Introduction

Assisted suicide has once again surfaced as an issue of public attention. Just in the past year, four cases have been in the news. In addition, the results of a major study on the attitudes of cancer patients in palliative care towards euthanasia and physician-assisted suicide and the results of an Ipsos Reid public opinion poll on assisted suicide were released. Vigorous calls both for

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1 For the purposes of this paper, we define assisted suicide as the act of intentionally killing oneself with the assistance of another.

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and against the decriminalization of assisted suicide followed. Given that it has been fifteen years since the release of the most famous assisted suicide case in Canada, and given this recent spate of attention, we believe that it is worth re-engaging with the issue of the legal status of assisted suicide in Canada. Therefore, in this paper, we first describe the history and current legal status of assisted suicide in Canada. We then argue that, under new evidence and new jurisprudence only available after the Rodriguez decision was released, s.241(b) of the Criminal Code (the prohibition on assisted suicide) is unconstitutional – violating s.7 of the Canadian Charter of Rights and Freedoms and not saved by s.1. We also append an annotated draft statute that the federal Parliament could use were it to take up the challenge we issue at the end of this paper.

Where we’ve come from and where we are

Legislation

The first Criminal Code included prohibitions on attempted and assisted suicide. In 1972, attempted suicide was removed from the Criminal Code. The current section of the Criminal Code therefore now reads:

s.241 Every one who
(a) counsels a person to commit suicide, or
(b) aids or abets a person to commit suicide, whether suicide

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6 S.7 “Everyone 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.” S. 1 “The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.” Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 [Charter].
7 “Everyone is guilty of an indictable offence and liable to imprisonment for life who counsels or procures any person to commit suicide, actually committed suicide in consequence of such counseling or procurement, or who aids or abets any person in the commission of suicide.” Criminal Code, 1892, S.C. 1892, c. 29, s. 237.
8 Criminal Law Amendment Act, 1972, S.C. 1972, c.13, s.16.
ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.\(^9\)

On December 17, 1992, Sue Rodriguez launched a challenge to the *Criminal Code* before the British Columbia Supreme Court. Sue Rodriguez was a woman suffering from amyotrophic lateral sclerosis (ALS, also commonly known as Lou Gehrig’s Disease). She believed that, at some point in the future, her quality of life would be such that she would no longer wish to continue living. She realized that by that time, she would no longer be physically able to commit suicide without assistance. She therefore sought to have the *Criminal Code* prohibition on assisted suicide struck down as a violation of her *Charter* rights. In 1993, her case was heard by the Supreme Court of Canada.

On September 30, 1993, the majority (5 judges) ruled that there was no breach of s.7 (there was a breach of security of the person but this was in accordance with the principles of fundamental justice). Further, they assumed without deciding that there was a breach of s.15 (there was discrimination on the basis of physical disability) but held that the s.15 breach was saved by s.1 (the breach was demonstrably justified in a free and democratic society). Chief Justice Lamer found a s.15 breach that was not saved by s.1. Justices McLachlin and L’Heureux-Dube found a s.7 breach that was not saved by s.1. Justice Cory found a breach of both s.7 and s.15 and held that neither was saved by s.1. Thus, s.241(b) was found, by the slimmest of majorities, to be constitutional.

After *Rodriguez*, the Senate of Canada set up a Special Committee to explore the issues of euthanasia and assisted suicide. It addressed the full spectrum of assisted death (including not just euthanasia and assisted suicide but also the withholding and withdrawal of potentially life-sustaining treatment and the provision of potentially life-shortening palliative treatment). For this paper’s purposes, it is most important to note that the Committee split, again by the slimmest of majorities, 4:3 against recommending the decriminalization of assisted suicide.

Consequently, after consideration by the Supreme Court of Canada and a Special Committee of the Senate of Canada, s.241(b) remained in the *Criminal Code*.

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Cases

Twenty cases are known to have reached the attention of the authorities in Canada. In three, no charges were laid (Lewis, Rodriguez, MacDonald). In two, charges were stayed or dropped (Doerksen, Breau). In three, the accused were found not guilty (Ishakak, Hussey, Martens). There have been eleven convictions (pleas or guilty verdicts) but, of these, eight resulted in suspended or conditional sentences or probation (Amah, Avinga, Nangmalik, Fogarty, Zsiros, Houle, Trites, Sharma). Only three resulted in jail time being served (Eerkiyoot, Genereux, Wilson). One case remains outstanding (Dufour). It is important to note here that there were no jail terms for individuals in the cases where the facts were the sort that proponents of decriminalization support (i.e., competent individuals suffering greatly and requesting assistance).

There is also some empirical evidence that assisted suicide is happening in Canada and simply not reaching the criminal justice system. Russel Ogden conducted a study in the HIV/AIDS community in British Columbia between 1980 and 1993 and testified before the Special Senate Committee on Euthanasia and Assisted Suicide:

I learned of 34 cases of assisted suicide and euthanasia amongst the AIDS population. I also learned of other deaths outside of the AIDS population, but did not include those in my data. I have learned of many more deaths amongst patients with ALS, cancer and AIDS since the publication of these findings.¹¹


¹¹ Downie, ibid. at 130.
A 1995 study conducted in Manitoba found that, of the physicians who responded to the survey, 15% had facilitated a patient’s request to shorten life by assisted suicide or euthanasia.\textsuperscript{12}

Conclusion

Thus it can be concluded that the law on the books is clearly prohibitive. However, the law on the street appears to be somewhat tolerant (albeit very unevenly). In other words, assisted suicide is illegal but practiced and, to a certain extent, countenanced.

Where we could go from here

Law reform can, of course, come from various directions. In the arena of assisted suicide, it might come from the exercise of prosecutorial discretion (not laying charges), jury nullification (refusing to convict even in the face of clear evidence of guilt), legislative reform (an Act to amend the \textit{Criminal Code}), or a \textit{Charter} challenge. In this paper, we focus on the possible \textit{Charter} challenge.\textsuperscript{13}

While we believe that a very convincing case can be made that \textit{Rodriguez} was wrongly decided in 1993, a number of authors have convincingly challenged various aspects of Justice Sopinka’s reasons. Rather than rehearse these critiques of \textit{Rodriguez} here, we would simply direct the reader to the literature.\textsuperscript{14} In this paper, we focus instead on the argument that


\textsuperscript{13} Readers interested in the other options are referred to Jocelyn Downie, “Assisted Death at the Supreme Court of Canada” in Jocelyn Downie & Elaine Gibson, eds., \textit{Health Law at the Supreme Court of Canada} (Toronto: Irwin Law, 2007) 219.

circumstances have changed since 1993 such that another Rodriguez case would be decided differently now. Specifically, both the evidence and the law have changed significantly such that, even if Rodriguez had been correctly decided in 1993, Rodriguez redux would have to be decided differently in 2008. Consider, first, the changes in evidence and, second, the changes in the law.

The Evidence

The claim that there have been critical changes in evidence can best be demonstrated by holding the central factual claims made and relied upon by the majority in Rodriguez in 1993 (presented in italics) up to evidence available to us in 2008 (presented in normal font).

**Public consensus on the morality of assisted suicide**

“[T]he decriminalization of attempted suicide cannot be said to represent a consensus by Parliament or by Canadians in general.”

There is now evidence of widespread and longstanding public support for decriminalization of assisted suicide and euthanasia in Canada. In 1997, the Angus Reid Group found that 76% of those polled supported the right to die, 17% did not support it, and 7% were unsure. A 2001 Leger Marketing poll found that 75.5% of Canadians believed a person who has helped end the life of a loved one suffering from an incurable and extremely painful illness should not be prosecuted. A June 2007 Ipsos Reid poll found that

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16 Ipsos News Center, News Release, “Canadians’ Views on Euthanasia” (6 November 1997), online: Ipsos News Center <http://www.ipsos-na.com/news/pressrelease.cfm?id=878>: “...whether a person who is terminally ill and wants to die before enduring the full course of the disease, should have the right to take their own life.”

71% of Canadians believe that physician-assisted suicide should be legally permitted.¹⁸

**Opposition of medical associations**

“I also place some significance in the fact that the official position of various medical associations is against decriminalizing assisted suicide (Canadian Medical Association, British Medical Association, Council of Ethical and Judicial Affairs of the American Medical Association, World Medical Association and the American Nurses Association).”¹⁹

The Canadian Medical Association policy on euthanasia and assisted suicide (Update 2007) now takes the position that “Canadian physicians should not participate in euthanasia or assisted suicide” (as it is currently illegal) but does not take a position on whether assisted suicide should be legalized. Rather, in its discussion of legalization, it states: “The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues.” It then offers a set of concerns that should be addressed “before any change in the legal status of euthanasia or assisted suicide is considered.”²⁰

Moving beyond Canada, the American Medical Women’s Association and the American Medical Student Association have taken official positions supporting the decriminalization of assisted suicide.²¹ The American Academy of Hospice and Palliative Medicine and the American Pharmaceutical Association, among others, have taken a position of “studied neutrality” on the decriminalization of physician-assisted suicide.²²

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¹⁸ *Supra* note 4: “one quarter (25%) of Canadians believe that ‘doctor assisted suicide should be prohibited by law.’ …[S]even in ten (71%) Canadians agree that ‘doctors willing to do this should be legally permitted to assist in the death’ of a terminally-ill patient.”

¹⁹ *Rodriguez, supra* note 5 at para. 175.


²² Timothy E. Quill & Christine K. Cassel, “Professional Organizations’ Position
Consistency with other countries

“A brief review of the legislative situation in other Western democracies demonstrates that in general, the approach taken is very similar to that which currently exists in Canada. Nowhere is assisted suicide expressly permitted, and most countries have provisions expressly dealing with assisted suicide which are at least as restrictive as our s. 241.”

While Justice Sopinka’s description of the law in other countries was literally accurate in 1993, it no longer remains so. In particular, assisted suicide is now legally permissible in the Netherlands, Switzerland, and Oregon.

In the Netherlands, the 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act effectively codified the approach that had been developed by the courts in a body of cases decided between 1952 and 1996. Therefore, under legislation, physicians in the Netherlands will not be charged under the Penal Code for providing assistance with suicide so long as they follow the requirements for “due care” and the reporting requirements set out in the 2002 Act and the Burial Act. For example, according to Article 2 of Chapter II of the 2002 Act, the attending physician must:

a. be satisfied that the patient has made a voluntary and carefully considered request;

b. be satisfied that the patient’s suffering was unbearable, and that there was no prospect of improvement;

c. have informed the patient about his situation and his prospects;


23 Rodriguez, supra note 5 at para. 163.

24 In May 2002, the Belgian Parliament approved a law permitting euthanasia in certain limited circumstances. See Belgium, The Belgian Act on Euthanasia of May 28th, 2002, trans. by Dale Kidd, online: Katholieke Universiteit Leuven Centre for Biomedical Ethics and Law <http://www.kuleuven.ac.be/cbmer/page.php?LAN=E&FILE=subject&ID=53&PAGE=1>. However, since this Act deals with euthanasia and not assisted suicide, it will not be discussed in this paper.

d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient’s situation;

e. have consulted at least one other, independent physician, who must have seen the patient and has given a written opinion on the due care criteria referred to in a. to d. above; and

f. have terminated the patient’s life or provided assistance with suicide with due medical care and attention.\(^{26}\)

Article 115 of the Swiss Penal Code allows for assisted suicide as long as the motives of the person providing the assistance are not selfish.

Whoever, from selfish motives, induces another person to commit suicide or aids him in it, shall be confined in the penitentiary for not over five years, or in the prison, provided that the suicide has either been completed or attempted.\(^{27}\)

In 1997, the Oregon Death with Dignity Act came into effect. The Act survived a constitutional challenge\(^ {28}\) as well as an attempt to subvert it by then U.S. Attorney General John Ashcroft. Ashcroft had issued a directive saying that doctors who prescribed lethal drugs under the Oregon law could face federal sanctions and prosecution under the Controlled Substances Act resulting in a revocation of the licenses of physicians who provided assistance with suicide.\(^ {29}\) Therefore, in Oregon, a physician may legally assist with a suicide for a patient if the patient is 18 years or older, resides in Oregon, is capable of making and communicating health care decisions, and has been diagnosed with a terminal illness that will lead to death within six months.\(^ {30}\)

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26 Ibid. c. II, art. 2.
29 Memorandum from John Ashcroft to Asa Hutchinson (6 November 2001), online: International Task Force on Euthanasia and Assisted Suicide <http://www.internationaltaskforce.org/ashdir.htm#1>.
Difficulty/impossibility of protecting the vulnerable

“[T]here is no certainty that abuses can be prevented by anything less than a complete prohibition. Creating an exception for the terminally ill might therefore frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop.”

There is now strong data to support the claim that it is, in fact, possible to craft permissive legislation that protects the vulnerable. A review of the data from Oregon is particularly persuasive on this point.

First, many patients who choose to obtain the prescription ultimately choose not to use it.

![Figure 1](image)

**Figure 1**

Clearly, the fact of initiating access to the assistance does not create a sense of obligation to commit suicide (one potential point of vulnerability). Rather, the prescription seems to serve as a “safety net” that some patients use and others do not.

31 Rodriguez, supra note 5 at para. 162.
Second, the individuals who access assistance are largely not members of the vulnerable groups that the majority in Rodriguez were concerned with protecting. The majority of those who chose to seek assistance were insured (100%), in hospice care (92%), male (53%), white (97%), and with at least some college education (62%).

Third, the concerns that motivated the vast majority of those who sought assistance were not those that the majority in Rodriguez was concerned about protecting:

### End of Life Concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>2005</th>
<th>1998-2004</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losing autonomy</td>
<td>79%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable</td>
<td>89%</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Loss of dignity</td>
<td>89%</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>Losing control of bodily functions</td>
<td>45%</td>
<td>59%</td>
<td>57%</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers</td>
<td>42%</td>
<td>36%</td>
<td>37%</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it</td>
<td>24%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Figure 2**

A rich body of evidence is also available now from the Netherlands and, as noted by Margaret Battin *et al.* in 2007:

rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured

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34 *Ibid.* at 23.
(inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.\(^\text{35}\)

Thus, insofar as there is evidence, it cuts against Justice Sopinka’s 1993 concerns. Indeed, based on the current evidence, it is reasonable to conclude that it is possible to protect the vulnerable and control abuse through means other than a complete prohibition on assisted suicide.

**Slipping from voluntary to involuntary/non-voluntary**

“Critics of the Dutch approach point to evidence suggesting that involuntary active euthanasia (which is not permitted by the guidelines) is being practised to an increasing degree. This worrisome trend supports the view that a relaxation of the absolute prohibition takes us down ‘the slippery slope.’”\(^\text{36}\)

First, it must be emphasized that there is no credible evidence that involuntary active euthanasia is occurring in the Netherlands – let alone occurring at increasing rates.\(^\text{37}\)

Second, while it must be acknowledged that non-voluntary euthanasia is occurring in the Netherlands, the evidence does not support drawing a conclusion that there has been a trend down a slippery slope from voluntary to non-voluntary euthanasia. The incidence of non-voluntary euthanasia is not linked in a causal way to the legal status of euthanasia in the Netherlands. The incidence has not increased over time.\(^\text{38}\) Furthermore, the incidence of non-voluntary euthanasia in the Netherlands (where it is legal) is

\[^{35}\text{Margaret Battin et al., “Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in ‘vulnerable’ groups” (2007) 33 Journal of Medical Ethics 591.}\]

\[^{36}\text{Rodriguez, supra note 5 at para. 165.}\]

\[^{37}\text{Jocelyn Downie, “The contested lessons of euthanasia in the Netherlands” (2000) 8 Health L. J. 119.}\]

not higher (indeed, in some cases is lower) than in countries where euthanasia is illegal (e.g., Australia).  

**Conclusion**

Thus it can be seen that even assuming for the sake of argument that the factual foundation for the majority’s decision in Rodriguez was sound in 1993, it is no longer sound.

Let us turn now to a consideration of similarly significant changes in the law. In this next section, we will argue that the law has changed since 1993 such that if a case like Rodriguez was brought now, s.241(b) would be found, based on the new jurisprudence, to violate s.7 and not to be saved by s.1.

**The Law**

**Section 7**

Section 7 of the *Canadian Charter of Rights and Freedoms* provides that:

> Everyone 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.

Clearly, a prohibition on assisted suicide breaches the right to security of the person. The contested issue will be whether this breach is in accordance with the principles of fundamental justice and it is precisely around the principles of fundamental justice that there have been significant developments in the law post-Rodriguez (i.e., post-1993).

The Supreme Court of Canada started to develop a new approach to defining principles of fundamental justice in 2003 in *R. v. Malmo-Levine*, and then completed this work in 2004 in *Canadian Foundation for Children, Youth*...
They determined that there are three main characteristics of a principle of fundamental justice: “it must be a legal principle;” “there must be sufficient consensus that the alleged principle is ‘vital or fundamental to our societal notion of justice;’” and lastly, “the alleged principle must be capable of being identified with precision and applied to situations in a manner that yields predictable results.”

The Supreme Court of Canada also introduced the doctrine of overbreadth in *R. v. Heywood* (released a year after *Rodriguez*). As defined in *Heywood*, overbreadth occurs when:

> The State, in pursuing a legitimate objective, uses means which are broader than necessary to accomplish that objective, [and] the principles of fundamental justice [are] violated because the individual’s rights will have been limited for no reason. The effect of overbreadth is that in some applications the law is arbitrary or disproportionate.

As noted by Rollie Thompson in his review of recent developments in s.7 jurisprudence, “Rounding Up the Usual Criminal Suspects, and a Few More Civil Ones: Section 7 After Chaoulli,”

[i]here are three critical steps in overbreadth analysis:

(i) define the purpose of the law;

(ii) interpret the statutory means adopted to accomplish that purpose;

(iii) consider reasonable hypotheticals about the possible conduct which might be caught by the means adopted yet which does not relate to the purpose ascribed.

It must be noted here that Justices Binnie and Gonthier (who wrote the majority opinion for McLachlin C.J. and Gonthier, Iacobucci, Major, Basta-
rache, and Binnie) appeared to have altered the *Heywood* test in 2003 in *R. v. Clay*: “Overbreadth… addresses the potential infringement of fundamental justice where the adverse effect of a legislative measure on the individuals subject to its strictures is *grossly* disproportionate to the state interest the legislation seeks to protect.”\(^47\) However, in 2004 in *Demers*, the Court returned to the *Heywood* analysis of overbreadth (i.e., not requiring gross disproportionality) and found that because “the means chosen are not the least restrictive of the unfit person’s liberty and not necessary to achieve the State’s objective,”\(^48\) they were deemed to be overbroad and unconstitutional. Thus, it can be seen that, in 2008, an avenue of argument that was simply unavailable at the time of *Rodriguez* would now be available.

Let us now analyze the constitutionality of s.241(b) of the *Criminal Code*. In light of the new approach to s.7 established through *Malmo-Levine, Canadian Foundation, Heywood*, and *Demers*, we believe that it can now be argued persuasively that s.241(b) of the *Criminal Code* breaches s.7 of the *Charter*.

It can reasonably be assumed that the SCC would still characterize the purpose of s.241(b) as “the protection of the vulnerable who might be induced in moments of weakness to commit suicide.”\(^49\) The SCC will most likely still be concerned about individuals suffering from depression or individuals pressured into committing suicide by others, i.e., incompetent individuals or competent individuals who are not freely making their decisions re: suicide.

The statutory means adopted to accomplish this purpose is s.241(b) of the *Criminal Code* – an absolute prohibition on all assisted suicide. The statutory means adopted does relate to the purpose as an absolute ban will protect the vulnerable (defined as those not making an autonomous choice to commit an assisted suicide, with autonomy compromised either by incompetence or coercion). However, reasonable hypotheticals abound that demonstrate that conduct will be caught by the means adopted that do not help to further the purpose of the legislation. The evidence is clear that the means chosen are broader than necessary.

Consider individuals who would like to gain access to assistance with suicide and share the following features: clearly competent; fully informed; suffering enormously; offered all available options for potentially reducing


\(^{49}\) *Rodriguez*, supra note 5 at para. 149.
suffering; and facing inevitable deterioration and death. All of these individuals would be caught by the legislation. The net cast by s.241(b) is very wide.

It might be argued that the net must be this wide in order to meet the purpose of the legislation. That is, if exceptions were made, the purpose of protecting the vulnerable would be frustrated; thus the hypotheticals are not reasonable and the means are no broader than necessary. However, as has been demonstrated earlier in this paper, there is now ample evidence to show that the net need not be cast so wide. It is possible to protect the vulnerable without restricting the liberty of competent individuals who make free and informed decisions to seek assistance with suicide (the draft statute appended to this paper provides a concrete illustration of how this could be achieved through legislation).

Therefore, s.241(b) of the Criminal Code breaches the right to security of the person and is not in accordance with the principles of fundamental justice: it violates s.7 of the Charter as it is now understood by the SCC.\textsuperscript{50} The next question that therefore must be addressed is whether this violation can be saved by section 1.

\textit{Section 1}

Let us now conduct a s.1 analysis of s.241(b) under contemporary (as opposed to 1993) jurisprudence. Section 1 provides that the rights and freedoms guaranteed under the Charter are “subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”\textsuperscript{51} However, as noted by Justice Arbour in \textit{R. v. Gosselin}, favourably citing remarks from Justice Lamer in \textit{New Brunswick (Minister of Health and Community Services) v. G.(J.)}:

Section 7 violations are not easily saved by s.1... This is so for two reasons. First, the rights protected by s.7 – life, liberty, and security of the person – are very significant and cannot ordinarily be overridden by competing social interests. Second, rarely will a violation

\textsuperscript{50} It should be noted here that s.241(b) could not be saved from a s.7 violation by interpreting any ambiguity so as to resolve any claim of overbreadth. \textit{Canada (Attorney General) v. JTI-Macdonald Corp.}, 2007 SCC 30 at para. 44, [2007] 2 S.C.R. 610.

\textsuperscript{51} \textit{Supra} note 6.
of the principles of fundamental justice... be upheld as a reasonable limit demonstrably justified in a free and democratic society.\textsuperscript{52}

Laws that fail a s.7 analysis on the grounds of a finding of overbreadth and hence a failure to be in accordance with the principles of fundamental justice are, as noted in 1994 in \textit{Heywood}, even less likely to be saved under s.1 – if realistic hypotheticals are suggested that are caught by the means adopted but do not relate to the purpose ascribed, the legislation “would appear to be incapable of passing the minimal impairment branch of the s.1 test.”\textsuperscript{53}

In order for legislation to be saved under s.1, the government’s lawyers must persuade the court that the objective of the law is pressing and substantial, the violation of the \textit{Charter} right is rationally connected to the objective of the legislation, the impugned law constitutes a minimal impairment of the right(s), and the deleterious and salutary effects of the law are proportional.\textsuperscript{54}

The objective of s.241(b) – protecting the vulnerable from non-autonomous assisted suicide – is clearly pressing and substantial. There is clearly a rational connection between a prohibition on assisted suicide and this objective. However, the law does not minimally impair the s.7 rights of many individuals. The rights of competent individuals who make a free and informed decision to seek assistance with suicide are limited by s.241(b). As demonstrated in the previous discussion of evidence available after \textit{Rodriguez} was decided, it is possible to protect the vulnerable without limiting the

\begin{itemize}

\item \textsuperscript{53} \textit{Heywood}, supra note 44 at para. 69. It should be noted here that in \textit{Charkaoui v. Canada (Citizenship and Immigration)}, 2007 SCC 9, [2007] 1 S.C.R. 350, the Supreme Court of Canada recently found that in “undistinguished circumstances” a violation of s.7 rights that was not in accordance with the principles of fundamental justice could nonetheless be upheld as a reasonable limit under s.1. However, this case did not involve overbreadth, and the logic of the claim of inconsistency between failing s.7 principles of fundamental justice and passing the minimal impairment requirement of the s.1 test is very strong for overbreadth. Furthermore, as will be demonstrated below, s.241(b) would fail a s.1 analysis.

\item \textsuperscript{54} \textit{R. v. Oakes}, [1986] 1 S.C.R. 103, 26 D.L.R. (4\textsuperscript{th}) 200.
\end{itemize}
rights of this group, for example, by providing an exception to s.241(b) in circumstances in which the individual requesting assistance has met a set of criteria designed to ensure that they are not “vulnerable” (including, but not necessarily limited to, the decision being free and informed and the individual being competent). Again, the draft statute appended to this paper concretely demonstrates how this could be done.

**Conclusion**

Even if one assumes for the sake of argument that *Rodriguez* was correctly decided in 1993,\(^{55}\) it can be concluded that, under post-*Rodriguez* SCC jurisprudence and in light of post-*Rodriguez* evidence, s.241(b) of the Criminal Code violates s.7 and cannot be saved by s. 1 of the Charter.

**A Call for Action**

As has been shown, we are currently in an untenable position with respect to assisted suicide law, policy, and practice in Canada. There is a significant disconnect between the law on the books and the law on the street and, given historical patterns, there is no reason to believe that this disconnect will become anything but more pronounced in coming years. There is also a significant disconnect between the law and public opinion. When over 70% of Canadians are supportive of decriminalization of a particular act for over three decades, there is good reason to at least revisit the law. Finally, the current law is unconstitutional. Clearly, it is time for action. Parliament should revise the Criminal Code or face the Supreme Court of Canada striking it down.

**Appendix**

The Process

Once it was clear that new legislation was needed to properly address both changes in law and public sentiment in Canada, we set out to draft a statute that would demonstrate how the vulnerable could be protected through law without violating the fundamental rights and freedoms of residents of Canada. This draft statute was developed after a comprehensive review of

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55 Arguments against this assumption are found in, among other places, Downie, *supra* note 10.
the following sources: the academic literature on euthanasia and assisted suicide previously referenced throughout this paper; the Final Report of the Special Senate Committee on Euthanasia and Assisted Suicide; public and parliamentary debate on previous related Canadian bills; assisted suicide and euthanasia bills and statutes from different countries; and relevant

56 Following the tradition of legislative drafting, we have not referenced wording drawn from other bills or statutes. However, we here acknowledge our debts to those who have drafted bills and statutes in Canada and elsewhere.


Canadian case law.\textsuperscript{60} We then revised the draft statute in light of feedback from a variety of individuals knowledgeable in the field who were asked for comments.

The Substance

There are multiple issues that must be addressed to protect the vulnerable and to preserve the rights and freedoms of residents of Canada. Who will assistance be granted to? Who can provide assistance? How can we avoid a descent down a slippery slope from only competent individuals to incompetent individuals? Or from voluntary to coerced assisted suicides? How can we ensure consistency across Canada and transparency in the application of the law? These questions must be answered through the legislation, using clear and concise language. The following is the statute we drafted, annotated (in italics) to explain those features about which we received the most questions when soliciting feedback on the draft.

\begin{quote}
\textbf{An Act to amend the Criminal Code to allow assisted suicide and to establish the Commission for the Monitoring and Reporting on Assisted Suicide in Canada}
\end{quote}

\textbf{SUMMARY}

This enactment amends the law to ensure that patients will not be denied aid in dying where that aid is in accordance with the Act. It also ensures that the incidence and circumstances of assisted suicide in Canada are well monitored and the vulnerable are well protected.

\textsuperscript{60} Supra notes 5, 10.
An Act to amend the Criminal Code to allow assisted suicide and to establish the Commission to Monitor and Report on Assisted Suicide in Canada

Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

1. Section 241 of the Criminal Code is replaced by the following:

241.(1) Subject to paragraph (4), every one 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.

(2) Merely providing information or being present at an assisted suicide does not constitute counselling, aiding, or abetting for the purposes of this section.

The suggestion has been made (for example, to researchers) that merely providing information or being present at an assisted suicide constitutes counseling, aiding, or abetting in assisted suicide. This section makes it clear that this is not so without the need for litigation to establish the point (as it surely would if this matter were litigated in a Canadian court). It also makes it clear that the deliberately onerous procedural requirements set out in the statute do not apply to merely providing information or being present at an assisted suicide.

(3) In this section,

“assistance” means the provision of means;

“assisted suicide” means the act of intentionally killing oneself with the assistance of another;

“attending physician” means the physician who has primary responsibility for the care of the patient;

“Commission” means the Commission to Monitor and Report on Assisted Suicide in Canada;

“competent” means capable of making an informed request;
“consulting physician” means a physician who is qualified by speciality or experience to form a professional opinion about the matter on which he has been consulted;

“free request” means a request made voluntarily (i.e., without coercion or duress);

“informed request” means a request made by a person who understands and appreciates the nature and consequences of the request and who understands and appreciates the person’s diagnosis and prognosis and the feasible alternative courses of action or inaction;

“health care provider” means a person licensed to practice in a health profession under the laws of the province or territory in which the assisted suicide is reasonably expected to occur;

“patient” means an individual under the care of a physician;

“physician” means a doctor of medicine licensed to practice medicine under the laws of the province or territory in which the assistance is provided;

“request” means something asked for by a person orally or in writing;

“witness” means an individual of the age of majority who is not a relative (by blood, marriage, or adoption), an owner, operator or employee of the health care facility in which the person making the request is receiving treatment, or a resident, a physician involved in the care of the patient, or at the time of acting as a witness entitled to any portion of the estate upon death under any will or by operation of law.

There is a great deal of confusion over terms in this area. It is therefore essential to clearly define all of the key terms. This will ensure the meaning of the legislation is clear and not misunderstood (by those considering passing the Bill, individuals seeking assisted suicide, individuals providing assistance, the public, police, prosecutors, and judges called upon to interpret the law). Clear definitions will also make the statute less vulnerable to a Charter challenge on “vagueness” grounds.

“Witness” is defined in this detailed way to prevent any possible conflict of interest clouding the process.
There is no reference in the statute to “terminal illness” as a prerequisite for requesting assistance. The term is too vague and would leave the statute open to a Charter challenge. There is no precise science to providing a prognosis of a terminal illness in terms of a specific length of time. Health care providers cannot be accurate enough, and if the statute does not include a time restriction then the condition “terminal illness” becomes too broad. For example, a person with Guillain-Barré syndrome will die from her disease, but may live ten years after prognosis. Further, the term is potentially overinclusive if used as a sufficient (but not necessary) condition to request assistance in death. For example, a person may be given a prognosis of ten years to live with a terminal illness, not be suffering, and yet still be eligible to request assistance. Alternatively, if the term “terminal illness” is made a necessary condition in the statute, then it would be underinclusive: there are many individuals whose lives are no longer worth living to them who have not been diagnosed with a terminal illness. They may be suffering greatly and permanently, but are not imminently dying. There is no principled basis for excluding them from assisted suicide.

No offence where conditions and requirements met

(4) No health care provider is guilty of an offence under this Act where the health care provider meets the requirements set out in paragraphs 5-8 and where the health care provider provides assistance with suicide to a competent person making a free and informed request.

The statute specifically restricts the provision of assistance to health care practitioners. This ensures that the individuals who provide assistance are knowledgeable with respect to competency assessments as well as the best means of assisting death (to avoid failed attempts).

The statute does not require that individuals who are given assistance with suicide are of the age of majority. Mature minors (i.e., individuals under the age of majority who are competent) are not excluded under this Act. This is consistent with the increasingly strong commitment to the mature minor rule in the common law and some provincial/territorial statutes.

Required assessments

(5) The attending physician shall have:

(a) examined the person making the request and have no reason to believe the person to be incompetent. If the attending physician has any doubts about the competence of a person who wishes to
make or has made a request, the attending physician shall refer the person to a consulting physician for a competency assessment and the request may not be acted upon unless the consulting physician subsequently determines that the person is competent; and

(b) examined the person making the request and have no reason to believe the person to be making a request that is not free; and

(c) informed the person making the request of the patient’s medical diagnosis, prognosis, the consequences of the request being honoured, the feasible alternatives including, but not limited to, comfort care, palliative or hospice care, and pain control, and the right to revoke the request at any time.

Required declaration

(6) The person shall have made a valid declaration of the request for assisted suicide and that declaration must be in force:

(a) In order to be valid, a declaration must be:

   (i) signed by the person in the presence of the attending physician and two witnesses or received as a solemn declaration under s.41 of the Canada Evidence Act;  

   This section is to make it possible for someone who is physically incapable of signing a document to make a legally valid declaration. It makes use of an existing legal mechanism (from the Canada Evidence Act) rather than creating a new one.

   (ii) signed in the presence of the person and the attending physician by two witnesses who, in the presence of the person attest that to the best of their knowledge the person is competent and the request is free and informed;

   (iii) made by an individual who is a citizen or permanent resident of Canada as at the date of the declaration; and

   This section is designed to prevent assisted suicide “tourism.”

   (iv) placed in the patient’s medical record.
(b) The declaration shall come into force fourteen days after being signed by the attending physician, the person making the declaration, and the witnesses.

This section is designed to seek a balance between ensuring time for reflection and imposing a lengthy time of suffering on the individual seeking assistance. It is hoped that the declaration process will be completed in advance of suffering such that the fourteen day requirement will not impose any undue hardship.

(c) The declaration shall cease to be in force if it has been revoked by the person who made it:

(i) a person may revoke a declaration at any time;

(ii) a written, oral, or other indication or withdrawal of consent is sufficient to revoke the declaration even though the person may not be competent when the indication is given; and

(iii) in the event of a declaration being revoked, the attending physician shall ensure that a note recording its revocation is made clearly on the declaration.

Required information

(7) The person shall have completed any forms required by the Commission and given it to the attending physician for inclusion in the patient’s medical record.

This section creates a process through which the Commission (described below) can gather information necessary for the performance of its monitoring function (e.g., demographic information and information about such issues as the reasons for seeking assistance about those who seek assistance and those who ultimately commit assisted suicide). Without requiring the completion of the forms, there could be significant privacy law and constitutional division of powers barriers to gathering the information.

Required documentation and filing

(8) The attending physician shall have ensured that:

(a) the following were filed in the patient’s medical record:
(i) the required declaration required under paragraph 6 and the information required under paragraph 7;

(ii) a note signed by the attending physician and patient stating that immediately prior to providing assistance, the physician offered the patient the opportunity to revoke the declaration; and

(iii) a note signed by the attending physician stating that he was satisfied that, at the date and time of his having provided assistance, all requirements under this Act had been met and indicating the steps taken to carry out the request.

(b) the information required under paragraph 7 was submitted to the Commission within fourteen days of having been placed in the patient’s medical record.

Initially and perhaps most fundamentally, the statute includes procedural protections that ensure that assessments, declarations, and documentation are properly completed and filed. These protections ensure that those who choose to access assisted suicide are competent and make free and informed decisions about assisted suicide. They also provide protection from liability to those who provide assistance according to the rules.

The requirement for physicians to submit the information to the Commission is included here because without it there would be no way for the Commission to access the information that it will need to meet its monitoring mandate (a federal Commission would have no jurisdiction to review individual health records). It also provides a mechanism for the gathering of information needed to monitor assisted suicide in Canada without breaching patient confidentiality (identifiable information will not be transmitted to the Commission and so will only be seen by health care providers who already have access to it).

Offences and penalties

(9) A person commits an offence if he wilfully falsifies or forges a declaration made under this Act with the intent or effect of causing the person’s death. A person guilty of an offence under this subsection shall be liable, on conviction, to imprisonment for a term not exceeding twenty-five years.
(10) A witness commits an offence if he wilfully puts his name to a statement he knows to be false. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(11) A person commits an offence if he wilfully conceals or destroys a declaration or revocation made under this Act. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(12) An attending physician commits an offence if he wilfully fails to submit the information required under paragraph 8. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(13) An attending or consulting physician or other health care provider involved in the care of a patient commits an offence if he takes any part whatsoever in assisting a patient to die or in giving an opinion in respect of such a patient, or acts as a witness if he has grounds for believing that he will benefit financially or in any other way as the result of the death of the patient. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

The inclusion of offences ensures that the prohibitions and conditions set out in the statute are taken seriously, all of the steps established to protect the vulnerable are followed, and that the important prohibitions remaining in the Criminal Code (e.g., providing assistance in suicide to incompetent persons) are treated seriously. They also provide reassurance to the public that the responsibility for regulating assisted suicide is being taken seriously by the state.

Inconsistencies

(14) Where there is any inconsistency or conflict between this section and any other provision of this Act or any other federal legislation, this section prevails to the extent of the inconsistency or conflict.

2. (1) The Commission to Monitor and Report on Assisted Suicide in Canada is hereby established as a body corporate that may exercise powers and perform duties only as an agent of Her Majesty in right of Canada.
(a) The Commission shall:

(i) develop a form that the patient must complete and give to the attending physician for inclusion in the patient’s medical record. This form shall solicit non-identifying information including but not limited to information about the patient including demographics (age, sex, marital status, education level, income level), medical condition, and reasons for seeking assistance;

(ii) collect and analyze data from the submitted forms; and

(iii) generate and make available to the public an annual statistical report of information collected under this Act.

(b) At its discretion, the Commission may:

(i) commission research based on patient medical record reviews in accordance with relevant federal, provincial, and territorial law and policy; and

(ii) make recommendations to the Attorney General of Canada about potential law and policy reform with respect to assisted suicide in Canada.

(c) The governance structure of the Commission and appointment of the Chair and members of the Commission shall be established by the Governor in Council.

(d) The Chair and members of the Commission are responsible for the overall management of the Commission and may, with the approval of the Governor in Council, make by-laws for the regulation of its proceedings and generally for the conduct of its activities.

The Commission will gather information and compile statistics surrounding assisted suicide and will serve as a valuable resource to ensure that the rules set out in this statute are being followed and to reassure those who are concerned about a slippery slope. The reporting and monitoring system required to protect and to be seen to be protecting cannot be done through any existing means. For example, a reporting requirement imposed by the federal parliament on coroners is not possible as coroners fall outside federal jurisdiction. The oversight of a section of the Criminal Code must be achieved through a mechanism within the jurisdiction of the federal government.