carter*;
- not requiring a psychiatric assessment by a psychiatric professional for a patient “diagnosed with an underlying mental health challenge” would put vulnerable persons at risk;
- emphasizing that palliative care needed to be “offered and available to any person contemplating [MAID]”; and
- stating that physicians who object to MAID for reasons of conscience should not be required to provide an effective referral, but should instead be required to provide information to patients on how to access MAID.

The New Democrat members of the Special Joint Committee presented a supplementary opinion that emphasized the need:

- to ensure that patients have access to MAID;
- to ensure that health care professionals who object to MAID for reasons of conscience are protected from disciplinary action; and
- to improve palliative care and to support caregivers by improving Employment Insurance Compassionate Care benefits.

For information on how the MAID regime established by Bill C-14 compares with those of other jurisdictions that allow MAID, as well as on how Bill C-14 compares with the recommendations made by the Special Joint Committee on Physician-Assisted Dying, see the appendix.

2 DESCRIPTION AND ANALYSIS

Rather than examining each provision, the description and analysis that follow focus on the substantive changes resulting from the bill.

2.1 PREAMBLE

The preamble to Bill C-14 outlines various factors identified as striking “the most appropriate balance between autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other.”

The preamble also states that the government “has committed to develop non-legislative measures” to improve end-of-life care and to “explore other situations” in which medical assistance in dying may be sought, “namely situations giving rise to requests from mature minors,²⁶ advance requests and requests where mental illness is the sole underlying mental condition.” It also states that the government will develop non-legislative measures “that would respect the personal convictions of health care providers.”²⁷

The preamble was amended during the House of Commons Standing Committee on Justice and Human Rights’ consideration of the bill to include references to freedom of conscience and religion. A clause was also added committing the federal government to working with partners on palliative and end-of-life care, dementia care, and culturally and spiritually appropriate end-of-life care for Indigenous patients.

2.2 DEFINITIONS
(CLAUSE 3)

New section 241.1 of the *Criminal Code* includes a number of definitions that relate to the practice of MAID:

- The term “medical assistance in dying” means:
 - administration of a substance by a medical practitioner or nurse practitioner at the request of a person that causes that person’s death (also known as voluntary euthanasia); or
 - a medical practitioner or nurse practitioner prescribing or providing a substance to a person, at that person’s request, that can be self-administered and that will cause the person’s own death (also known as medically- or physician-assisted suicide).
- A “medical practitioner” is a person entitled to practise medicine according to provincial laws (i.e., a physician in Canada).
- A “nurse practitioner” (NP) is a registered nurse entitled under provincial laws to practise as a nurse practitioner (or equivalent) and autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.
- A “pharmacist” is a person entitled to practise pharmacy under provincial laws.

2.3 ACTS AND INDIVIDUALS TO BE EXEMPTED FROM CRIMINAL LIABILITY
(CLAUSES 1 TO 3 AND 6)

Previously, the *Criminal Code* made it an offence either to kill someone at that person’s request or to assist the person in committing suicide. Bill C-14 amends section 241 of the *Criminal Code* and introduces a new section 227 to allow MAID (both voluntary euthanasia and assisted suicide) if a number of conditions, which are outlined below, are met.

New section 227 states that physicians and NPs do not commit culpable homicide if they provide MAID. In addition, the section provides that an individual who aids a physician or NP to provide MAID is not a party to culpable homicide. It also clarifies that section 14 of the *Criminal Code*, which makes it illegal to consent to one’s own death and clarifies that such consent does not affect the criminal responsibility of a person who inflicts death on another, does not apply with respect to MAID.

Amended section 241 outlines the exemptions from the offence of aiding a suicide and specifies those to whom the exemptions apply.

The exemptions from criminal liability for MAID apply to:

- physicians and NPs who provide a person with MAID, as well as individuals aiding physicians and NPs (new section 227 and amended section 241);
 - pharmacists who dispense a substance prescribed for MAID (new section 241(4)); and
 - persons who aid a person, at that person’s explicit request, to self-administer a substance prescribed as part of the provision of MAID (new section 241(5)).
- The House of Commons Standing Committee on Justice and Human Rights added a “for-greater-certainty” clause to clarify that it is not an offence for health care professionals to provide information about MAID (new section 241(5.1)).**

If a person has a reasonable but mistaken belief about any fact that is an element of the exemption, the exemptions from the offences of homicide or aiding a suicide are available (new section 227(3) and amended section 241(6)).

Clause 6 of the bill amends section 245 of the *Criminal Code* to exempt physicians, NPs and persons assisting them from the offence of administering a noxious thing or poison in relation to MAID.

2.4 CONDITIONS OF ELIGIBILITY (CLAUSE 3)

New section 241.2(1) outlines the conditions required for an individual to be eligible for MAID. Five substantive criteria, **all of which must be met for a patient to be eligible for MAID**, relate to the individual’s circumstances:

- The person is eligible for government-funded health services in Canada or would be, but for a minimum residency or waiting period (new section 241.2(1)(a)).
- The person is at least 18 years old and capable of making decisions with respect to his or her health (new section 241.2(1)(b)).

The Department of Justice online glossary for MAID defines competence and capacity as follows:

A person is mentally competent or capable when they have the capacity to understand the nature and consequences of their actions and choices, including decisions related to medical care and treatments.²⁸

- The person has a grievous and irremediable medical condition (new section 241.2(1)(c)).

The phrase “grievous and irremediable medical condition” is defined in new section 241.2(2) as requiring all of the following criteria:

- the person has a serious and incurable illness, disease or disability;
- the person is in an advanced state of irreversible decline in capability;
- the illness, disease or disability or the state of decline causes enduring physical or psychological suffering that is intolerable and cannot be relieved under conditions that the person considers acceptable; and

- natural death has become reasonably foreseeable, taking into account all of the medical circumstances, although a prognosis as to the specific length of time remaining is not necessary.

The term “grievous and irremediable” was used by the Supreme Court of Canada in *Carter*, but was not defined beyond a clarification that having an “irremediable” condition does not necessarily mean that individuals are required to undertake treatments that they deem unacceptable.²⁹ This consideration is not contained within the definition given in the bill.

The requirements that the person be in an advanced state of irreversible decline in capability and that death be reasonably foreseeable do not explicitly appear in *Carter*, nor does the bill provide definitions for these criteria. However, the Department of Justice’s online glossary explains them as follows:

Advanced state of irreversible decline in capability: When combined with the requirements that death be reasonably foreseeable and that the person be suffering intolerably, the requirement to be in an advanced state of irreversible decline ensures that medical assistance in dying would be available to those who are in an irreversible decline towards death, even if that death is not anticipated in the short term. This approach to eligibility gives individuals who are in decline toward death the autonomy to choose their preferred dying process.

Reasonably foreseeable death: In the context of medical assistance in dying, it means that there is a real possibility of the patient’s death within a period of time that is not too remote. In other words, the patient would need to experience a change in the state of their medical condition so that it has become fairly clear that they are on an irreversible path toward death, even if there is no clear or specific prognosis. Each person’s circumstances are unique, and life expectancy depends on the nature of the illness, and the impacts of other medical conditions or health-related factors such as age or frailty. Physicians and nurse practitioners have the necessary expertise to evaluate each person’s unique circumstances and can effectively judge when a person is on a trajectory toward death. While medical professionals do not need to be able to clearly predict exactly how or when a person will die, the person’s death would need to be foreseeable in the not too distant future.³⁰

- The person has made a voluntary request without external pressure (new section 241.2(1)(d)).
- The person gives informed consent (new section 241.2(1)(e)).

Informed consent, a well-understood concept in the practice of medicine, is defined in the Department of Justice glossary as follows:

Informed consent is a medical term that means that a person has consented to a particular medical treatment after having been given all of the information they need to make that health care decision. Information that is necessary to be provided includes their diagnosis, their prognosis, available forms of treatment and the benefits and side-effects of those treatments. It also requires that the person be mentally competent or capable, i.e., that they be able to understand the relevant information and the consequences of their choices.³¹

The Senate amended the provision relating to informed consent to require that prior to consent being given, a palliative care consultation would have to occur and the patient would have to be informed of options that could relieve suffering.³² The House of Commons amended that amendment to require instead that patients first be informed of “the means that are available to relieve their suffering, including palliative care.”³³

2.5 PROCEDURAL SAFEGUARDS (CLAUSE 3)

In addition to the substantive criteria noted above, Bill C-14 specifies a number of procedural requirements to safeguard the MAID process. According to new sections 241.2(3) to 241.2(6), before providing MAID, the physician or NP must:

- be of the opinion that the conditions of eligibility in section 241.2(1) listed above are satisfied (new section 241.2(3)(a));
- ensure that the request was made in writing and signed by the patient (or by another person in the patient’s presence if the patient is unable to sign, **provided that the other person would not benefit financially or materially from the patient’s death**) and that the written request was signed and dated after a physician or NP had told the patient that **the patient had a grievous and irremediable medical condition** (new section 241.2(3)(b));
- be satisfied that the written request was signed and dated by the patient or another person authorized to do so before two witnesses who also signed and dated the request (witnesses must be at least 18 years of age, understand the nature of the request, not be involved in providing care for the patient, not be an owner or operator of a facility where the person is being treated or resides, nor know or believe they have a financial or material interest in the death) (new sections 241.2(3)(c) and 241.2(5));
- ensure that the person is informed that the person may withdraw the request at any time and in any manner and, immediately before the provision of MAID, ensure once more that the person gives express consent and is offered an opportunity to withdraw the request (new sections 241.2(3)(d) and 241.2(3)(h));
- ensure that another physician or NP has provided a written opinion confirming that the person meets the criteria (new section 241.2(3)(e));
- be satisfied that both physicians or NPs are independent (they are not in a business relationship, nor is one mentoring or supervising the other; they do not know or believe they will have a financial or material benefit from the death; and they are not connected to each other or the patient in any other way that may affect their objectivity) (new sections 241.2(3)(f) and 241.2(6));
- ensure that **10** clear days³⁴ elapse between the day the request is signed and the day when MAID is provided. Where both physicians and/or NPs are of the opinion that the person’s death or loss of capacity to provide informed consent is imminent, the waiting period will be based on what the first physician or NP considers appropriate in the circumstances (new section 241.2(3)(g)); **and**
- **provide a reliable means of communication in situations where a patient has difficulty communicating (new section 241.2(3)(i)).**

The physician or NP must provide MAID with reasonable knowledge, care and skill and in accordance with applicable provincial laws, rules and standards (new section 241.2(7)). A physician or NP who prescribes or obtains a substance for use in MAID must also inform the pharmacist of the intended purpose before that pharmacist dispenses the substance (new section 241.2(8)).

2.6 NEW CRIMINAL OFFENCES AND OBLIGATIONS TO FILE INFORMATION (CLAUSES 3 TO 5)

Bill C-14 introduces a number of new criminal offences that apply where there is a failure to comply with the procedural safeguards. New section 241.3 makes it an offence for a physician or NP to fail to comply with the safeguards in new sections 241.2(3)(b) to 241.2(3)(i) outlined above and to fail to inform the pharmacist of the intended purpose of the substance as outlined in new section 241.2(8).

The House of Commons added a new section 241.2(9) to specify that section 241.2 does not compel an individual to provide or to assist in providing MAID.

New section 241.4 creates two new offences:

- forgery in relation to a request for MAID;³⁵ and
- the destruction of documents relating to MAID where the intent is to interfere with:
 - the access of another person to the service;
 - the lawful assessment of a request;
 - the invocation of one of the exemptions to criminal liability outlined in Bill C-14; or
 - the filing of information in relation to MAID (discussed in more detail below).

The new offences in sections 241.3 and 241.4 are hybrid offences that may be prosecuted by way of indictment with a maximum of five years' imprisonment or as summary conviction offences with a maximum of 18 months' imprisonment.

The federal Minister of Health is **required** by new section 241.31(3) to make regulations **that the minister considers necessary** relating to the provision, collection, use and disposal of information regarding requests and provision of MAID in order to monitor the practice, and may exempt certain classes of person from filing requirements. **Guidelines relating to death certificates and MAID must also be established by the minister (new section 241.31(3.1)).**

New section 241.31(1) requires physicians and NPs who receive a written request for MAID to provide information, as required by regulations, to the designated recipient unless they are exempted from doing so. Pharmacists must do the same where they dispense a substance for MAID (new section 241.31(2)).

Physicians, NPs and pharmacists who knowingly fail to comply with the filing requirements can be found guilty of a hybrid offence, as can anyone who knowingly contravenes the regulations (new sections 241.31(4) and 241.31(5)). Upon conviction, a person is liable to a maximum punishment of two years' imprisonment on indictment or a maximum punishment of a \$5,000 fine, or six months' imprisonment, or both, upon summary conviction.³⁶

**2.7 AMENDMENTS TO OTHER LEGISLATION
(CLAUSES 7 TO 9)**

**2.7.1 PENSION ACT AND CANADIAN FORCES MEMBERS AND VETERANS
RE-ESTABLISHMENT AND COMPENSATION ACT
(CLAUSES 7 AND 9)**

The *Pension Act* provides for pensions for individuals who have become disabled or have died as a result of military service, and for their dependents.³⁷ No pension is awarded where disability is a consequence of improper conduct. Clause 7 amends the definition of improper conduct to clarify that a wound resulting from MAID does not constitute improper conduct. It also clarifies that members of the Canadian Forces who receive MAID will be deemed to have died from the illness, disease or disability that **made them eligible** to receive such assistance.

The *Canadian Forces Members and Veterans Re-establishment and Compensation Act* provides a framework for various benefits and services to members of the Canadian Forces and veterans who have been injured or died as a result of their military service, and to their families. Clause 9 makes changes similar to those made to the *Pension Act* to this Act.

**2.7.2 CORRECTIONS AND CONDITIONAL RELEASE ACT
(CLAUSE 8)**

Section 19 of the *Corrections and Conditional Release Act* requires that when an inmate dies in federal custody, the Correctional Service of Canada must investigate and report on the death to the Commissioner of Corrections or a designated person and provide a copy of the report to the Correctional Investigator (the ombudsman for federal offenders). Clause 8 of the bill removes the requirements for an investigation and report in the case of an inmate who receives MAID.

**2.8 INDEPENDENT REVIEW
(CLAUSE 9.1)**

The House of Commons Standing Committee on Justice and Human Rights added a provision that requires an independent review of issues relating to MAID for mature minors, advance requests for MAID, and requests for MAID where mental illness is the sole underlying condition. The Senate added a further requirement that the report of any such review be laid before each House of Parliament within two years of the start of the review.

These three issues had been considered by the Special Joint Committee on Physician-Assisted Dying. To take measures for mature minors into account, the Special Joint Committee recommended a two-stage legislative approach. Individuals 18 years or older are immediately eligible for MAID in the first stage, with mature minors becoming eligible in the second stage, which comes into force within three years of the first stage. The Special Joint Committee also recommended that the government “immediately commit to facilitating a study of the moral, medical and legal issues surrounding the concept of ‘mature minor.’”³⁸

With respect to advance requests for MAID, the Special Joint Committee recommended that they be allowed “any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable.”³⁹

Finally, with respect to mental illness as the sole underlying condition, the Special Joint Committee stated:

The Committee recognizes that there will be unique challenges in applying the eligibility criteria for MAID where the patient has a mental illness, particularly where such an illness is the condition underlying the request. However, where a person is competent and fits the other criteria set out by law, the Committee does not see how that individual could be denied a recognized Charter right based on his or her mental health condition. Furthermore, we do not understand the *Carter* decision to exclude mental illnesses.⁴⁰

2.9 REVIEW OF THE ACT (CLAUSE 10)

Clause 10 requires referral of the law to a committee of the Senate, House of Commons or both for review at the start of the fifth year after the day the Act receives Royal Assent. The committee is to provide a report to the house or houses of Parliament of which it is a committee and to include a statement setting out any changes to the legislation that it recommends. **The House of Commons Standing Committee on Justice and Human Rights amended clause 10 to include examining the state of palliative care as part of the statutory review.**

2.10 COMING INTO FORCE (CLAUSE 11)

Clauses 4 and 5 (relating to the filing of information) came into force **within 12 months of Royal Assent**. Presumably, this allowed for the time required to set up a system for data collection, use, analysis and disposal before reporting requirements were implemented. The rest of the bill came into force upon Royal Assent.

3 COMMENTARY

The response to Bill C-14 has been mixed. A number of media reports, editorials and responses from stakeholders relating to the bill suggest that the government has taken a reasonable approach to the issue.⁴¹ Other commentators, however, have identified potential legal issues with the bill; they argue that by restricting the availability of MAID to adults, barring individuals with psychiatric disorders who still have capacity to consent from accessing MAID, and not allowing a request for MAID to be made in advance, the bill fails to respect the Charter and will likely give rise to court challenges.⁴²

That MAID will be available to “dying patients”⁴³ suggests to some commentators that it is available only to terminally ill individuals, although the bill does not explicitly state that one must have a terminal illness to have access to MAID. It has been argued that restricting access to MAID to terminally ill individuals would be contrary to the *Carter* decision.⁴⁴ Some MPs and other stakeholders have suggested that, to avoid future potential Charter challenges, the government refer the bill to the Supreme Court of Canada for a determination as to whether the bill complies with the Charter.⁴⁵

Some of the amendments that were adopted by the Senate were not agreed to by the House of Commons.⁴⁶ Notably, the Senate deleted new section 241.2(2), which established the criteria for having a “grievous and irremediable” medical condition. The House of Commons disagreed with this and a few other amendments on the basis that

they would undermine objectives in 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 perception about the quality of life of persons who are elderly, ill or disabled.⁴⁷

NOTES

1. [Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts \(medical assistance in dying\)](#), 1st Session, 42nd Parliament.
2. [Criminal Code](#), R.S.C. 1985, c. C-46.
3. [Carter v. Canada \(Attorney General\)](#), 2015 SCC 5.
4. Prior to Bill C-14 receiving Royal Assent, the *Criminal Code*, s. 14, provided that:

No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Section 241 of the *Criminal Code* provides:

Everyone who

- (a) counsels a person to commit suicide, or
- (b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

5. For more information on the *Carter* decision, see Martha Butler and Marlisa Tiedemann, [Carter v. Canada: The Supreme Court of Canada's Decision on Assisted Dying](#), Publication no. 2015-47-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 29 December 2015.
6. [Carter v. Canada \(Attorney General\)](#), 2016 SCC 4.
7. [Rodriguez v. British Columbia \(Attorney General\)](#), [1993] 3 S.C.R. 519.
8. Senate, Special Committee on Euthanasia and Assisted Suicide, [Of Life and Death – Final Report](#), 1st Session, 35th Parliament, June 1995.
9. Udo Schuklenk et al., *End-of-Life Decision Making*, Royal Society of Canada, November 2011.
10. [Act respecting end-of-life care](#), R.S.Q., c. S-32.0001. For more information on assisted dying in Canada, see Julia Nicol and Marlisa Tiedemann, [Euthanasia and Assisted Suicide in Canada](#), Publication no. 2015-139-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 15 December 2015.
11. House of Commons, [Journals](#), No. 7, 1st Session, 42nd Parliament, 11 December 2015, p. 50; and Senate, [Journals](#), No. 6, 1st Session, 42nd Parliament, 11 December 2015, p. 56.
12. [Carter v. Canada \(Attorney General\)](#), 2012 BCSC 886, para. 23.
13. *Ibid.*
14. *Ibid.*, para. 37.
15. [Act respecting end-of-life care](#), s. 3(6).
16. Senate and House of Commons, Special Joint Committee on Physician-Assisted Dying, [Medical Assistance in Dying: A Patient-Centred Approach](#), 1st Session, 42nd Parliament, February 2016, p. 10.
17. [Carter v. Canada \(Attorney General\)](#), 2013 BCCA 435.
18. [Carter v. Canada \(Attorney General\)](#), 2015 SCC 5, para. 127.
19. [Carter v. Canada \(Attorney General\)](#), 2016 SCC 4, para. 6.
20. Government of Canada, "[Letter from Minister Wilson-Raybould and Minister Philpott to the External Panel on Options for a Legislative Response to Carter v. Canada](#)," Backgrounder, 14 November 2015.
21. 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.
22. Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, [Final Report](#), 30 November 2015.
23. House of Commons, (2015), p. 50; and Senate (2015), p. 56.
24. *Ibid.*
25. Senate and House of Commons (2016).
26. As part of its background documents relating to MAID, the Department of Justice has a glossary that explains a number of terms that are used in the bill. It is important to note that this glossary is not part of the bill itself. The [Glossary](#) defines mature minors as

[m]inors (below 18 or 19 depending on applicable provincial laws) who have the intellectual capacity and maturity to understand the information relevant to their medical decision and appreciate the consequences of such decision.

27. Bill C-14, “Preamble.”
28. Department of Justice, *Glossary*.
29. *Carter v. Canada (Attorney General)*, 2015 SCC 5, para. 127.
30. *Ibid.*
31. *Ibid.*
32. **House of Commons, [Journals](#), No. 74, 1st Session, 42nd Parliament, 16 June 2016.**
33. **Senate, [Journals](#), Issue 51, 1st Session, 42nd Parliament, 16 June 2016.**
34. The [Interpretation Act](#), R.S.C. 1985, c. I-21, defines “clear days” as follows: “27(1) Where there is a reference to a number of clear days or ‘at least’ a number of days between two events, in calculating that number of days the days on which the events happen are excluded.”
35. Forgery is currently an offence under section 366 of the *Criminal Code*.
36. See section 787 of the *Criminal Code* regarding penalty for summary conviction when there is no specific penalty mentioned for the offence.
37. [Pension Act](#), R.S.C. 1985, c. P-6, s. 2.
38. **Senate and House of Commons (2016), p. 21.**
39. ***Ibid.*, p. 24.**
40. ***Ibid.*, p. 14.**
41. See, for example, “A needed compromise,” Editorial, *Montreal Gazette*, 15 April 2016; Tasha Kheiriddin, “[The Liberals’ assisted death bill strikes a difficult, necessary balance](#),” *iPolitics*, 14 April 2016; “Till death do us part,” Editorial, *Globe and Mail*, 16 April 2016; and Canadian Medical Association, “[Canadian Medical Association lauds historic federal law on assisted dying](#),” News release, 14 April 2016.
42. See, for example, Ian Macleod, “Right to die only for some: Assisted dying bill excludes those whose death is not ‘reasonably foreseeable,’” *Ottawa Citizen*, 15 April 2016; Katherine Dedyne, “Assisted-death law dismays Victoria experts,” *Times Colonist*, 15 April 2016; Tiffany Crawford, “B.C. advocates pan right-to-die law: Critics decry exclusions, restrictions in federal assisted dying legislation,” *Vancouver Sun*, 15 April 2016; British Columbia Civil Liberties Association, “[Assisted Dying – Plaintiffs in court challenge criticize legislation](#),” News release, 14 April 2016; and Chantal Hébert, “[Liberals have met only bare minimum with assisted-dying bill](#),” *Toronto Star*, 16 April 2016.
43. Government of Canada, “[Government introduces legislation to provide medical assistance in dying](#),” News release, 14 April 2016.
44. See, for example, Dying with Dignity Canada, “[DWDC responds as assisted dying bill tabled in Parliament](#),”; and British Columbia Civil Liberties Association (2016).
45. See, for example, Joan Bryden, The Canadian Press, “[Federal government tables long-awaited assisted-dying bill](#),” *CTV News*, 14 April 2016.
46. **Not all of the amendments that were agreed to by the Senate and that were subsequently rejected by the House of Commons are described here. For the full list of Senate amendments that were rejected by the House of Commons, see Senate (2016).**
47. *Ibid.*

APPENDIX – MEDICAL ASSISTANCE IN DYING

Table 1 – Comparison of Provisions Related to Medical Assistance in Dying Found in Laws in Various Jurisdictions, Bill C-14 and Recommendations of the Special Joint Committee on Physician-Assisted Dying

	Oregon	The Netherlands	Belgium	Luxembourg	Quebec	Bill C-14	Special Joint Committee
Voluntary euthanasia (E)/ assisted suicide (AS) allowed?	AS allowed	E and AS allowed	E and AS allowed	E and AS allowed	E allowed	E and AS allowed	E and AS allowed
Terminal illness required?	Yes	No	No	No	Yes	Not specified	No
Residency required?	Yes	Yes, although not explicitly in the law	Yes, although not explicitly in the law	Yes, although not explicitly in the law	Yes	Yes	Yes
Advance directives permitted?	No	Yes	Yes (only for unconscious persons)	Yes (only for unconscious persons)	No	No	Yes
Permitted for minors?	No	Yes (12 years and older or newborn)	Yes (restricted eligibility criteria)	No	No	No	Yes
Permitted for person with dementia/ psychiatric illness not capable of making decisions?	No	Yes, if there is a signed advance directive	Yes, but the person must be competent at time of request	Yes, but the person must be competent at time of request	No	No	Yes, if there is a signed advance request
Psychological suffering sufficient?	No	Yes	Yes	Yes	No	No	Yes
Form of request	2 oral, 1 written	Oral request sufficient; no requirement for multiple requests but that is the practice	A number of appointments with a reasonable delay between them, 1 written request	A number of appointments with a reasonable delay between them, 1 written request	Talk with patient at reasonably spaced intervals given progress of the condition; 1 written request	1 written	In writing (where possible)
Witness(es) required?	2 witnesses	No	No	No	1 witness (can be attending physician)	2 witnesses	2 witnesses
Waiting period?	15 days between oral requests; 48 hours between written request and prescription	Not specified	1 month where death not imminent	Not specified	Not specified	10 days, unless death or loss of capacity imminent	Flexible
Number of doctors and specialization	2 physicians; referral to counselling in case of impairment resulting from psychiatric/ psychological	2 doctors	2 doctors; 3 doctors, including a specialist, if patient is not near death	2 doctors; discretion to consult an expert	2 doctors	2 doctors	2 doctors

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	Oregon	The Netherlands	Belgium	Luxembourg	Quebec	Bill C-14	Special Joint Committee
	disorder or depression						
Informing family	Must request that patient inform family but cannot obligate them		Consult relatives at patient's request	Consult person listed in end-of-life plan unless patient refuses	Consult relatives at patient's request		
Reporting requirements and oversight	Case reports to Oregon's Department of Human Services; annual reports	Case reports to regional review committee; annual reports; more comprehensive reviews took place in 2007 and 2012	Case reports to Federal Evaluation and Control Commission; annual reports	Case reports to Federal Evaluation and Control Commission; annual reports	Case reports to council of physicians, dentists and pharmacists of the institution or to Collège des médecins du Québec; annual reports by College; Commission on end-of-life care to evaluate implementation and report every 5 years	Filing requirements (details to be determined in regulations); statutory review at start of 5 th year	Annual reporting; plus statutory review every 4 years
Conscientious objection	No requirement to participate or refer but participation is defined to exclude referral; an institution can prevent assisted suicide in its premises	Freedom of conscience but not mentioned in the law	No requirement to participate or refer (must transfer file if requested)	No requirement to participate or refer (must transfer file if requested)	No requirement to participate, must inform institution which takes steps to find a willing physician	Mentioned in preamble (government is committed to "respect the personal convictions of health care providers") No one is compelled to provide or assist in providing MAID	Effective referral required

Note: This table includes a number of elements to highlight the differences between jurisdictions, but does not include all criteria that must be met to satisfy the conditions in each jurisdiction.

Sources: United States: Oregon Health Authority, [Death with Dignity Act](#), Oregon Revised Statutes, c. 127, 127.800.

The Netherlands: The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* came into effect on 1 April 2002. An English translation of the law can be found at [Review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act \(Termination of Life on Request and Assisted Suicide \(Review Procedures\) Act\)](#).

Belgium: Association pour le Droit de Mourir dans la Dignité, "Texte consolidé de la loi du 28/05/2002 relative à l'euthanasie," [Législation belge](#).

Luxembourg: Le gouvernement du Grand-Duché de Luxembourg, "A46: Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide," [Mémorial A n° 46 de 2009](#).

Canada: [Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts \(medical assistance in dying\)](#) (S.C. 2016, c. 3) (Royal Assent version); Special Joint Committee on Physician-Assisted Dying, [Medical Assistance in Dying: A Patient-Centred Approach](#), 1st Session, 42nd Parliament, February 2016; and Quebec, [Act respecting end-of-life care](#), c. S-32.0001.