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A Legal Framework for the Assessment of a Voluntary Request for Medical Assistance in Dying

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A thesis submitted in partial fulfillment of the requirements for the Master of Laws degree in Law

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Abstract

In response to the Supreme Court of Canada's ("SCC") 2016 ruling *Carter v. Canada*, Parliament passed Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. Bill C-14 primarily amended section 241 of the *Criminal Code* to create an exemption to the crime of counselling or aiding suicide, thereby allowing physicians and nurse practitioners to provide eligible patients with medical assistance in dying (MAID). Since Bill C-14, there has been further evolution in the law to allow patients to access MAID if their natural death is reasonably foreseeable or even if natural death is not reasonably foreseeable provided the associated safeguards are met. The evolution of the law to include those whose natural death is not reasonably foreseeable has raised concerns in the medical and legal community about the interpretation of the legal requirement that a request for MAID be voluntary and not the result of external pressure. These concerns include who should be involved in assessing voluntariness and how this is best achieved. Recently this has expanded to include the extent to which psycho-social-economic concerns, factors that may be beyond the control of the individual requesting MAID and the health care team, influence the assessment of voluntariness.

This project examines the idea of voluntariness and argues that social workers are uniquely situated to assist with assessing whether a patient's request is voluntary. Chapter two explores the historical decriminalization of assisted suicide and how voluntariness has been considered in the relevant jurisprudence, including *Rodriguez v British Columbia (Attorney General)* and *Carter v Canada (Attorney General)*. Chapter three expands my scope of review to other areas of law that consider voluntariness such as the confessions rule arising in the criminal law context, unconscionability as it relates to contract law, and informed consent in health law. A comprehensive review of the various special senate committee reports, which address the development of Bill C-14 and the subsequent expansion of Canada's MAID regime, is used to inform the intention of the voluntary request provision. Chapter four explores the role of social workers in assisting with voluntariness assessments and considers how they are uniquely situated to assist with this work arising from their professional Code of Ethics and scope of practice. The social work profession has a particular interest in the needs of the vulnerable and identifying barriers to services and unmet psycho-social-economic needs. The consideration of unmet needs play an important role in the assessment of voluntariness. Chapter five pulls together the learnings from the previous chapters and identifies the key legal considerations when assessing voluntariness and the important role of social workers in this work.

This project ultimately identifies a role for social workers in assisting physicians and nurse practitioners with voluntariness assessments and suggests they serve as an additional safeguard for ensuring comprehensive voluntariness assessments that consider the individuals' biopsychosocial context in which the request for MAID arises. It concludes by identifying key legal considerations to assess voluntariness and how the law supports the role of social workers in this work.

Keywords

Medical assistance in dying, physician assisted suicide, voluntary, voluntariness, charter of rights and freedoms, vulnerability, self-determination, bodily autonomy, informed consent, capacity, social work, biopsychosocial, assessment, external pressure, coercion, duress, ambivalence

Summary for Lay Audience

In response to the Supreme Court of Canada's ("SCC") 2016 ruling *Carter v. Canada*, Parliament passed Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. Bill C-14 primarily amended section 241 of the *Criminal Code* to create an exemption to the crime of counselling or aiding suicide, thereby allowing physicians and nurse practitioners to provide eligible patients with medical assistance in dying (MAID). The *Criminal Code* sets out a number of eligibility criteria, along with associated safeguards that must be met prior to the provision of MAID.

One of the *Criminal Code* eligibility criteria requires that the person makes a voluntary request for MAID that is not the result of external pressures. Through the evolution of the law, concerns have been raised about the interpretation of voluntariness including how to assess and who should complete this assessment. Generally, the underlying concern relates to ensuring vulnerable persons are not coerced or unduly influenced to request MAID based on external pressures such as socio-economic concerns. This project examines the idea of voluntariness and argues that social workers are uniquely situated to assist with assessing whether a patient's request is voluntary.

This project ultimately identifies a role for social workers in assisting physicians and nurse practitioners with voluntariness assessments and suggests they serve as an additional safeguard for ensuring comprehensive voluntariness assessments that consider the individuals' biopsychosocial context in which the request for MAID arises. It concludes by identifying key legal considerations to assess voluntariness and how the law supports the role of social workers in this work.

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Dad, without knowing it, you inspired me to take the first step in starting this research, and seven years later you continue to inspire me through your resilience, strength, and grace. Your glass half-full approach to life and riding the waves as they come, has made me who I am and has taught me how to ride the waves with you. You are the most remarkable man I know, and I will always be grateful to you for guiding me through this life and reminding me we can do really hard things. To live each moment - to be silly - to love hard.

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May we all have the choice to live and die on our own terms.

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List of Abbreviations

BCCA – British Columbia Court of Appeal

BCSC – British Columbia Supreme Court

CASW – Canadian Association of Social Workers

College – Alberta College of Social Workers

MAID – Medical Assistance in Dying

MD-SUMC – Mental Disorder as Sole Underlying Medical Condition

NDRF – Natural Death is Reasonably Foreseeable

NDNRF – Natural Death is Not Reasonably Foreseeable

ONSC – Ontario Superior Court of Justice

Practitioner – Includes medical practitioner and nurse practitioner

QCCS – Quebec Superior Court

SCC – Supreme Court of Canada

Track 1 – includes eligible persons whose natural death is reasonably foreseeable

Track 2 – includes eligible persons whose natural death is not reasonably foreseeable

Voluntary Provision – refers to the criminal code requirement that a request for medical assistance in dying is voluntary and not the result of external pressures.

Chapter 1

1 A Voluntary Request for Medical Assistance in Dying

1.1 Introduction

Following the Supreme Court of Canada's (the "SCC") ruling in *Carter v. Canada*, 2015¹ ("**Carter SCC**") in June 2016, Parliament passed Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* ("**Bill C-14**").² Bill C-14 primarily amended section 241 of the *Criminal Code*³ to create an exemption to the crime of counselling or aiding suicide, thereby allowing physicians and nurse practitioners to provide eligible patients with medical assistance in dying ("**MAID**").

MAID is defined in the *Criminal Code* as either the administering by a medical practitioner or nurse practitioner (the "**Practitioner**") of a substance to a person, at their request, that causes their death⁴; or the prescribing by a Practitioner of a substance to a person, at their request, that causes their death.⁵ The definition of MAID permits a patient to self-administer a lethal substance, which has been lawfully prescribed by a Practitioner, to cause their death. The term MAID has been a prevailing term in the public discourse and subsequent court cases on MAID. As such, the term MAID will be used in this thesis as a catchall phrase to capture all legal physician-assisted suicides and assisted-suicides.

The introduction of the MAID legislation has been controversial and emotionally charged for persons involved in the debate. There are a variety of issues raised with respect to the decriminalization of physician-assisted death including the moral, religious, and concerns

¹ *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR [*Carter SCC*].

² Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2015 (as passed by the House of Commons June 17, 2016) [Bill C-14].

³ *Criminal Code*, RSC 1985, c C-46, s 241 [*Criminal Code*].

⁴ *Ibid* at s 241.1(a). Note: a *medical practitioner* means a person who is entitled to practice medicine under the laws of a province; and *nurse practitioner* means a registered nurse who, under the laws of a province, is entitled to practice as a nurse practitioner — or under an equivalent designation — and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.

⁵ *Ibid* at s 241.1(b).

for vulnerable persons. A thorough review of the issues and perspectives raised with respect to the decriminalization of MAID is beyond the scope of this paper, but, in brief, proponents of MAID highlight the importance of autonomy, self-determination and dignity of the person whereas critics of MAID raise concerns about it being immoral, against religious beliefs and fear of potential abuse of vulnerable persons.⁶

Irrespective where one situates herself in the debate, what is clear is that MAID is not strictly an academic issue. Since the legalization of MAID, the number of medically assisted deaths in Canada has been increasing steadily. In 2017, 2,838 MAID deaths were reported to Health Canada, in 2018 4,493 deaths, in 2019 5,665 deaths, in 2020 7,611 deaths, in 2021 10,092 deaths, and in 2022 there were 13,241 deaths.⁷

While the *Criminal Code* is under federal jurisdiction, and thus the MAID framework is to be implemented across the country, ultimately the administration of healthcare falls within the jurisdiction of the province.⁸ Therefore, each province has the authority to implement their own law for the administration of MAID, if they so choose. As of the writing of this thesis, Quebec is the only Canadian province to have implemented legislation regulating MAID.⁹ The majority of healthcare organizations have implemented applicable policies and procedures that govern the administration of MAID, which has resulted in some variations in provincial approaches. A potential concern with the varying provincial approaches is ensuring equal access to MAID across Canada.

The SCC's ruling in *Carter* changed the healthcare landscape in Canada, as it found that the criminal prohibition against MAID violated section 7 of the *Charter of Rights and*

⁶ *Carter v Canada (Attorney General)*, 2012 BCSC 886 [*Carter BCSC*]. This decision provides an extensive review of the various perspectives on the assisted suicide.

⁷ Health Canada, *Fourth Annual Report on Medical Assistance in Dying in Canada* (Ottawa: Health Canada, 2023) at 20 [Annual Report].

⁸ *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, ss 92(7), 92(13) and 92(16), reprinted in RSC 1985, Appendix II, No 5.

⁹ *Act respecting end-of-life care*, CQLR, c. S-32.0001.

Freedoms.¹⁰ As a result of the Court finding section 241.1 of the *Criminal Code* was unconstitutional, the provision was of no force or effect.¹¹ Subsequent to the *Carter SCC* decision, Parliament amended the *Criminal Code* to create a framework for the provision of MAID in Canada, whereby a Practitioner, and those permitted to assist them, would be exempt from criminal culpability if MAID was provided in accordance with the *Criminal Code*.¹² As a result, the *Criminal Code* now includes a framework for the administration of MAID, which encompasses (i) eligibility criteria¹³, (ii) a definition which must be met for a grievous and irremediable medical condition¹⁴, and (iii) numerous safeguards.¹⁵ The evolution of MAID has seen an expansion of persons who may be eligible to include those whose natural death is reasonably foreseeable (“**Track 1**”) and whose natural death is not reasonably foreseeable (“**Track 2**”).¹⁶ In 2022, MAID deaths accounted for 4.1% of all deaths, of all causes, in Canada, and 3.5% of those MAID recipients were assessed as falling under Track 2, representing 0.14% of all deaths, of all causes, in Canada, indicating most MAID recipients fall under Track 1.¹⁷

The expansion of MAID to include Track 2 patients arose as a result of *Truchon v Attorney General (Canada) and Attorney General (Quebec)* (2019), wherein the Quebec Superior Court (“**QCCS**”) found that the reasonably foreseeable death eligibility criterion discriminated against persons with disabilities.¹⁸ Meaning, persons with disabilities who

¹⁰ *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, Constitution Act, 1982, R.S.C. 1985, App. II, No. 44, Schedule B. Note: section 7 of the charter states, “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”.

¹¹ *Criminal Code*, *supra* note 3; *Constitution Act*, 1982, Schedule B to the *Canada Act 1982* (UK), 1982, c. 11 at section 52 [*Constitution 1982*].

¹² *Criminal Code*, *supra* note 3.

¹³ *Ibid* at s 241.2(1)(d).

¹⁴ *Ibid* at s 241.2(2). Under the Act, a *grievous and irremediable medication condition* is one in which meets all of the following criteria: (a) a serious and incurable illness, disease, or disability (the “condition”); (b) advanced state of irreversible decline; (c) the condition causes enduring physical and psychological suffering that is intolerable to the patient and cannot be relieved under conditions the patient considers acceptable; and (d) death is reasonably foreseeable.

¹⁵ *Ibid* at s 241.2(3).

¹⁶ *Ibid* at s 241.2(3.1) and 241.2(3.2), respectively.

¹⁷ Annual Report, *supra* note 7, at 34.

¹⁸ *Truchon v Procureur general du Canada*, 2019 QCCS 3792, [2019] QJ No. 7750 [*Truchon*].

meet all other eligibility criteria can access MAID. Following *Truchon*, there was debate about whether the removal of the criterion that natural death is reasonably foreseeable would lead some individuals to request MAID due to inadequate social determinants of health, including things such as a lack of access to appropriate care, ongoing abuse or violence, or socioeconomic factors such as income, education, race, age, health insurance and institutionalization.¹⁹ There is some empirical evidence that supports the view that disability can reduce an individual's social determinants of health including financial issues, which has subsequent negative effects on housing, transport and social interactions along with interpersonal relationships.²⁰ The Canadian Parliament and courts have considered the arguments related to concerns with people accessing MAID as a result of poor social determinants of health, as opposed to the underlying medical condition, and have concluded that despite the concerns, an individual case-by-case assessment is appropriate rather than group-based exclusions.²¹ Social workers have been identified as playing a role in the administration of MAID and specifically are skilled at addressing the social determinants of health, which can be used to determine whether external pressures are compromising the voluntariness of a MAID request.²²

The MAID law presently contemplates the involvement of other healthcare providers beyond practitioners.²³ For example, in practice, I have seen nurses involved in the administration of MAID in Alberta. Specifically, registered nurses often fulfil the "Nurse Navigator" role, which is the first point of contact a person makes when they seek information about MAID through the Alberta Health Services ("AHS") MAID Care Coordination Service (the "**MAID Care Coordination Service**"). The MAID Care

¹⁹ Jocelyn Downie & Udo Schuklenk, "Social Determinants of Health and Slippery Slopes in Assisted Dying Debates: Lessons from Canada" (2021) 47:662–669 *J Med Ethics* [Jocelyn Downie]; *Truchon*, *supra* note 18, at para 252.

²⁰ Amanda Frier et al, "Understanding Disability and the 'Social Determinants of Health': How Does Disability Affect Peoples' Social Determinants of Health?" (2018) 40(5):538 *Journal of Disabil Rehabil*.

²¹ Jocelyn Downie, *supra* note 19 at 666.

²² Canada, Parliament, External Panel on Options for a Legislative Response to *Carter v Canada*, *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings, Final Report* (15 December 2015) at 11 [First Report]; Canadian Association of Social Workers, *Safety, Community and Social Work: Possibilities for Canadians* (2022) at 20.

²³ *Criminal Code*, *supra* note 3 at s 241(3).

Coordination Service was developed by AHS to act as a single point of contact for patients, families, and healthcare providers to access education and supports, referrals to other community services, linkages to all end-of-life care options and arrange MAID eligibility assessments and provisions.²⁴ In addition to Nurse Navigators, social workers form part of the multi-disciplinary team, which may be accessed by the MAID Care Coordination Service for a variety of purposes.

As a practicing health lawyer for a provincial health authority, I provide legal advice to Practitioners, allied healthcare providers and administrators with respect to MAID, and support the provinces approach to the administration of MAID. I am in a unique position where I have witnessed the evolution of MAID through the courts and legislature, and through case specific legal consults. Through this experience, I have developed a practical and academic interest in understanding what it means for a person to voluntarily request MAID, that is to say, a request that is not the result of external pressures (the “**Voluntary Provision**”).²⁵

The Voluntary Provision has proven to raise concerns for Practitioners, allied health care providers, healthcare administrators and lawyers, specifically as it relates to **how** to assess voluntariness, **who** is best situated to assist a Practitioner with assessing voluntariness, and the legal factors that ought to be addressed when assessing voluntariness. While there is some jurisprudence and literature that provide insight into the interpretation of voluntariness, it is limited as it does not address the second part of the Voluntary Provision, which requires the request to not be the result of external pressures.

The purpose of this thesis is to two-fold and includes: (1) identifying the role of social workers in assisting with assessing the voluntariness of a MAID request; and (2) development of a framework to assess voluntariness, including key legal factors that must be considered when assessing voluntariness. This thesis argues social workers are well situated to assist Practitioners with assessing voluntariness and that the key legal factors to

²⁴ Alberta Health Services, *Patients or Family Members - Medical Assistance in Dying* (3 March 2024).

²⁵ *Criminal Code*, *supra* note 3 at s 241.2(1)(d).

determine whether a request for MAID is voluntary, include considering vulnerability, coercion, duress, and ambivalence. The assessment of voluntariness cannot be so restrictive it excludes individuals who otherwise would be eligible for MAID.

1.2 Overview

This thesis begins in chapter two by providing an overview of the historical criminalization of assisted suicide and traces the evolution of Canadian jurisprudence and legislation related to MAID, highlighting social progress and a desire to strike a balance between autonomy, dignity, and self-determination with the societal interest of protecting vulnerable people. This chapter is organized in a way to reflect the key time periods including (1) *Pre-Rodriguez* era; (2) *Rodriguez* and *Post-Rodriguez* era; (3) *Carter* era; and (4) *Post-Carter* era. Each section reviews the relevant jurisprudence and legislation and aims to provide context to the concerns with legalizing MAID, which were used to inform the safeguards in the MAID law and will be used to inform this writer's interpretation of the Voluntary Provision.

Chapter three provides a comprehensive review of the parliamentary committee reports that seek to explore and consider the development of a robust MAID framework in Canada that balances the protection of vulnerable persons while respecting individual rights to bodily autonomy and self-determination. It also considers the expert reports that address specific concerns related to the administration of MAID to mature minors, persons whose sole underlying medical condition is mental disorder (“**MD-SUMC**”) and the inclusion of MAID in advance directives. To supplement this review, I expand my scope to include other areas of law that contemplate the meaning of voluntariness, including the confessions rule, unconscionability, and informed consent. The purpose of this chapter is to identify the ways in which the law currently contemplates voluntariness and is used to inform my interpretation of the Voluntary Provision in the context of MAID.

Chapter 4 explores the role of social workers in the assessment of voluntariness. As it is beyond the scope of this paper to provide an examination of all the roles a social worker may have within the broader MAID context, which would include all interactions a social worker may have with a patient leading up to a request and family support before and after

a MAID provision, this analysis focuses on how social workers can assist a Practitioner with assessing the voluntariness of a MAID request. The social work profession has a particular interest in the needs of the vulnerable and identifying barriers to services and unmet psycho-social-economic needs. This writer advocates for the inclusion of social workers in the assessment of voluntariness because of their unique skill set in identifying and addressing social determinants of health by way of biopsychosocial assessments, and their professional Code of Ethics that emphasizes the inherent worth of persons and the expectation that social workers uphold each person's right to self-determination.

Chapter five focuses on pulling together the learnings from the preceding chapters to put forward a proposed framework to identify the legal considerations when assessing voluntariness. This includes an application of how other areas of law, the courts and government reports have considered voluntariness generally and specific to MAID and identifies an interpretation of the Voluntary Provision that articulates the scope of the assessment, the key legal factors to be considered, and the role of social workers in this assessment.

Chapter six concludes by identifying recommendations for future research and limitations with the present research.

1.3 Methodology

This project utilized two methodologies: (a) doctrinal legal analysis; and (b) an analysis of government reports that have been developed by, or at the request of, the Government of Canada, related to the development, implementation, and evolution of MAID in Canada. These methodologies are informed by my position as a health lawyer, specializing in MAID law. This project initially sought to understand the role of the social worker at a time when the MAID law was novel, and I was not yet practicing MAID law. Over time, my research has evolved to respond to a specific, and very practical legal question, that has been highlighted numerous times by Practitioner's seeking advice on the interpretation of the Voluntary Provision. As a result of health care and health care professionals being provincially regulated, when it is necessary to identify a provincial approach or regulation, the Alberta context will be used.

1.3.1 Positionality

Before reviewing the methodology employed in this thesis, it is beneficial to first identify my own positionality, which has informed the research question and approach. I am a health lawyer practicing in one of Canada's largest provincial healthcare authorities, AHS, and lead the organization's MAID program from a legal perspective. Prior to pursuing my legal career, I trained as and practiced social work in a variety of contexts, including healthcare and grass-roots projects and, I continue to inform my legal practice by social work theories and values. Specifically, the right to self-determination and bodily autonomy have been foundational values underpinning my legal advice to clients. The wearing of two professional identities can, at times, lead to conflict but mostly it allows me to step outside of the confines of either practice area and integrate both identities to provide patient-centered advice.

In 2016, when I started my studies at Western University's Master of Law program, I set out to consider the role of the social worker in the new MAID law in Canada. From the beginning of developing the MAID regime in Canada, the MAID law and the Canadian Association of Social Workers, contemplated a role for appropriately trained social workers to assist in the administration of MAID in Canada. At the time, I was practicing insurance law and was not providing legal advice to individuals involved in the administration of MAID. However, a personal interest in MAID arose following a tragic accident that left my dad with a brain injury and the loss of my grandfather. It initiated questions related to what it means to live and die well, and how, as a society and individuals, we can usher our loved ones through the dying process in a dignified and respectful way.

Since 2016, my thesis has been paused numerous times due to the unfolding of life including a relocation from Ontario to Alberta, a change in family circumstances that saw me welcome my first baby as a single parent and starting a fast paced and emotionally laden career as a health lawyer. As a health lawyer, I provide timely advice to a variety of front-line healthcare providers related to MAID, consent and capacity, mental health law (civil and forensics), privacy, health professions, quality and patient safety, emergency

medical services, among other areas of health law. During this time, there was also significant evolutions in MAID law.

My health law practice has been the most rewarding and fulfilling career adventure to date. Since 2018, I have immersed myself in the development of the provincial health authorities MAID program, including policy development and responding to the evolution of the law, along with providing advice to Practitioners, allied health providers and administrators involved in the administration of MAID in Alberta. This extends to the interpretation of the *Criminal Code* MAID provisions and application to complex fact scenarios. As I write this dissertation, I am actively involved in litigation related to MAID that will inevitably be a precedent setting case in Alberta.²⁶

1.3.2 Statutory Interpretation

To interpret the meaning of the Voluntary Provision, this paper will undertake a modern approach to statutory interpretation. The modern approach to statutory interpretation supports the view that Parliament's intention is the relevant guide to the interpretation of statutes and can be determined by reference to external sources,²⁷ such as MAID related jurisprudence and government reports.²⁸

Statutory interpretation is often described as more of an art than a science.²⁹ Today there is one widely accepted “principle or approach [to statutory interpretation], namely, the words of an Act are to be read in their entire context in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament”.³⁰ This approach was adopted by the SCC in *Stuart Investments Ltd v The*

²⁶ *WV v MV*, 2024 ABKB 174, [2024] AJ No. 334 [*WV*].

²⁷ EA Driedger, *The Construction of Statutes*, 2d ed (Toronto: Butterworths, 1983) at 87 [Driedger]; Ruth Sullivan, *Driedger on the Construction of Statutes*, 3d ed (Markham: Butterworths, 1994) at 131 [Sullivan, 1994].

²⁸ A. Cramm, “Medical Assistance in Dying: The Nature of A Voluntary Request”, paper submitted in Independent Research Course, Dr. Randal Graham, 2017 [Cramm].

²⁹ Randal Graham, “Western Law: Statutory Interpretation” Lecture notes from *Orientation to Law and the Legal System*, (Faculty of Law, Western University, 2016) [Graham 2016].

³⁰ Driedger, *supra* note 27 at 87; Cramm, *supra* note 28.

*Queen*³¹ and affirmed in *R v Sharpe*,³² and has become known as the modern approach to statutory interpretation.³³ There are three essential elements to the modern approach as adopted in *Stuart Investments*, being (a) the ordinary meaning of the words, (b) the context, and (c) the purpose of the Act.³⁴ The importance of the purpose of the Act is also established by section 12 of Canada's *Interpretation Act*, which requires statutes to be interpreted in a manner which ensures that the statute achieves its intended purpose.³⁵ Section 12 reads as follows:

Every enactment is deemed remedial, and shall be given such fair, large and liberal construction and interpretation as best ensures the attainment of its objects.

The “attainment of its objects” is understood as attaining the purpose of the Act and using the purpose to guide your interpretation of the provision.³⁶ In summary, Ruth Sullivan has restated the modern rule as follows:

There is only one rule in modern interpretation, namely, courts are obliged to determine the meaning of legislation in its total context, having regard to the purpose of the legislation, the consequences of proposed interpretations, the presumptions and special rules of interpretation as well as admissible external aids.³⁷

Accordingly, the interpretation of the Voluntary Provision is undertaken using a modern approach to statutory interpretation, which identifies the purpose of the Voluntary Provision by way of considering judicial interpretation of voluntariness and informed by external sources specific to the Voluntary Provision as contemplated in MAID.

³¹ *Stuart Investments Ltd v The Queen* [1984] 1 SCR 536 [*Stuart Investments*].

³² *R v Sharpe*, [2001] 1 SCR 45 at para 33.

³³ Driedger, *supra* note 27 at 87; Cramm, *supra* note 28.

³⁴ *Stuart Investments*, *supra* note 31.

³⁵ *Interpretation Act*, RSC 1985 c I-21 at s 12 [*Interpretation Act*]. Alberta's provincial *Interpretation Act*, RSA 1980 cI-7 has a similar provision at section 10; Cramm, *supra* note 28.

³⁶ Randal Graham, *Statutory Interpretation: Theory and Practice* (Emond Montgomery Publications, 2001) at 111 [R. Graham 2001].

³⁷ Sullivan, 1994, *supra* note 27 at 131; Cramm, *supra* note 28.

A review of secondary sources specific to voluntariness in the Canadian MAID context was completed and sources were identified using Western Libraries electronic database by using the following search terms, in various combinations: “medical assistance in dying” & “volunt*” & “canad*” & “assess*” & “interp*”. I further narrowed the search within the following time period: June 1, 2016, to June 1, 2024. The rationale for narrowing the search based on this time period was to assist with identifying secondary sources that would be interpreting voluntariness, at least in part, based on Bill C-14. I intentionally limit the consideration of relevant secondary sources as I am concerned with how the courts have interpreted voluntariness and not how academics or others have interpreted the meaning of voluntariness. I have identified and relied upon secondary sources in understanding the interpretation of voluntariness where there was no legal consideration and further clarity was provided by the secondary source. Notably, there is very little academic literature on the interpretation and assessment of a voluntary request in the MAID context. In addition, the secondary sources identified were not from a legal perspective but rather a clinical perspective. The clinical perspective has utility for those who are completing the voluntariness assessment but does not add much value to the framing of the legal interpretation of voluntariness. I also looked at the Hansard debates related to all MAID related Bills to determine the language used when discussing voluntariness and inform my understanding of the possible intention of the Voluntary Provision.

I acknowledge there is a significant body of literature on voluntariness from an ethical perspective. I intentionally did not review this literature as my interest is to interpret and provide a framework for the assessment of voluntariness based on the current law. The ethical framing of voluntariness is an important consideration and would be an important perspective to consider in assessing voluntariness but does not supersede or change the legal interpretation of voluntariness as reflected in the jurisprudence.

1.3.3 Doctrinal Research

The purpose of the Voluntary Provision is articulated based on a review of *Carter*, government reports and subsequent MAID jurisprudence. Through this review, the purpose of the Voluntary Provision is made clear and helps inform the interpretation of voluntariness in the MAID context.

Doctrinal research is used to identify how the courts have interpreted voluntariness specific to the MAID context.³⁸ MAID jurisprudence was identified using Quicklaw by noting up section 241.2(1) of the *Criminal Code*. Given the limited MAID jurisprudence, I was able to conduct a preliminary review of all the caselaw and narrowed my research by systematically identifying cases that referred to, or considered, voluntariness by using the following search terms: “abuse” & “ambivalence” & “coerc*” & “influence” & “social determinants” & “undue” & “unduly” & “voluntary” & “voluntariness” & “vitiating” & “vulnerable” & “vulnerability”. I completed a full review of these cases and synthesized the key factors to be considered when assessing voluntariness.

As the primary interest was on the *voluntariness* of a MAID request, I also set out to identify how voluntariness has been discussed by the courts in other contexts. Based on my professional experience, I used purposive sampling and deliberately chose three other areas of law I was aware of that explicitly consider voluntariness, including the confessions rule, unconscionability, and informed consent. The jurisprudence was identified by using Halsbury’s Laws of Canada and Quicklaw. The other areas of law are used to supplement the limited jurisprudence in the MAID context due to MAID being relatively new in Canada. The court’s interpretation of voluntariness is of significance as it is the court that will be tasked with interpreting the Voluntary Provision. To understand the role of the social worker in MAID, I relied upon the regulation of social workers in Alberta as the profession is provincially regulated. I reviewed secondary sources that were directly related to social work practice in MAID and how social workers have been involved to date. These documents were identified by using Western Libraries electronic database by using the following search terms: “assessment” & “biopsychosocial” & “Canada” & “economic” & “medical assistance in dying” & “MAID” & “practice” & “role” & “responsibil*” & “social determinant of health” & “social work” & “voluntary” & “vulnerab*”. Similar to the MAID jurisprudence, there is limited secondary sources on this topic and the sources identified were all reviewed.

³⁸ Dawn Watkins, *Research Methods in Law*, 2nd ed (Routledge, 2018) at 9-10; Mike McConville, Wing Hong Chui, *Research Methods for Law*, (Edinburgh: University Press, 2017) at 21, 25.

1.3.4 Analysis of Government Reports

A purposive approach was used to identify the specific government reports that have been written for the development of the MAID regime outlined in the *Criminal Code*. I specifically focused on government reports as my main interest was determining how those who are charged with interpreting voluntariness, the courts and government, have interpreted voluntariness and not how others have suggested voluntariness should be interpreted. This included any resulting reports that reviewed specific issues related to MAID in Canada, such as the expansion of MAID to mature minors and persons whose sole underlying medical condition is mental disorder. As a result of my professional practice, I was aware of the related government reports, which were all located online on the Health Canada and Government of Canada websites. The government reports offer significant insight into the purpose of the Voluntary Provision and identifies specific concerns for which the Voluntary Provision seeks to address.

Chapter 2

2 The History of Medical Assistance in Dying in Canada

The following chapter provides an overview of the historical criminalization of assisted suicide and traces the evolution of Canadian jurisprudence and legislation related to MAID, highlighting social progress and a desire to strike a balance between autonomy, dignity and self-determination with the societal interest of protecting vulnerable people. The purpose of this chapter is two-fold: (1) to provide an overview of important jurisprudence and legislation in the evolution of MAID; and (2) highlight key considerations that will assist with interpreting voluntariness in the context of MAID. In order to interpret and understand voluntariness, it is critical to review the history of MAID to identify the longstanding concerns with legalization as, undoubtedly, this has informed our current MAID regime and approach to voluntariness. The modern approach to statutory interpretation requires a contextual analysis and examines the social, cultural, and historical realities relevant to the Voluntary Provision.³⁹ The context of the Voluntary Provision is of paramount importance, as articulated in *AG v Prince of Hanover*,

For words, and particularly general words, cannot be read in isolation: their colour and content are derived from their context. So it is that I conceive it to be my right and duty to examine every word of a statute in its context, and I use “context” in its widest sense...as including not only other enacting provisions of the same statute, but its preamble, the existing state of the law, other statutes *in pari materia*, and the mischief which I can, by those and other legitimate means, discern the statute was intended to remedy.⁴⁰

³⁹ Cramm, *supra* note 28.

⁴⁰ *AG v Prince of Hanover*, [1957] AC 436 at 461 [*Prince of Hanover*].

A significant source of context is found within the *Carter* decision and reviewing this decision is appropriate as it forms the basis of the MAID law.⁴¹ Additional context is garnered by considering the evolution in the jurisprudence related to physician assisted suicide and legislation starting with the *Pre-Rodriguez* era.

The contextual analysis begins with canvassing the *pre-Rodriguez era*, from the early 1800s to the SCC's 1993 decision in *Rodriguez v British Columbia (Attorney General)* ("**Rodriguez SCC**").⁴² This era is characterized by the criminalization of attempting suicide and assisted suicide and culminated in the first federal working paper that considered decriminalizing assisted suicide.⁴³ This is followed by the *Rodriguez-era*, as defined by the SCC's precedent setting decision in *Rodriguez SCC* that, while Rodriguez was unsuccessful in decriminalizing assisted suicide, this decision fundamental in prompting discussions around end-of-life care and how Canadians view autonomy and self-determination. The post-*Rodriguez* era extends to 2015, and saw multiple federal reports that sought, in part, to address the important issues raised in *Rodriguez SCC*. Additionally, this marked the beginning of attempts in Parliament to decriminalize assisted suicide. Next, I review the trilogy of *Carter v Canada (Attorney General)*⁴⁴, which overturned *Rodriguez SCC*, and paved the way for the decriminalization of assisted suicide if assistance was provided by a Practitioner. The Post-*Carter era* includes consideration of the legislatures response to *Carter SCC*, outlines the important judicial decisions since *Carter SCC*, and legislative amendments to the *Criminal Code*, that contribute to the continuing evolution of MAID in Canada. This chapter concludes by putting forward key legal criteria, as identified through the jurisprudence and legislation, that ought to be considered when seeking to assess the voluntariness of the request for MAID.

⁴¹ Driedger, *supra* note 27 at 87; Sullivan, 1994, *supra* note 27 131; Memorandum from Dr. Randal Graham, Professor at the Faculty of Law at Western University (nd) "Bill C-14" appearing before the Senate of Canada [Graham memo]; Cramm, *supra* note 28.

⁴² *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 SCR 519, [1993] 3 RCS 519 [*Rodriguez SCC*].

⁴³ Canada, Law Reform Commission of Canada, *Working Paper No. 28, Euthanasia, Aiding Suicide and Cessation of Treatment*, (1982) [Euthanasia Working Paper].

⁴⁴ *Carter BCSC*, *supra* note 6; *Carter v Canada (Attorney General)* 2013 BCCA 435 [*Carter BCCA*]; *Carter SCC*, *supra* note 1.

2.1 The Pre-*Rodriguez* Era

Assisted suicide and attempting suicide have a long history of criminalization. As cited in *Carter BCSC*, until 1823 English common law provided that suicide was deemed a form of homicide that was thought to “offend against both God and the King’s interest in the life of his citizens”.⁴⁵ With the enactment of the first Canadian *Criminal Code* in 1892, the offences of assisting suicide and attempting suicide were codified as criminal offences by virtue of sections 237 and 238, respectively.⁴⁶ These offences remained largely unaltered until 1954, when the *Criminal Code* underwent a “general overhaul”.⁴⁷ With this overhaul, the maximum penalty for assisting suicide was reduced from life imprisonment to 14 years and “attempted suicide was converted into a summary conviction offence with a maximum penalty of six months incarceration”.⁴⁸ It was not until 1972, when Bill C-2 was passed that the offence of attempted suicide was abolished. As explained by then Minister of Justice Otto Lang, attempted suicide did not require a legal remedy (nor a deterrent under the legal system) and that any solutions could be found outside of the law, within sciences.⁴⁹ Prior to the passing of Bill C-2, there were about 300 to 400 convictions under the predecessor sections to section 241.⁵⁰

In 1982, the Law Reform Commission of Canada (the “**Law Reform Commission**”) gave consideration to the question of physician assisted death in its Working Paper No. 28, *Euthanasia, Aiding Suicide and Cessation of Treatment* (the “**Euthanasia Working Paper**”).⁵¹ While the Euthanasia Working Paper stopped just short of recommending the decriminalization of assisted suicide, due to concerns about the potential abuse of vulnerable persons, it proposed an amendment to section 224 (now section 241) that would

⁴⁵ *Carter BCSC*, *supra* note 6 at para 102.

⁴⁶ *Ibid* at para 103.

⁴⁷ *Ibid* at para 104.

⁴⁸ *Ibid* at para 104.

⁴⁹ *House of Commons Debates*, 28-4, No 2 (27 April 1972) at 1699 (Hon Otto Lang). Lang does not elaborate on what these solutions are.

⁵⁰ *Rodriguez v. British Columbia (Attorney General)*, [1993] BCJ No. 461, [1993] 3 WWR 553 at para 16 [*Rodriguez BCCA*].

⁵¹ Euthanasia Working Paper, *supra* note 43.

require written authorization from the Attorney General to prosecute a person under this section.⁵² The intent of this proposed amendment was to acknowledge the element of altruism and compassion involved in cases of assisting a terminally ill loved one to die.⁵³ In *Rodriguez v Attorney General of British Columbia and Attorney General of Canada*,⁵⁴ (“*Rodriguez BCCA*”) Chief Justice McEachern (as he was then known), of the British Columbia Court of Appeal (the “*BCCA*”) noted the proposed amendment received widespread criticism and disagreement, which resulted in the proposal being withdrawn in the Law Reform Commission’s 1983 Report to the Minister of Justice.⁵⁵ The last change to the *Criminal Code*, prior to the recent amendments following the *Carter* decision, occurred in 1985 when the phrase “counsels and procures” in section 241 was changed to “counsels.”

Since 1985, there has been significant consideration of whether there should be an exception to the offence of aiding suicide for those who are wishing to end their lives. The next section will consider the judicial history of *Rodriguez*, followed by a high-level synopsis of the resulting legislative activities.

2.2 The *Rodriguez* Era

Whether or not assisted suicide should be a criminal offence became the subject of public discourse when the constitutionality of section 241 of the *Criminal Code* was first considered by the Canadian courts in 1992, by the BCSC in *Rodriguez v British Columbia (Attorney General)*.⁵⁶ Following the SCC’s decision in *Rodriguez*, the public discourse on assisted suicide prompted, in part, the forming of the Special Senate Committee on Euthanasia and Assisted Suicide (the “**Special Senate Committee**”).⁵⁷ Additionally, nine Private Members’ bills seeking to amend legislation for the purposes of allowing some

⁵² *Ibid*; *Rodriguez BCCA*, *supra* note 50 at para 17.

⁵³ Euthanasia Working Paper, *supra* note 43, at pg. 69; *Rodriguez BCCA*, *supra* note 50, at para 15.

⁵⁴ *Rodriguez BCCA*, *supra* note 50.

⁵⁵ *Ibid* at para 20.

⁵⁶ *Rodriguez v. British Columbia (Attorney General)*, 1992 CanLII 726 (BCSC) [*Rodriguez BCSC*].

⁵⁷ Canada, Parliament, Senate of Canada, Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death – Final Report*, 35th Parl, 1st Sess (June 1995) [Special Senate Committee].

form of assisted suicide were unsuccessfully introduced prior to the *Carter* decision.⁵⁸ While a comprehensive review of these bills is beyond the scope of this paper, special attention will be paid to Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*,⁵⁹ as this was the last attempt to legislate physician assisted suicide before the judicial consideration in *Carter* and, importantly for our purposes, implicitly considers the requirement of voluntariness.

2.2.1 Supreme Court of British Columbia

At the time Sue Rodriguez filed her application with the BCSC in December 1992, she was 42 years old and suffering from amyotrophic lateral sclerosis (ALS). ALS is an incurable, progressive disease affecting the nervous system, leading to extensive muscle wasting.⁶⁰ Medical evidence presented to the court indicated that patients with ALS generally die within three years after receiving the diagnosis, due to wasting of muscles used in breathing.⁶¹ Prior to death, patients experience difficulty with speech, chewing and swallowing and the loss of most bodily functions.⁶²

In her application, Rodriguez sought a declaration from the court that section 241 of the *Criminal Code*, which makes counselling or aiding suicide a criminal offence, was invalid as the prohibition on physician-assisted death infringed her *Charter* rights, namely sections 7, 12 and 15.⁶³ Rodriguez wished to be able to die on her own terms, and argued she would require the assistance of a medical practitioner to help her commit suicide when she was no longer able to do so on her own given the degenerative nature of ALS.⁶⁴

At trial, Rodriguez claimed that section 241 of the *Criminal Code*, which prevented anyone

⁵⁸ *Carter BCSC*, *supra* note 6 at para 109.

⁵⁹ Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*, 2nd Sess, 40th Parl, 2009 [Bill C-384]. A full review of all nine bills was not conducted as the focus of the paper is how voluntariness has been considered in law and not what has been proposed.

⁶⁰ *Rodriguez BCSC*, *supra* note 56 at para 7.

⁶¹ *Ibid.*

⁶² *Ibid* at para 588.

⁶³ *Ibid* at paras 1–2; *Charter*, *supra* note 10 at ss 7, 12 and 15.

⁶⁴ *Rodriguez BCSC*, *supra* note 56 at para 3.

from assisting her in terminating her life once her disease rendered her incapable of doing so on her own, deprived her both of her right to liberty and her right to security of the person, as guaranteed by section 7 of the *Charter*.⁶⁵ Section 7 of the *Charter* guarantees,

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.⁶⁶

In *Rodriguez BCSC* the court said one of the purposes of section 7 is to ensure the government does not interfere with human dignity and individual control, so long as it harms no one else.⁶⁷ To demonstrate that her section 7 rights had been infringed, Rodriguez was required to show that not only her right to liberty and security were undermined, but that they were lost due to unjustified state interference. As the BCSC observed, “rights to life, liberty and security of the person may be lost as a result of state interference when that interference is in accordance with the principles of fundamental justice”.⁶⁸ Principles of fundamental justice here refers to those “principles that govern the justice system. They determine the means by which one may be brought before or within the justice system.”⁶⁹

Rodriguez argued that she had the right to enjoy her remaining life, with dignity, bodily autonomy and control, and the liberty to control the circumstances of her death.⁷⁰ Justice Melvin of the BCSC held the impugned provision did not infringe Rodriguez’s section 7 *Charter* rights, and, further, it was not necessary to consider section 1 of the *Charter*. Melvin J. held that section 241 of the *Criminal Code* could be demonstrably justified in a free and democratic society as it was designed to protect vulnerable individuals.⁷¹

⁶⁵ *Ibid.*

⁶⁶ *Charter*, *supra* note 10 at s 7.

⁶⁷ *Rodriguez BCSC*, *supra* note 56 at para 75.

⁶⁸ *Ibid* at paras 11 and 13.

⁶⁹ *Ibid* at para 13.

⁷⁰ *Ibid* at para 6.

⁷¹ *Ibid* at para 22.

In arriving at his decision, Melvin J. placed significant importance on the context in which section 7 appears in the *Charter*.⁷² Since Rodriguez herself could not be brought before the justice system under section 241, as it would only apply to those who counselled or assisted in her suicide, this meant that Rodriguez's section 7 rights were not violated. The Court held that Rodriguez's fundamental decisions concerning her life were not restricted by the state but rather by her illness, which may restrict her ability to implement her decisions.⁷³ Moreover, an individual could still choose to assist or aid Rodriguez in terminating her life, but by doing so they risk being brought before the justice system.

The Court paid limited attention to the claim that section 241 of the *Criminal Code* violated Rodriguez's section 12 *Charter* rights. Section 12 of the *Charter* enshrines every Canadians' right "not to be subjected to any cruel and unusual treatment or punishment."⁷⁴ To engage the protection afforded by section 12, two things must be demonstrated: "(1) that the applicant is subjected to treatment or punishment at the hands of the state; and (2) that such treatment or punishment is cruel and unusual".⁷⁵ Rodriguez argued that the prohibition of assisted suicide infringed section 12 of the *Charter* because it forced her to choose between enduring a prolonged period of suffering until her natural death occurred or required her to end her life prior to when she wished so that she can do so without assistance. Further, by prohibiting another individual from assisting her in the termination of her life, the state was imposing cruel and unusual treatment or punishment on her.

The Court held that the right enshrined in section 12 of the *Charter* is the right not to be subjected to any cruel and unusual treatment or punishment by the state. Similar to the section 7 analysis, the Court found that Rodriguez's section 12 rights were not infringed, as she was not personally subjected to any treatment or punishment imposed by the state.⁷⁶

⁷² *Ibid* at para 11.

⁷³ *Ibid* at para 15.

⁷⁴ *Charter*, *supra* note 10 at s 12.

⁷⁵ *Rodriguez BCSC*, *supra* note 56 at para 62.

⁷⁶ *Ibid* at para 20.

Rodriguez argued that her section 15 *Charter* rights were infringed as the criminal prohibition discriminated against disabled persons who are unable to commit suicide without assistance, in that it deprives them of the right to choose suicide, while able-bodied persons could. Section 15 of the *Charter* guarantees equality rights and states,

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.⁷⁷

Rodriguez argued that due to the degenerative nature of her disease, there would come a time when she would no longer be able to physically terminate her life and, as such, the prohibition against counselling and aiding suicide impacts unequally on her, and others like her, that do not have the physical ability to terminate their own life but require assistance. Justice Melvin did not accept this argument, but found that the protection afforded by section 241 of the *Criminal Code* “applies equally to all persons regardless of their condition or the cause of any vulnerability which may result in them expressing a desire to terminate their lives”.⁷⁸ Melvin J. further opined section 241 is designed to protect, not discriminate, and consequently found that there was no violation of section 15 of the *Charter*.

Following this decision, Rodriguez filed an appeal with the British Columbia Court of Appeal.

2.2.2 British Columbia Court of Appeal

In February 1993, the BCCA was tasked with considering Rodriguez’s argument. The BCCA dismissed Rodriguez’s appeal in a two to one decision, with Chief Justice McEachern dissenting. As will be reviewed, the majority decision of the BCCA held the decision of physician assisted suicide needs to be a decision made by Parliament and not the Courts, whereas McEachern C.J. was willing to make a declaration permitting an

⁷⁷ *Charter*, *supra* note 10 at s 15.

⁷⁸ *Rodriguez BCSC*, *supra* note 56 at para 22.

unnamed physician to assist Rodriguez with ending her life without the risk of criminal liability.

Before undertaking his analysis, McEachern C.J. in his dissenting opinion states that the rights guaranteed by section 7 must be considered in the context of the values and principles underlying the *Charter* as a whole. In his analysis, McEachern C.J. refers to *The Queen v Oakes* (“*Oakes*”) wherein the SCC found that the values and principles essential to a free and democratic society:

...embody, to name but a few, respect for the inherent dignity of the human person, commitment to social justice and equality, accommodation of a wide variety of beliefs, respect for cultural and group identity, and faith in social and political institutions which enhance the participation of individuals and groups in society.⁷⁹

McEachern C.J. found that Rodriguez “qualifies under the value system upon which the *Charter* is based to protection under the rubric of either liberty or security of her person. This would include at least the lawful right of a terminally ill person to terminate her own life, and, in my view, to assistance under proper circumstances”.⁸⁰ Further he opined that the *Charter* is not just concerned with the fact of life but also the quality and dignity of life.⁸¹

McEachern C.J. held that the operation of section 241, and in the particular circumstances in which Rodriguez found herself, violated her section 7 *Charter* rights to liberty and the security of her person.⁸² Contrary to the view of Justice Melvin, McEachern C.J. found that Rodriguez's section 7 rights could be triggered in her particular circumstance as she could be found guilty of the criminal offence of conspiracy, and, at least up until her death, she could be found guilty as a party to the offence being committed by those assisting her.⁸³

⁷⁹ *R. v. Oakes*, [1986] 1 SCR 103, 53 OR (2d) 71 at para 136 [*Oakes*].

⁸⁰ *Rodriguez BCCA*, *supra* note 50 at para 50.

⁸¹ *Ibid* at para 51.

⁸² *Ibid* at para 77.

⁸³ *Ibid* at para 43.

As such, there was a possibility that Rodriguez could be brought before the justice system, resulting in her section 7 rights being triggered.

McEachern C.J. considered whether the deprivation of Rodriguez's right to security of the person and liberty were justifiable. To comply with the requirements of section 7 any deprivation of rights must be in accordance with the principles of fundamental justice.⁸⁴ Citing the *R v Morgentaler*, (1988) SCC⁸⁵ ("***Morgentaler SCC***") decision, McEachern C.J. indicated that a provision that operates unequally or causes "manifest unfairness" would not conform to the principles of fundamental justice.⁸⁶ In taking this approach, McEachern C.J. adopts a broader understanding of the principles of fundamental justice than Justice Melvin in *Morgentaler SCC*. He argues that the principles of fundamental justice include "whatever might reasonably be expected in and from a society and a system of justice which is...founded upon a belief in the dignity and worth of the human person and the rule of law".⁸⁷

McEachern C.J. also broadens the context in which section 7 rights arise, noting that a challenge does not need to fall exclusively within the jurisdiction of criminal law for section 7 to apply.⁸⁸ McEachern C.J. concludes:

s. 7 was enacted for the purpose of ensuring human dignity and individual control, so long as it harms no one. When one considers the nobility of such purpose, it must follow as a matter of logic as much as law, that any provision which imposes an indeterminate period of senseless physical and psychological suffering upon someone who is shortly to die anyway cannot conform with any principle of fundamental justice. Such a provision, by any measure, must clearly be characterized as the opposite of fundamental justice.⁸⁹

⁸⁴ *Ibid* at para 61.

⁸⁵ *R. v. Morgentaler*, [1988] 1 SCR 30, 63 OR (2d) 281 [*Morgentaler SCC*].

⁸⁶ *Ibid* at 72; *Rodriguez BCCA*, *supra* note 50 at para 62.

⁸⁷ *R v Vaillancourt*, [1987] 2 SCR 636, 47 DLR (4th) 399 at para 651; *Rodriguez BCCA*, *supra* note 50 at para 65.

⁸⁸ *Rodriguez BCCA*, *supra* note 50 at para 66.

⁸⁹ *Ibid* at para 75.

McEachern C.J. determined that this infringement could not be saved by section 1 of the *Charter* in the specific circumstances Rodriguez found herself.⁹⁰ McEachern C.J. did not consider all of the elements of the *Oakes* test as he found section 241 did not satisfy the minimum impairment portion of the test, and, accordingly, the section “overshoots” its purposes.⁹¹

In the broader context, McEachern C.J. held that section 241 of the *Criminal Code* is unlikely to be found unconstitutional by virtue of section 52 of the *Charter*⁹², and stressed it was the specific circumstances of Rodriguez that gave rise to the finding of an unjustifiable infringement of her section 7 rights.⁹³ Where a piece of legislation is inconsistent, or partially inconsistent with the *Charter*, the appropriate remedy should be determined by considering “the purpose of the impugned law, the nature of the constitutional defect and the impact of the remedy upon the impugned legislation”.⁹⁴ McEachern C.J. found that section 241 had a valid purpose, which was to protect vulnerable persons, and therefore only wanted to grant an individual remedy to Rodriguez as opposed to finding the provision of no force or effect.⁹⁵ This included a declaration limited to Rodriguez and any physicians assisting her, defining the nature and terms of the remedy considered appropriate and just.⁹⁶ Having determined that Rodriguez’s section 7 rights were violated, McEachern C.J. did not assess the merits of the arguments with respect to sections 12 and 15.

Justice Hollinrake agreed with McEachern C.J.’s conclusion that section 241 of the *Criminal Code* violated Rodriguez’s section 7 *Charter* rights but disagreed that the

⁹⁰ *Ibid* at para 86.

⁹¹ *Ibid* at para 82.

⁹² *Ibid* at paras 86 and 89. Note: Section 52 (1) of the Constitution of Canada states that the Constitution is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

⁹³ *Ibid* at para 86.

⁹⁴ *Ibid* at para 87.

⁹⁵ *Ibid* at para 99.

⁹⁶ *Ibid* at para 99.

deprivation was contrary to the principles of fundamental justice.⁹⁷ In arriving at this decision, Hollinrake J. considered the legislative, social and philosophical context of society to inform his understanding of the principles of fundamental justice. In particular, Hollinrake J. conducted a review of the legislative and medical history of the prohibition and found that there was no legislative or medical history to conclude that physician assisted suicide had been accepted by Parliament or the medical profession.⁹⁸ In coming to this conclusion, Hollinrake J. distinguishes Rodriguez's claim from that in *Morgentaler SCC*⁹⁹ on the basis that there was an exception to the prohibition of abortion, namely, the condition that an administrative framework was followed. In effect, Parliament had recognized that circumstances exist in which an abortion can be procured lawfully and as a result "opened the door to the assertion that there was a constitutional right of every woman to an abortion under the rubric of s. 7".¹⁰⁰

In contrast, Parliament had never recognized any circumstances in which physician assisted suicide was lawful.¹⁰¹ Hollinrake, J. considered the practice of palliative sedation, where physicians may administer heavy doses of pain relieving drugs for the purposes of alleviating suffering, recognizing it may accelerate death. He distinguished this practice from assisted suicide based on intent; administering drugs to alleviate pain knowing it may hasten death has a different intent than providing assisted suicide, which is made available to cause death.¹⁰² In conclusion, Hollinrake, J. found that there must be a basis in legislative, medical or societal history before it can be said that a deprivation of a right to physician assisted suicide is not in accordance with the principles of fundamental justice.¹⁰³

⁹⁷ *Ibid* at para 117.

⁹⁸ *Ibid* at para 134.

⁹⁹ *Morgentaler SCC*, *supra* note 85.

¹⁰⁰ *Rodriguez BCCA*, *supra* note 50 at para 142.

¹⁰¹ *Ibid* at para 140.

¹⁰² *Ibid* at para 147.

¹⁰³ *Ibid* at para 151.

Like McEachern C.J., Justice Hollinrake also chose not to consider Rodriguez's claim that section 241 violated her section 12 and 15 *Charter* rights. He opined that there was very little, if anything, that could support the view that the facts of this case engaged sections 12 or 15 of the *Charter*.¹⁰⁴

In her reasons concurring with Hollinrake J.'s judgment, Madam Proudfoot J. put forth two reasons for disagreeing with the Chief Justice's approach to the section 7 analysis. First, Madam Proudfoot J. distinguished the *Morgentaler SCC* decision on the basis that *Morgentaler SCC* dealt with the right to security of the person being infringed by restricting access to medical treatment, whereas, in Rodriguez's case, she found that physician assisted death did not fall within a "safe medical procedure".¹⁰⁵ Further, she opined that *Morgentaler SCC* does not "go beyond the preservation of health" and death is the "antithesis of the s. 7 guarantee of "life, liberty and security of the person"."¹⁰⁶ In addition, she found *Morgentaler* had no application to the subject case because it was decided in a criminal context. Madam Proudfoot J. found that Rodriguez was not engaged in the criminal context as she could not be charged under section 241, and therefore there had been no state interference upon Rodriguez. In obiter, Madam Proudfoot J. shared the view expressed by Hollinrake J. that legalizing physician-assisted death was the responsibility of Parliament, not the court.

2.2.3 Supreme Court of Canada

In September 1993, the SCC held in a 5-4 decision¹⁰⁷ that the criminal prohibition on physician-assisted death was constitutional and would remain in force.¹⁰⁸ The majority held that section 241 of the *Criminal Code* infringed Rodriguez's section 7 rights but the deprivation was in accordance with the principles of fundamental justice.¹⁰⁹ The analysis

¹⁰⁴ *Ibid* at para 157.

¹⁰⁵ *Ibid* at para 165.

¹⁰⁶ *Ibid* at para 165.

¹⁰⁷ *Rodriguez SCC*, *supra* note 42. Sopinka, J, La Forest, Gonthier, Iacobucci and Major JJ concurring; McLachlin J. and L'Heureux-Dube J. dissenting and concurring; Lamer C.J.C. dissenting; Cory J. dissenting.

¹⁰⁸ *Ibid* at paras 595, 608.

¹⁰⁹ *Ibid* at para 617.

considered the balancing of an individual's right to autonomy and the interests of the state, in this case, the preservation and protection of vulnerable persons. Similar to the reasons offered by Hollinrake J. in the BCCA decision, the majority reviewed legislation, social policy, the history of the provisions and the law in other jurisdictions. The majority held that the blanket prohibition on assisted suicide reflects "fundamental values at play in our society" as it serves "to protect the vulnerable who might be induced in moments of weakness to commit suicide".¹¹⁰ In arriving at this decision the majority held that when considering the principles of fundamental justice it is appropriate and fair to strike a balance between the interests of the state (preservation and protection of vulnerable persons) and the individual (autonomy and dignity of the person).¹¹¹

Unlike the lower courts, the SCC considered Rodriguez's claim that section 241 infringed her section 12 and 15 *Charter* rights. The majority found that section 241 did not infringe Rodriguez's rights under section 12 of the *Charter*, as she was not subjected by the state to any form of cruel and unusual treatment or punishment.¹¹² Rodriguez argued that the prohibition on assisted suicide had the effect of imposing a cruel and unusual treatment on her, by subjecting her to either prolonged suffering until her natural death or by requiring her to prematurely terminate her own life while she remained physically capable of doing so. The SCC outright rejected the possibility that the prohibition subjected Rodriguez to any cruel or unusual "punishment". Where the majority seemed to be less clear, however, was whether or not Rodriguez was subjected to cruel and unusual "treatment".¹¹³ Specifically, the SCC sought to determine the "degree to which "treatment" in section 12 may apply outside the context of penalties imposed to ensure the application and enforcement of the law".¹¹⁴ Due to the timing of the Rodriguez case, and the limited *Charter* jurisprudence, the SCC had little jurisprudence on the judicial interpretation of the meaning of "treatment" in this context.

¹¹⁰ *Ibid* at para 60.

¹¹¹ *Ibid* at para 31.

¹¹² *Ibid* at paras 61–68.

¹¹³ *Ibid* at para 62.

¹¹⁴ *Ibid* at para 63.

The cases reviewed by the SCC indicated that the following would constitute “treatment”: the lobotomization of certain dangerous offenders and the castration of sexual offenders,¹¹⁵ strip searches¹¹⁶, and medical care imposed without consent on those suffering with mental illness.¹¹⁷ The court also found authority for the proposition that section 12 may have application outside of the criminal context.¹¹⁸ The majority concluded that Rodriguez’s section 12 rights may be engaged by the prohibition. Sopinka J. stated:

I am prepared to assume that “treatment” within the meaning of s. 12 may include that imposed by the state in contexts other than that of a penal or quasi-penal nature. However, it is my view that a mere prohibition by the state on certain action, without more, cannot constitute “treatment” under s. 12.¹¹⁹

The SCC held for section 12 to be engaged, there must be more than a prohibition of a certain action to constitute treatment. Accordingly, the prohibition did not infringe section 12 of the *Charter*.

With respect to Rodriguez’s section 15 claim, the majority held that even if section 241 infringed section 15, this infringement was justified under section 1. Section 1 of the *Charter* provides that the state can infringe a right as long as the state can demonstrate the violation can be demonstrably justified in a free and democratic society. Writing for the majority, Sopinka J. held that the prohibition on assisted suicide, without exception, reflects a substantial consensus that it is necessary in order to protect the vulnerable and, further, exceptions would be unsatisfactory in fully achieving the legislative purpose of the prohibition.¹²⁰ Accordingly, the Court found that although Rodriguez’s individual rights may be infringed by section 241, the infringement is justifiable in order to protect

¹¹⁵ *R v Smith*, [1987] 1 SCR 1045, 15 BCLR 2(d) 273.

¹¹⁶ *Weatherall v Canada (Attorney General)* (1987), [1988] 1 FC 369 (TD).

¹¹⁷ *Howlett v Karunaratne* (1998), 64 OR (2d) 418 (Dist. Ct).

¹¹⁸ *Chiarelli v Canada (Minister of Employment & Immigration)*, [1992] 1 SCR 711, 135 NR 161.

¹¹⁹ *Rodriguez SCC*, *supra* note 42 at para 62.

¹²⁰ *Ibid* at para 615.

vulnerable persons in society and this interest could not be protected in a less broad manner.¹²¹

In their independent dissenting opinions McLachlin J. (as she was then) and Cory J. both found that the prohibition of assisted suicide infringed Rodriguez's section 7 rights, and not in accordance with the principles of fundamental justice. Further, they found that this infringement could not be saved by section 1.¹²² McLachlin J. found that the prohibition against assisted suicide was arbitrary, given that suicide is lawful under the *Criminal Code*.¹²³ Cory J. argued that section 7 "emphasizes the innate dignity of human existence" and found that dying is an integral part of living and is entitled to the same protection afforded by section 7.¹²⁴ Further, he stated that, "State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity".¹²⁵ As such, both McLachlin and Cory JJ. found that the prohibition on assisted suicide violates the principles of fundamental justice.

Chief Justice Lamer based his dissenting opinion upon section 15 of the *Charter* and found section 241 infringed the right to equality contained in section 15.¹²⁶ He held that individuals who had the physical ability to end their life would be able to do so, while those who were physically unable to end their lives unassisted would be prevented from committing suicide as a result of the prohibition.¹²⁷ In his opinion, this infringement could not be saved by section 1 of the *Charter* as the "fear of a slippery slope cannot justify the over-inclusive reach of the *Criminal Code* to encompass not only persons who may be vulnerable to the pressure of others but also persons with no evidence of vulnerability."¹²⁸

¹²¹ *Ibid* at para 614.

¹²² *Ibid* at para 617.

¹²³ *Ibid* at para 198.

¹²⁴ *Ibid* at para 230.

¹²⁵ *Ibid* at para 231.

¹²⁶ *Ibid* at para 544.

¹²⁷ *Ibid* at para 544.

¹²⁸ *Ibid* at para 567.

In summary, the majority opinion found that the prohibition on assisted suicide did not violate the rights guaranteed in sections 7 and 12, and if there was a violation of section 15 of the *Charter*, this infringement was demonstrably justifiable in a free and democratic society. The dissenting opinions of L’Heureux-Dube and McLachlin JJ., found section 241 infringed the right to security of the person included in section 7 and could not be saved by section 1. While L’Heureux-Dube and McLachlin JJ. found section 241 did not infringe section 15, the dissenting opinion of Lamer C.J. disagreed and found it did infringe section 15 and could not be saved by section 1 as the provision was over-inclusive and concerns about vulnerable persons being put at risk could not justify the over-inclusive reach of section 241. Justice Cory J also wrote a dissenting opinion that substantially agreed with the reasons given by Lamer C.J. and McLachlin J., such that section 241 infringed sections 7 and 15 and could not be saved by section 1.

2.3 The Post-*Rodriguez* Era

Despite Rodriguez’s loss at the SCC, her court action helped bring the issue of physician-assisted suicide to the forefront of public discourse. It resulted in significant dialogue about end-of-life health care and decision-making, including the right of individuals to withhold and withdraw treatment, in addition to assessing the legal, social and ethical issues related to assisted suicide. The following section provides an overview of the judicial and legislative history following the SCC’s decision in *Rodriguez*, including the appointment of a special senate committee, jurisprudence, and legislative attempts to decriminalize physician assisted suicide. First, I consider the Special Senate Committee Report, which was appointed to “examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide”.¹²⁹ This is followed by a review of the SCC’s 2001 decision in *Wakeford v Canada (Wakeford SCC)*, which dismissed the Plaintiff’s leave to appeal seeking a declaration that section 241 infringed section 15 of the *Charter*.¹³⁰ *Wakeford SCC* is the only other court matter that sought to decriminalize physician assisted

¹²⁹ Special Senate Committee, *supra* note 57 at 1.

¹³⁰ *Wakeford v. Canada*, [2002] SCCA No. 72 [*Wakeford SCC*].

suicide following *Rodriguez SCC* and before *Carter BCSC*. Following the review of *Wakeford SCC*, I consider Bill C-384, which sought to decriminalize assisted suicide and was the last bill to propose amendments to the *Criminal Code* prior to the *Carter BCSC* decision.¹³¹ The following sections demonstrate the evolution of physician assisted suicide since *Rodriguez SCC* and highlights the social, medical, ethical and legal progress towards the decriminalization of physician assisted suicide, including consideration of the appropriate safeguards to protect vulnerable persons from abuse.

2.3.1 Special Senate Committee on Euthanasia and Assisted Suicide, 1995

The Special Senate Committee, formed by the Honourable Senator Joan Neiman, undertook to examine the legal, social and ethical issues relating to euthanasia and assisted suicide. Following the Senate Committee's comprehensive review of the issues it submitted *Of Life and Death – Final Report*¹³² (the “**Final Report**”), released in June 1995. The Final Report detailed the Special Senate Committee's efforts to understand the complexities of euthanasia and assisted suicide, and included hearing testimony from witnesses and reviewing written material submitted by Canadians and experts over the course of 14 months.¹³³ The Final Report considers a variety of matters that arise in end-of-life health care and offered recommendations related to access to palliative care, pain control and sedation practices, withdrawal and withholding of life sustaining care, advances directives, assisted suicide, and euthanasia. The Final Report considered amendments to section 241 of the *Criminal Code*, with the majority concluding no amendments should be made but further research be undertaken to determine the extent to which individuals are requesting assisted suicide, the reason it is being requested and whether there are alternatives that would be acceptable to individuals making these requests.¹³⁴ A minority recommended an exemption to section 241 to permit some form of

¹³¹ Bill C-384, *supra* note 59. Note: Between the SCCs decision in *Rodriguez* and Bill C-384, there were nine unsuccessful private member's bills introduced seeking to amend the *Criminal Code*.

¹³² Special Senate Committee *supra* note 57, at 1.

¹³³ *Ibid.*

¹³⁴ *Ibid* at 29–30.

physician assisted suicide that would require the development of procedural safeguards and a review prior to and after the act of assisted suicide to avoid abuse.¹³⁵ The procedural safeguards recommended are very similar to the current MAID eligibility criteria in the *Criminal Code* and include:

- The individual must be competent and must be suffering from an irreversible illness that has reached an intolerable stage, as certified by a medical practitioner.
- The individual must make a free and informed request for assistance, without coercive pressures.
- The individual must have been informed of and fully understand his or her condition, prognosis and the alternative comfort care arrangements, such as palliative care, which are available.
- The individual must have been informed of and must fully understand that he or she has a continuing right to change his or her mind about committing assisted suicide.
- A health care professional must assess and certify that all of the above conditions have been met.¹³⁶

The requirement that an individual make a free and informed request for assistance, without coercive pressures, is the closest comparable safeguard to the current Voluntary Provision but does not use the term voluntary. The Final Report provides definitions of voluntary, nonvoluntary and involuntary, although they are not overly helpful to understanding what a voluntary request for MAID requires. The following definitions are provided in the Final Report:

Voluntary: means done in accordance with the wishes of a competent individual or a valid advance directive.

Nonvoluntary: means done without the knowledge of the wishes of a competent or an incompetent individual.

Involuntary: done against the wishes of a competent individual or a valid advance directive.¹³⁷

¹³⁵ *Ibid* at 29–30.

¹³⁶ *Ibid* at 29.

¹³⁷ *Ibid* at 15.

Much of the discussion around these terms relates to the slippery slope argument. The opponents of assisted suicide that appeared before the Special Senate Committee shared similar arguments to those in *Rodriguez*, including: the “slippery slope” argument which posits that allowing assisted suicide could lead to abuses of the elderly, disabled or otherwise vulnerable people arising from dependency or coercion.¹³⁸ Opponents went so far as to suggest that if assisted suicide was legalized it would become nearly impossible to construct a law that would prohibit people from using persuasion, however subtle, on people to encourage them to request euthanasia.¹³⁹ Pressure or influence from individuals was not the only concern raised in the Final Report. It also identifies the possibility of external forces pressuring individuals to request assisted suicide, such as scarce financial and institutional resources.¹⁴⁰

The proponents of decriminalizing assisted suicide highlighted the limits of palliative care and the importance of bodily autonomy and self-determination.¹⁴¹ These individuals suggested assisted suicide is already taking place despite its illegality and, as a result, was occurring without adequate controls.¹⁴² In their view, this creates a greater risk of abuse of vulnerable persons.¹⁴³ Legalizing assisted suicide would address this, as it would regulate the practice and ensure that appropriate safeguards were in place to protect the vulnerable from abuse or coercion.¹⁴⁴

While the Final Report provides a comprehensive review of the legal, social, and ethical issues related to assisted suicide, it did not bring about any law reform. Although the Special Senate Committee made recommendations about improving end-of-life health care (specifically palliative care aimed at relieving suffering) and educating the public about their rights related to refusing end of life health care, it was unable to achieve unanimity

¹³⁸ *Ibid* at 28.

¹³⁹ *Ibid* at 22.

¹⁴⁰ *Ibid* at 28.

¹⁴¹ *Ibid* at 28.

¹⁴² *Ibid* at 29.

¹⁴³ *Ibid* at 29.

¹⁴⁴ *Ibid* at 29.

with respect to recommendations related to assisted suicide. The entire Special Senate Committee recommended the offence of “counselling suicide” to remain intact and a majority of members recommended no amendments to “aiding suicide,” while a minority recommended that an exemption be added to allow assisted death under clearly defined conditions.¹⁴⁵ The Final Report does not identify how many people formed the minority or majority views.

2.3.2 *Wakeford v Canada (Attorney General)*

In 2001, James Wakeford, who was suffering from AIDS, sought a declaration from the Ontario Superior Court of Justice, that sections 14 and 241 of the *Criminal Code* infringed his section 15 *Charter* rights. Wakeford was advised by his physician that he only had a few years left to live and did not want to experience the “loss of dignity and autonomy that accompanies the final stages of death by AIDS.”¹⁴⁶ Rather, he wished to end his own life, with dignity and medical assistance. Wakeford relied upon the Final Report to demonstrate the “legislative facts”¹⁴⁷ underpinning the *Rodriguez* decision had changed since the ruling and the SCC may rule differently. He argued that the impugned provisions could no longer be supported under section 1 of the *Charter*.¹⁴⁸ The Ontario Superior Court of Justice granted the Attorney General of Canada’s summary judgment, agreeing with their motion to dismiss the action as there was nothing within the Plaintiff’s pleadings that would suggest *Rodriguez* was open for reconsideration and to the contrary the Special Senate Committee’s Final Report recommended that the assisted suicide provisions remain in place. The decision was appealed to the Ontario Court of Appeal, where it was dismissed, and further to the SCC where leave to appeal was refused.¹⁴⁹

¹⁴⁵ *Ibid* at 29.

¹⁴⁶ *Wakeford v Canada (Attorney General)*, [2001] OJ No. 390, [2001] O.T.C. 84 at para 2 [*Wakeford ONSC*].

¹⁴⁷ *Ibid* at para 10.

¹⁴⁸ *Ibid* at para 11.

¹⁴⁹ *Wakeford SCC*, *supra* note 130.

2.3.3 Bill C-384, An Act to Amend the Criminal Code (right to die with dignity), 2009

The impact of the *Rodriguez* decision on the public discourse concerning assisted suicide is perhaps best demonstrated by the numerous attempts to decriminalize assisted suicide that arose following the decision. Subsequent to the *Rodriguez* trial in 1991, nine private members' bills¹⁵⁰ were introduced in the House of Commons seeking to amend the *Criminal Code* to allow for the lawful facilitation of assisted suicide or euthanasia.¹⁵¹ Here, Bill C-384, *An Act to Amend the Criminal Code (right to die with dignity)* (“**Bill C-384**”)¹⁵² is canvassed as it was the last legislative attempt to decriminalize assisted suicide prior to the *Carter* decision and, particularly relevant for this project, includes a provision on voluntariness.

In 2009, the private member's bill, Bill C-384, was introduced to the House of Commons by Francine Lalonde.¹⁵³ Bill C-384 proposed to amend sections 14, 222 and 241 of the *Criminal Code*. Section 222 makes it a criminal offence to commit homicide and the intention was to provide for an exemption to the crime of homicide if a physician assisted a person to die in accordance with set criteria.¹⁵⁴ Bill C-384 was debated at second reading in the House of Commons, which highlighted the tension between permitting an exception to the crime of aiding suicide to allow physician assisted suicide with the concern for abuse of vulnerable persons.¹⁵⁵ These concerns related to the proposed eligibility criteria and associated safeguards that were argued to be inadequate to protect vulnerable persons.¹⁵⁶

¹⁵⁰ As noted above, this paper is interested in how the law has considered and interpreted voluntariness and not with what has been proposed regarding voluntariness. Accordingly, a review of the private members' bills has not been completed.

¹⁵¹ *Carter BCSC*, *supra* note 6 at para 109.

¹⁵² Bill C-384, *supra* note 59.

¹⁵³ *Carter BCSC*, *supra* note 6 at para 110.

¹⁵⁴ Bill C-384, *supra* note 59.

¹⁵⁵ *House of Commons Debates*, 2-144, No. 089 (October 2, 2009) at 34–41.

¹⁵⁶ *Ibid.*

With respect to voluntariness, one of the safeguards articulated in Bill C-384 required the medical practitioner to have no reasonable grounds to believe the patient's request for physician assisted suicide was made under duress. The provision stated:

the medical practitioner...has no reasonable grounds to believe that the written request [for physician assisted suicide] were made under duress or while the person was not lucid.¹⁵⁷

A review of the Hansard debates does not provide further context related to the concerns related to “duress” and how this term was being considered. Arguably, Bill C-384's underlying concern with ensuring decisions were made without duress is recognition of the need for the request to have been made voluntary.¹⁵⁸ In April 2010, the motion to advance Bill C-384 was defeated by a vote of 228 to 59. This was the last attempt to amend the *Criminal Code* prior to the court challenge brought forward by Kay Carter and Gloria Taylor.¹⁵⁹

2.4 The *Carter* Era

In 2011, the BCSC was asked to consider whether sections 14 and 241 of the *Criminal Code* were unconstitutional. Like *Rodriguez*, following the BCSC, *Carter* was appealed all the way to the SCC.¹⁶⁰

In *Carter*, two Plaintiffs, Gloria Taylor and Kay Carter, sought a declaration from the court that section 241 of the *Criminal Code* was unconstitutional as it infringed their sections 7, 12 and 15 *Charter* rights. In 2008, at the age of 87, Carter was diagnosed with spinal stenosis, a condition involving progressive compression of the spinal cord. Carter's condition deteriorated steadily over the months and by August 2009, she required assistance for all her daily activities and experienced chronic pain.¹⁶¹ In early 2010, due to her declining medical condition, Carter, accompanied by two of her children, elected to

¹⁵⁷ Bill C-384, *supra* note 59 at 2(7)(b)(ii).

¹⁵⁸ *Ibid.*

¹⁵⁹ *Carter BCSC*, *supra* note 6.

¹⁶⁰ *Ibid.*

¹⁶¹ *Ibid* at para 57.

travel to Switzerland to die by way of physician-assisted death.¹⁶² Her daughter and son-in-law, Lee Carter and Hollis Johnson, agreed to continue the lawsuit on her behalf.¹⁶³ The other applicant, Taylor, was diagnosed with amyotrophic lateral sclerosis (ALS), a fatal neurodegenerative disease, in 2009.¹⁶⁴ Despite Taylor's one-year life expectancy prognosis, she survived for three years and lived to see the trial decision released in 2012. She died of natural causes suddenly and unexpectedly from an infection in 2012 while the case was under appeal.¹⁶⁵

The following provides an overview of the *Carter* decisions, wherein, despite the *Rodriguez* precedent, the SCC held the prohibition against assisting an individual to die was unconstitutional as the impugned provision violated section 7 of the *Charter* in a manner that was not demonstrably justified in a free and democratic society.¹⁶⁶

Of particular interest to this paper is Justice Smith's extensive review of the Plaintiffs proposed voluntariness safeguard and the intention behind the requirement of voluntariness. In response to the *Charter* claim, the Federal government raised various risks associated with physician assisted death including competence, voluntariness, informed consent, ambivalence, and socially vulnerable individuals.¹⁶⁷ Specifically, Canada argued the risk of involuntary deaths would require a request for assisted death to be voluntary,

that is, free from coercion, pressure, undue inducement, and psychological or emotional manipulation. Some of the external forces that can influence a patient's decision include illness; lack of information about options; concerns about burdening, or pressure from, family members; the physician's influence, particularly in light of the power differential that exists between physician and patient; and society's approval of physician-assisted death. Such forces can elude detection.¹⁶⁸

¹⁶² *Carter SCC*, *supra* note 1 at para 111.

¹⁶³ *Ibid* at para 11.

¹⁶⁴ *Ibid*.

¹⁶⁵ *Carter BCCA*, *supra* note 44 at para 34.

¹⁶⁶ *Carter SCC*, *supra* note 1.

¹⁶⁷ *Carter BCSC*, *supra* note 6 at paras 215–237.

¹⁶⁸ *Ibid* at para 750.

In brief, Smith J.'s consideration of the requirement for voluntariness focused on concerns related to abuse of vulnerable persons and being able to identify coercion and undue influence. The discussion of coercion and undue influence relates to how influences of family, friends and health care providers, unconscious bias, institutional culture, and the devaluing of those who are "no longer useful to society"¹⁶⁹, may coerce or unduly influence a person to request physician assisted death. In her view, ensuring a request for physician assisted death is voluntary and without external pressure could be addressed by a physician, in a similar manner as they currently do in assessing voluntariness in the context of other end of life decision making.¹⁷⁰

2.4.1 Supreme Court of British Columbia

In 2011, the BCSC had an opportunity to revisit the constitutionality of section 241 of the *Criminal Code*. This is an expansive decision, totaling nearly 400 pages, and provides an overview of the history of section 241 of the *Criminal Code*, expert opinion evidence, medical ethics and medical end-of-life practices, consideration of other permissive jurisdictions, feasibility of implementing safeguards to permit assisted suicide, the impact of the precedent set in *Rodriguez*, and consideration of the constitutional arguments put forward by both sides.¹⁷¹

Both Canada and British Columbia sought to have the Plaintiffs claim dismissed as they argued facts in *Carter* were "virtually identical" to those in *Rodriguez* and settled by the SCC.¹⁷² Canada argued the principle of *stare decisis*, a decision of the SCC with materially similar facts and invoking the same legal principles, is binding upon the Court, and would prevent the Plaintiffs from proceeding with their claim.¹⁷³ The Plaintiffs disagreed and argued *Rodriguez* failed to consider legal principles that were now being brought forward. Justice Smith agreed with the Plaintiffs, noting the majority in *Rodriguez* did not address

¹⁶⁹ *Ibid* at paras 800–815.

¹⁷⁰ *Ibid* at paras 815, 1240.

¹⁷¹ *Ibid*.

¹⁷² *Ibid* at para 891.

¹⁷³ *Ibid* at paras 891, 899.

whether the right to life of the Plaintiff, part of section 7 analysis, was engaged by section 241 of the *Criminal Code* and, further, did not address whether the deprivation of security of the person or liberty was contrary to overbreadth and gross disproportionality.¹⁷⁴ Accordingly, Justice Smith found since this issue was not considered in *Rodriguez*, she could not be bound by stare decisis.

In addition, Justice Smith found *Rodriguez* did not address whether section 241(b) of infringed section 15 of the *Charter* but rather assumed it was a violation and only summarily addressed the final step in the section 1 analysis, balancing salutary and deleterious effects of the legislation.¹⁷⁵ Justice Smith highlights that the experience regarding physician assisted suicide in permissive regimes was not available when the Court considered *Rodriguez* and *Wakeford* but was produced by the Plaintiffs in *Carter*.¹⁷⁶ Further, she highlights the difference between the evidence produced as to the legislative and social facts in *Carter*, including the Canadian public opinion regarding physician assisted death, medical ethics and various government reports published since *Rodriguez*.¹⁷⁷ As a result, Justice Smith proceeded to consider the merits of the Plaintiffs' claim under sections 7 and 15, along with the corresponding *Oakes* analysis.

The Plaintiffs argued the prohibition against assisted suicide creates a distinction for persons with a disability. Specifically, they argued the prohibition imposes a disproportionate burden on persons who are physically disabled by depriving them of the choice to commit suicide at a time of their choosing, resulting in a distinction between them and able-bodied persons who are permitted to complete suicide.¹⁷⁸ The Defendants argued there was no distinction, as persons with a disability are treated equally to able-bodied persons given that both groups are denied access to assisted death and, further, they are not disproportionality burdened because a person with a disability could still commit suicide

¹⁷⁴ *Ibid* at para 936.

¹⁷⁵ *Ibid* at para 936.

¹⁷⁶ *Ibid* at para 944.

¹⁷⁷ *Ibid* at para 942.

¹⁷⁸ *Ibid* at paras 1031, 1040.

by way of starvation.¹⁷⁹ Justice Smith found the impact of section 241 on the Plaintiffs, and others similarly situated, is distinct based on the enumerated ground of disability. Further, she found those with disabilities to be disproportionately burdened as the means of suicide available to them (i.e., self-imposed starvation and dehydration) were far more onerous than those available to able-bodied persons.¹⁸⁰

The Court was also required to consider whether the distinction creates a disadvantage by perpetuating prejudice or stereotype.¹⁸¹ The Plaintiffs argued people with physical disabilities who suffer with grievous illnesses are disadvantaged and that this law only further disadvantaged them.¹⁸² They argued specifically the distinction is based on a stereotype, predicated on the belief that physically disabled persons lack autonomy or agency to make “momentous decisions”.¹⁸³ This assumption infantilizes persons with a disability and perpetuates discrimination.¹⁸⁴ Canada argued that if the prohibition creates a distinction based on disability it did not arise from discrimination but from a “neutral and rationally defensible policy choice”.¹⁸⁵ Justice Smith rejected this argument and concluded the law perpetuates or worsens a disadvantage experienced by persons with disabilities and, accordingly, the Plaintiffs’ section 15 rights were infringed.¹⁸⁶

Having found the impugned provision infringed the Plaintiffs’ section 15 rights, Justice Smith turned to section 1 of the *Charter* to determine whether the impugned provision was demonstrably justified in a free and democratic society. The analytical framework for a section 1 analysis (the *Oakes* test) requires a two-step process that asks:

1. Is the purpose for which the limit is imposed pressing and substantial?

¹⁷⁹ *Ibid* at paras 1069, 1070.

¹⁸⁰ *Ibid* at para 1076.

¹⁸¹ *Ibid* at para 1079.

¹⁸² *Ibid* at para 1087.

¹⁸³ *Ibid* at para 1088.

¹⁸⁴ *Ibid* at para 1088.

¹⁸⁵ *Ibid* at para 1089.

¹⁸⁶ *Ibid* at para 1161.

2. Are the means by which the legislative purpose is furthered proportionate?
 - i. Is the limit rationally connected to the purpose?
 - ii. Does the limit minimally impair the *Charter* right?
 - iii. Is the law proportionate in its effect?

The first line of inquiry was uncontested; all parties agreed the purpose of the impugned provision was pressing and substantial.¹⁸⁷ Justice Smith found the purpose of the impugned provision was to protect vulnerable persons from being induced to commit suicide at times of weakness, and the underlying state interest this purpose seeks to preserve is the protection of life.¹⁸⁸

The subsequent question was whether the prohibition was rationally connected to the purpose and proportionate to it.¹⁸⁹ The Court concluded it was bound by the finding in *Rodriguez* that the prohibition was rationally connected to the purpose of section 241.¹⁹⁰ It went on to consider whether the limit on the *Charter* right was reasonable and minimally impaired the right, meaning, Smith J. assessed whether there were other reasonable means for achieving this purpose. Canada argued there was no “halfway measure” that would achieve the purpose of the impugned provision and pointed to permissive jurisdictions where wrongful deaths can and do occur.¹⁹¹ In contrast, the Plaintiffs argued that a blanket prohibition against assisted death was not minimally impairing as it “does not affect their rights as little as possible”.¹⁹² They argued a properly administered regime with safeguards could achieve the objectives of the impugned provision in a real and substantial way without infringing *Charter* rights.¹⁹³ Justice Smith found the evidence supported the Plaintiffs’ position and that any risks of harm created by a regime to regulate physician-

¹⁸⁷ *Ibid* at paras 1204–1205.

¹⁸⁸ *Ibid* at para 1190.

¹⁸⁹ *Ibid* at para 1206.

¹⁹⁰ *Ibid* at paras 1208–1209.

¹⁹¹ *Ibid* at para 1221.

¹⁹² *Ibid* at para 1223.

¹⁹³ *Ibid* at para 1225.

assisted death could be “greatly minimized”. Moreover, Justice Smith found that physicians have the requisite skills and competencies to consider key issues, such as patient competency, voluntariness and non-ambivalence in the context of end-of-life decision making and would be able to apply different levels of scrutiny to patients’ decisions depending on the gravity of the consequences.¹⁹⁴

Justice Smith further concluded the evidence from other jurisdictions where physician assisted suicide was permitted did not confirm the concerns related to the slippery slope argument,¹⁹⁵ nor was there evidence to support the abuse of vulnerable persons in those jurisdictions.¹⁹⁶ She stated the objectives of the impugned provision could be met with a carefully crafted exception to the general prohibition to “competent persons, who are grievously ill and irremediably suffering, who request physician assisted death, are fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards”.¹⁹⁷

The last step of the proportionality analysis is to determine whether the “benefits of the impugned law are worth the costs of the rights limitation”.¹⁹⁸ Canada argued the weighing of the deleterious effects (i.e., limitations on autonomy, increased individual suffering and the dangers of unregulated physician-assisted dying) against the benefits, reveals the blanket prohibition is reasonable in relation to the potential for wrongful death.¹⁹⁹ The benefits of the prohibition can be generally identified as follows: protection of vulnerable persons, prevention of wrongful deaths, weakening of palliative care and reaffirming the value of human life.²⁰⁰ Canada further suggested that the majority of people can have their suffering relieved or reduced through palliative care and the “harm to those who cannot

¹⁹⁴ *Ibid* at para 1240.

¹⁹⁵ As referenced above, the slippery slope argument posits allowing assisted suicide could lead to abuses of the elderly, disabled or otherwise vulnerable people arising from dependency or coercion.

¹⁹⁶ *Carter BCSC*, *supra* note 6 at paras 1241–1242.

¹⁹⁷ *Ibid* at para 1243.

¹⁹⁸ *Ibid* at para 1246.

¹⁹⁹ *Ibid* at paras 1248–1249.

²⁰⁰ *Ibid* at paras 1252–1253.

does not outweigh the risk of wrongful death”.²⁰¹ The Plaintiffs argued the deleterious effects of the law outweighed the benefits as it deprives individuals the ability to control the timing and manner of death or the quality of their remaining life, and that this created psychological stress.²⁰² They argued the evidence presented by the Defendants did not establish the impugned provision produces the salutary effect of preventing death.²⁰³ On the evidence, Justice Smith was not convinced that the absolute prohibition met the objectives of the purpose, and, further, held the benefits of the impugned provision are not worth the costs of the rights limitation it creates.²⁰⁴

In accordance with the majority ruling in *Rodriguez*²⁰⁵ the Court agreed that Taylor’s²⁰⁶ security of the person interest is engaged by the legislation, and the Defendants agreed given that the liberty interest of a person who assists or supports another person to obtain an assisted death is necessarily engaged by the threat of prosecution.²⁰⁷ Specifically the Plaintiffs argued Taylor’s right to liberty is engaged by state interference with the right of “grievously and irremediably ill individuals to a protected sphere of autonomy over decisions of fundamental personal importance”.²⁰⁸ Canada argued the liberty interest does not extend so far as to protect an individual’s choice of a particular medical treatment, although it may protect the right to refuse treatment.²⁰⁹ Justice Smith, relying on the SCC’s decision in *AC v Manitoba (Director of Child and Family Services)*,²¹⁰ found the liberty interest encompasses “the right to non-interference by the state with fundamentally important and personal medical decision-making”.²¹¹ Justice Smith concluded that “Ms.

²⁰¹ *Ibid* at para 1250.

²⁰² *Ibid* at para 1256.

²⁰³ *Ibid* at para 1259.

²⁰⁴ *Ibid* at para 1258.

²⁰⁵ *Rodriguez SCC, supra* note 42.

²⁰⁶ Note, throughout the decision the BCSC often referred solely to Ms. Taylor, as Ms. Carter travelled to Switzerland and died by way of physician assisted death in 2010, before the matter was heard in court.

²⁰⁷ *Carter BCSC, supra* note 6 at para 1294.

²⁰⁸ *Ibid* at para 1295.

²⁰⁹ *Ibid* at para 1297.

²¹⁰ *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] SCR 181 [AC].

²¹¹ *Carter BCSC, supra* note 6 at para 1302.

Taylor's interests in security of the person and liberty, and liberty interests of Mr. Johnson and Ms. Carter [litigation representatives for Kay Carter], are engaged by the impugned provision".²¹²

With respect to the right to life, Taylor argued this right was engaged because the impugned provision deprives her of the right to plan and carry out decisions to end her life. Further, she argued that to exercise the same right of an able-bodied person, she would be forced to end her life earlier than wished out of fear of losing the physical ability to do so later on.²¹³ On the other hand, Canada argued the right to life does not include the right to death and granting such a right would entail a significant departure from existing jurisprudence.²¹⁴ Justice Smith concluded the right to life is engaged by the impugned provision as it may have the effect of forcing people in Taylor's situation to prematurely end their life due to fear of becoming physically unable to do so at a later date.²¹⁵

To accord with the principles of fundamental justice a law must not be arbitrary, overbroad or grossly disproportionate. Justice Smith did not provide an opinion on whether the impugned provision was arbitrary as the SCC concluded in *Rodriguez* it was not arbitrary.²¹⁶ However, when *Rodriguez* was decided, it did not consider whether the impugned provision was overbroad or grossly disproportionate.

The principle of overbreadth requires that any "restriction on life, liberty and security of the person must not be more broadly framed than necessary to achieve the legislative purpose".²¹⁷ The Plaintiffs argued the provision failed to meet the overbreadth test and was broader than necessary to achieve the purpose of protecting vulnerable persons.²¹⁸ Canada argued that given the risks were so serious and consequences irreversible, the onus was on

²¹² *Ibid* at para 1304.

²¹³ *Ibid* at paras 1307,1309.

²¹⁴ *Ibid* at para 1314.

²¹⁵ *Ibid* at para 1322.

²¹⁶ *Ibid* at para 1337.

²¹⁷ *Ibid* at para 1339.

²¹⁸ *Ibid* at para 1348.

the Plaintiffs to offer compelling and conclusive evidence that there was no risk to vulnerable persons should the blanket prohibition be amended.²¹⁹ Justice Smith did not accept this, and concluded the impugned provision was overbroad as it was not the least restrictive means of protecting vulnerable persons from being induced into suicide.²²⁰

Justice Smith briefly considered whether the impugned provision was grossly disproportionate and concluded the effect of the prohibition on the section 7 rights were very severe and “grossly disproportionate to its effect on preventing inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people and upholding the state interest in the preservation of human life”.²²¹

Having examined the principles of fundamental justice, Justice Smith concluded it was not necessary to consider the section 1 justification. Further, even if it were necessary, she observed this analysis would reach the same conclusion as her *Oakes* analysis for the section 15 claim.²²²

Justice Smith granted two declaratory orders declaring the impugned provision unjustifiably infringed sections 7 and 15 and were of no force or effect to the extent:

they prohibit physician assisted suicide by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully informed, non-ambivalent competent adult patient” who (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) is materially physically disabled or is soon to become so, has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring

²¹⁹ *Ibid* at para 1349.

²²⁰ *Ibid* at para 1371.

²²¹ *Ibid* at para 1378.

²²² *Ibid* at para 1383.

physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.²²³

The declarations were suspended for one year to give the government time to provide a legislative response.²²⁴ Taylor requested, and was granted, a constitutional exemption permitting her to obtain physician-assisted death during the suspension of the declaration of constitutional invalidity, albeit under set conditions.²²⁵ Once these conditions were met, Taylor could make an application to the BCSC for an Order permitting a physician to assist her death.²²⁶

Unsurprising, the Attorney General of Canada appealed the decision.

2.4.2 British Columbia Court of Appeal

In 2013, the Attorney General of Canada (the “AGC”) appealed Justice Smith’s order including the constitutional exemption granted to Taylor. Before the BCCA, the AGC argued Smith J. erred in finding the impugned provisions of the *Criminal Code* infringed the respondents’ rights under sections 7 and 15 of the *Charter* and erred in distinguishing *Rodriguez*.²²⁷ The AGC conceded the constitutional exemption issue was moot as Taylor had subsequently passed away.²²⁸ The BCCA allowed the appeal, with Chief Justice Finch dissenting. The court concluded *Rodriguez* determined the issue and Smith J. was bound by stare decisis to apply *Rodriguez* and thus set aside Smith J.’s order.²²⁹ It should be noted there were several intervenors.²³⁰

Chief Justice Finch’s dissenting opinion concludes Smith J. made no error with respect to her section 7 and corresponding section 1 analysis but erred in concluding the infringement

²²³ *Ibid* at para 1393.

²²⁴ *Ibid* at para 1399.

²²⁵ *Ibid* at para 1414.

²²⁶ *Ibid* at para 1415.

²²⁷ *Carter BCCA*, *supra* note 44 at para 3.

²²⁸ *Ibid* at para 7.

²²⁹ *Ibid* at paras 241, 242 and 352.

²³⁰ There were intervenors representing both sides of the debate.

of section 15 was not saved by s. 1, as concluded in *Rodriguez*.²³¹ With respect to section 7, Chief Justice Finch agreed with Smith J. that *Rodriguez* did not consider the right to life and did not consider whether the impugned provision was overbroad or grossly disproportionate.²³² With respect to risks of coercion, Finch C.J. agreed with Smith J. that the requirement for voluntariness when requesting physician assisted suicide and the continued criminalization of coercing individuals to commit suicide, offer safeguards against coercion.²³³ In this analysis, Chief Justice Finch suggests ensuring voluntariness offers a safeguard to address coercion-related concerns.²³⁴

The AGC argued when Smith J. was examining whether the impugned provisions were overly broad and minimally impaired the respondents' rights, she should have asked whether there was a "reasonable apprehension of harm that Parliament could only address with an absolute prohibition on assisted death".²³⁵ The AGC took the position the only issue at trial, and on appeal, was whether the prohibition against assisted suicide was within the "range of reasonable legislative alternatives".²³⁶ It argued Smith J. erroneously asked instead whether there is "an alternate, less drastic, means of achieving the objective in a real and substantial matter".²³⁷ Chief Justice Finch disagreed and found that because the prohibition was overbroad in that it impairs section 7 more than is necessary to achieve its objectives of the legislation, it could not pass the minimal impairment section of the *Oakes* test. For the first two-part parts of the *Oakes* test, Finch C.J. agreed the objectives of the impugned provision were pressing and substantial, and that the prohibition against assisting suicide was rationally connected to the objectives and therefore the prohibition was a rational response by Parliament.²³⁸

²³¹ *Carter BCCA*, *supra* note 44 at para 4.

²³² *Ibid* at para 5.

²³³ *Ibid* at para 163.

²³⁴ *Ibid* at para 163.

²³⁵ *Ibid* at para 31.

²³⁶ *Ibid* at para 32.

²³⁷ *Ibid* at para 32.

²³⁸ *Ibid* at paras 174–175.

The Applicant's argued that Smith J. erred in concluding that section 241 infringed the Respondent's section 15 rights, and further, she was precluded from considering the issue as a result of the precedential effect of *Rodriguez SCC*. With respect to whether the principle of *stare decisis* prevented Smith J. to consider section 15, Finch C.J. agreed this was open for Smith J. to consider as in *Rodriguez SCC*, Sopinka J., assumed, rather than decided, the impugned provision violated section 15.²³⁹ Meaning, the principle of *stare decisis* did not apply. However, since Justice Sopinka completed the *Oakes* analysis on the assumption section 15 was violated and found it was saved by section 1, Smith J. would have to distinguish the result in *Rodriguez*.²⁴⁰

At trial, the respondents argued the SCC decision in *Alberta v Hutterian-Brethren of Wilson Colony, 2009 SCC 37* ("**Hutterian-Brethren**") modified the law to create a "more rigorous analysis of proposed justification for *Charter*-infringing legislation than was conducted in *Rodriguez*".²⁴¹ In accepting this argument, Smith J. held *Hutterian-Brethren* changed the law, the final step for a section 1 analysis, and permits courts to "widen their perspective at the final stage to take full account of the deleterious effects of the infringement on individuals or groups, and determine whether the benefits of the legislation are worth that cost".²⁴² In finding that *Hutterian-Brethren* changed the section 1 analysis, and therefore it could not be the same as Sopinka J.'s analysis in *Rodriguez*, Smith J. concluded she was not bound by the analysis in *Rodriguez*. Chief Justice Finch disagreed with this, and concluded *Hutterian-Brethren* did not change the issues to be decided under section 1 and therefore Smith J. remained bound by *Rodriguez*.²⁴³ Chief Justice Finch would have dismissed the appeal with respect to section 7 but would have allowed the section 15 appeal.

²³⁹ *Ibid* at para 98

²⁴⁰ *Ibid* at para 98.

²⁴¹ *Ibid* at para 101.

²⁴² *Ibid* at para 102.

²⁴³ *Ibid* at para 106.

Madam Justice Newbury, writing for the majority of the court, with Madam Justice Saunders concurring, held that *Rodriguez SCC* determined the appeal and that only Parliament could provide a relief against section 241.²⁴⁴ The majority disagreed with Smith J.'s finding that *Rodriguez SCC* did not consider "life" under section 7, and to the contrary found life was "inherent in the majority's reasons in *Rodriguez [SCC]*" and that "life" in the context of section 7 has a "narrow compass and does not include the right to die in the manner and at the time of one's choosing."²⁴⁵ If the majority's finding was wrong on this point, Newbury J. held it was correct to say *Rodriguez SCC* found the prohibition on assisted dying accorded with the principles of fundamental justice and the law met the tests for arbitrariness and what are now referred to as overbreadth and gross disproportionality.²⁴⁶

Ultimately, the majority found *Rodriguez SCC* decided the issue in that the prohibition was rationally connected to the objectives, rendering the blanket prohibition preferable to a law that might not adequately prevent abuse.²⁴⁷ Meaning, Smith J. was bound by *stare decisis* to conclude the Plaintiffs' case had already been determined by the SCC. The majority allowed the appeal on the basis that the Plaintiffs' case had been authoritatively decided by *Rodriguez SCC*. As expected, following the BCCA setting aside the trial judge's decision, the respondents appealed to the SCC.

2.4.3 Supreme Court of Canada

In February 2015, in a unanimous ruling, the SCC allowed the appeal and held that the prohibition on assisted suicide infringed the Plaintiffs' rights under section 7 and could not be saved by section 1. Since the prohibition on physician-assisted death was void under section 7, the SCC held that there was no need to consider the section 15 claim. The Court held that the prohibition on physician-assisted dying:

²⁴⁴ *Ibid* at para 241.

²⁴⁵ *Ibid* at para 281.

²⁴⁶ *Ibid* at para 282.

²⁴⁷ *Ibid* at para 315.

is void insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person 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.²⁴⁸

A fundamental question for the SSC was whether the trial judge was bound by *Rodriguez* or if she was permitted to consider the constitutionality of the impugned provisions. The SCC stated that trial courts may reconsider settled rulings of higher courts in two situations: “(1) where a new legal issue is raised; and (2) where there is a change in the circumstances or evidence that fundamentally shifts the parameters of the debate”.²⁴⁹ The SCC concluded both of these conditions were met. Thus, Justice Smith was correct to conclude there were changes in the legal framework for section 7 (in particular, the law relating to the principles of overbreadth and gross disproportionality²⁵⁰) and new evidence had emerged about the ability to control any potential abuses associated with assisted suicide.²⁵¹

The following outlines the SCC’s reasons for concluding the Plaintiffs’ section 7 rights were infringed and could not be saved by section 1 of the *Charter*.

2.4.3.1 Section 7 analysis

The SCC concluded the prohibition against physician assisted dying infringes all parts of section 7 and in a manner that was overbroad and not in accordance with the principles of fundamental justice.²⁵² The SCC agreed with Smith J.’s conclusion that the Plaintiffs’ right to life was violated as the prohibition had the effect of causing some individuals to prematurely to take their life due to fear they would lose the physical ability to do so when they reached the point of intolerable suffering.²⁵³ The considered jurisprudence supports the position that the right to life is engaged where the “law or state action imposes death or

²⁴⁸ *Carter SCC*, *supra* note 1 at para 4.

²⁴⁹ *Ibid* at para 44.

²⁵⁰ *Ibid* para 46.

²⁵¹ *Ibid* para 45.

²⁵² *Ibid* at para 56.

²⁵³ *Ibid* at para 57.

an increased risk of death on a person, either directly or indirectly”.²⁵⁴ Further, the SCC agreed with the Smith J.’s analysis on the Plaintiffs’ right to liberty and security of the person,²⁵⁵ as the impugned provision interfered with “fundamentally important and personal decision-making,” which could impose pain and psychological stress and deprive the Plaintiffs of control over their bodily integrity.²⁵⁶

2.4.3.2 Section 1 analysis

The SCC agreed with Smith J. that despite the prohibition being prescribed by law and the law having a pressing and substantial objective, the prohibition was not proportionate to the objective.²⁵⁷ In other words, the impugned provision could not be saved by section 1. The Court also found it could not justify a section 7 violation as these are fundamental rights and “are not easily overridden by competing social interests”.²⁵⁸ Despite the prohibition being rationally connected to the objective of the provision, to protect vulnerable persons from taking their lives in a moment of weakness, the SCC agreed with Smith J. that the necessity of the absolute prohibition was not supported by evidence in order to substantially meet the government’s objective.²⁵⁹

In arriving at this conclusion, Smith J. had reviewed extensive and compelling evidence, including from scientists, medical practitioners, others involved in end-of-life decision making, other jurisdictions with a permissive regime, along with evidence that showed physicians can reliably assess competence, voluntariness, and non-ambivalence in patients, to apply the informed consent requirement.²⁶⁰ With appropriate safeguards and

²⁵⁴ *Ibid* at para 62.

²⁵⁵ *Ibid* at para 64: Liberty protects “the right to make fundamental personal choices free from state interference”. Security of the person encompasses “a notion of personal autonomy involving . . . control over one’s bodily integrity free from state interference” and it is engaged by state interference with an individual’s physical or psychological integrity, including any state action that causes physical or serious psychological suffering.

²⁵⁶ *Ibid* at para 64.

²⁵⁷ *Ibid* at para 96.

²⁵⁸ *Ibid* at para 95.

²⁵⁹ *Ibid* at para 109.

²⁶⁰ *Ibid* at paras 103–104, 106.

monitoring, Smith J. concluded a permissive regime could be “carefully designed” to adequately address the risk to vulnerable persons.²⁶¹ In this appeal, Canada argued Smith J. made a palpable and overriding error in concluding that safeguards would minimize the risk associated with assisted dying.²⁶² The SCC disagreed with Canada’s submission as it had not established the trial judge’s conclusion was “unsupported, arbitrary, insufficiently precise or otherwise in error”²⁶³, and agreed with Smith J. finding of fact as outlined above.²⁶⁴ Ultimately, the SCC held that Canada did not establish the prohibition minimally impaired the Plaintiffs’ section 7 rights, as a “theoretical or speculative fear cannot justify an absolute prohibition”.²⁶⁵

The SCC did not weigh the impact of the law on the *Charter* rights against the beneficial effect of the law as they found the law did not minimally impair the protected rights and, as such, could not be saved by section 1.²⁶⁶

The SCC held that to the extent that the impugned laws deny the section 7 rights of people the law was void, relying on section 52 of the *Constitution Act, 1982*.²⁶⁷ The declaration of invalidity states:

s. 241(b) and s. 14 of the Criminal Code 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. “Irremediable”, it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.²⁶⁸

²⁶¹ *Ibid* at para 105.

²⁶² *Ibid* at para 108.

²⁶³ *Ibid* at para 109.

²⁶⁴ *Ibid* at paras 116–117.

²⁶⁵ *Ibid* at para 119.

²⁶⁶ *Ibid* at paras 122–123.

²⁶⁷ *Constitution*, *supra* note 11 at s 52.

²⁶⁸ *Carter SCC*, *supra* note 1 at para 127.

The remedy offered by the SCC was to suspend the declaration of invalidity for 12 months to allow Parliament and the provincial legislatures to respond by “enacting legislation consistent with the constitutional parameters set out in these reasons”.²⁶⁹ Several intervenors asked the SCC to confirm that nothing in the decision would compel a physician, who consciously objects to physician assisted dying, to participate. The Court found this unnecessary as, in their view, nothing in their decision would compel physicians to provide physician assistance in dying.²⁷⁰

The SCC held this case was not appropriate to create a mechanism for constitutional exemptions during the period of suspended validity and that Parliament must be given an opportunity to consider an appropriate response.²⁷¹

On January 15, 2016, the SCC unanimously extended the suspension of the declaration of invalidity by six months, to allow the federal government more time to determine a legislative regime for physician assisted suicide in Canada. The SCC held extraordinary circumstances must be shown to permit the extension of a suspension of the declaration of invalidity and agreed with the AGC the interruption of work on a legislative response to the Court’s decision due to a federal election constitutes such a circumstance.²⁷² It further held that in the interim those who met the criteria set out in *Carter SCC* and who wished to seek the assistance of a physician to end their life could apply to the court for an individual constitutional exemption, given that the provisions of the *Criminal Code* were still in force.²⁷³

2.5 The Post-*Carter* Era

The SCC’s decision in *Carter* was a landmark decision that changed the landscape of death and dying in Canada. The Post-*Carter* era can be characterized as clarifying and expanding

²⁶⁹ *Ibid* at para 126.

²⁷⁰ *Ibid* at paras 130, 132.

²⁷¹ *Ibid* at paras 125, 129.

²⁷² *Carter v Canada (Attorney General)*, 2016 SCC 4, [2016] 1 SCR 13 at para 2 [*Carter SCC* Extended Suspension of a Declaration of Invalidity].

²⁷³ *Ibid* at para 5.

the scope of MAID through legislation and jurisprudence. The following sections considers these important legislative and judicial decisions and starts by considering the Federal Ministers of Justice and Health response to *Carter SCC* by establishing the External Panel on Options for a Legislative Response to *Carter v Canada* (the “**Panel**”).²⁷⁴ The resulting report, the *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings Final Report (the “First Report”)*,²⁷⁵ helped inform the federal government’s legislative framework for the provision of physician-assisted suicide in Canada. This was outlined in Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*.²⁷⁶ Bill C-14 was introduced in the House of Commons in 2015 and received Royal Assent in June 2016.²⁷⁷ Shortly after Bill C-14 received Royal Assent, critics quickly identified the eligibility criteria that natural death be reasonably foreseeable was not a requirement stipulated in *Carter SCC* and was too restrictive.

The uncertainty of what constituted a “reasonably foreseeable natural death” amongst the health care community was also highlighted and considered in *AB v Canada (Attorney General)*²⁷⁸ (“**AB**”) in June 2017. Although *AB* does not consider voluntariness in detail, it is an important decision in the history of MAID as it highlights concerns with the term “reasonably foreseeable natural death”, identified the role of the court in considering MAID eligibility assessments, and clarified differing medical opinions regarding a person’s MAID eligibility is not fatal, but to be expected. Following *AB*, *Truchon v Procureur General Du Canada*²⁷⁹ (“**Truchon**”) is considered, which expanded the scope of persons eligible for MAID, to those whose natural death is not reasonably foreseeable.

As *Truchon* provides some context to the assessment of voluntariness and due to its critical role in shaping the expansion of MAID in Canada, it is an important decision to review. Canada’s legislative response to *Truchon* was outlined in Bill C-7, *An Act to Amend the*

²⁷⁴ First Report, *supra* note 22.

²⁷⁵ *Ibid.*

²⁷⁶ Bill C-14, *supra* note 2.

²⁷⁷ *Ibid.*

²⁷⁸ *AB v Canada*, 2017 ONSC 3759, [2017] OJ No 3140 [*AB*].

²⁷⁹ *Truchon*, *supra* note 18.

Criminal Code (Medical Assistance in Dying),²⁸⁰ which received Royal Assent in March 2021. Bill C-7 mainly created two tracks for MAID and expanded the eligibility criteria to include persons whose natural death is not reasonably foreseeable. Since Bill C-7, the majority of the debate around MAID relates to the continued expansion to include persons whose sole underlying condition is mental illness, which was expected to be law in March 2023 but has been delayed until March 2027.²⁸¹

The following summarizes the various government reports, legislation and jurisprudence since *Carter*. This review pays particular attention to the discussion related to voluntariness.

2.5.1 External Panel on Options for a Legislative Response to *Carter v Canada*, 2015

Following the SCC's ruling in *Carter*, the Federal Ministers of Justice and Health established the External panel on Options for a Legislative Response to *Carter v Canada* (the “**Panel**”).²⁸² The Panel's mandate was to hold discussions with intervenors in *Carter* and “relevant medical authorities”, and to “hold online consultations open to all Canadians and other stakeholders”.²⁸³ The Panel was required to provide the Ministers with a summary of the consultation activities, including key findings. It specifically focused on the following: the different forms of physician-assisted dying; eligibility criteria and definition of key terms; risks to individuals and society associated with physician-assisted dying; and safeguards to address risks and procedures for assessing requests for assistance in dying as well as protection of physicians' freedom of conscience to refuse to

²⁸⁰ Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2021 [Bill C-7].

²⁸¹ Bill C-39, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 44th Parl, 2023 [Bill C-39]; Bill C-62, *An Act to Amend the Criminal Code (medical assistance in dying)*, 1st Sess, 44th Parl, 2024 [Bill C-62].

²⁸² First Report, *supra* note 22.

²⁸³ *Ibid* at 7.

participate.²⁸⁴ In December 2015, the Panel submitted its final report titled *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings*.²⁸⁵

With respect to the Panel's consideration of the voluntariness safeguard, they highlighted similar issues as Smith J. in *Carter*.²⁸⁶ This included stipulating that for a request to be voluntary it must be evaluated for possible coercion, undue influence and ambivalence.²⁸⁷ It further explained coercion and undue influences are external pressures that individuals may experience from family, friends, authority figures or society at large.²⁸⁸ Finally, ambivalence "reflects the individual's own potentially conflicting thoughts on whether to proceed with physician-assisted dying".²⁸⁹ According to Professor Wayne Sumner, an expert that testified before the Panel, influence will be "undue" "when it rises to the level of fraud, deceit, duress, or coercion".²⁹⁰

The Panel found the majority of the submissions made with respect to voluntariness articulated various approaches to ensure inducement does not occur.²⁹¹ Some of the intervenors raised doubts that physicians would be able to assess voluntariness in the presence of "mental illness, language and cultural barriers and other social vulnerabilities."²⁹² The Panel also heard from witnesses that allied health professionals, such as social workers or psychologists, could help address and assess the social determinants of health that may compromise the autonomy of a person who is vulnerable to abuse, coercion or undue influence.²⁹³

²⁸⁴ *Ibid* at 7-8.

²⁸⁵ First Report, *supra* note 22.

²⁸⁶ *Carter BCSC*, *supra* note 6.

²⁸⁷ First Report, *supra* note 22 at 69.

²⁸⁸ *Ibid*.

²⁸⁹ *Ibid*.

²⁹⁰ *Ibid*.

²⁹¹ *Ibid*.

²⁹² *Ibid* at 70.

²⁹³ *Ibid* at 11.

Following the release of the *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings*, the legislature was tasked with drafting a legislative framework to safely provision MAID.

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

Following *Carter*, Parliament worked to draft new law that created an exemption to the criminal prohibition of counselling or aiding suicide to allow for the lawful facilitation and administration of MAID to eligible patients. The outcome of these efforts was enshrined in Bill C-14, which received royal assent in June 2016.²⁹⁴ Counselling or aiding suicide remains a criminal offence in Canada, but Bill C-14 created an exemption to the offence provided MAID is facilitated in compliance with clear perimeters, which are identified below.

Bill C-14 introduced the term “medical assistance in dying” and defined it as:

- (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.²⁹⁵

Although *Carter* specifically referred to physicians being involved in MAID, the legislature determined it appropriate to include nurse practitioners in assessing and provisioning MAID.

Pursuant to Bill C-14, a person may receive MAID if they meet all of the following eligibility criteria:

- a) They are eligible for health services funded by a government in Canada;
- b) They are at least 18 years of age and capable of making health care decisions;
- c) They have a grievous and irremediable medical condition;

²⁹⁴ Bill C-14, *supra* note 2.

²⁹⁵ *Ibid* at cl 241.1.

- d) They have made a voluntary request for MAID that was not a result of external pressure; and
- e) They give informed consent to receive MAID after having been informed of the means that are available to relieve their suffering, including palliative care.²⁹⁶

With the new law, a ‘grievous and irremediable medical condition’ would be defined within the *Criminal Code* as:

241.2 (2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.²⁹⁷

Bill C-14 required, among other things, that Practitioners satisfy strict safeguards, including ensuring the patient met all the eligibility criteria prior to provisioning MAID.

The intent of the safeguards was to protect vulnerable persons from inappropriately accessing MAID. Table A reviews the full listing of the safeguards contained within the *Criminal Code*.

SECTION	SAFEGUARD
241.2(3)	Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must

²⁹⁶ *Criminal Code*, *supra* note 3, at s 241.2 (1).

²⁹⁷ *Ibid* at s 241.2 (2).

241.2(3)(a)	Be of the opinion that the person meets all eligibility criteria set out in subsection (1)
241.2(3)(b)	Ensure the person's request for medical assistance in dying was: <ul style="list-style-type: none"> • made in writing and signed and dated by the person or another person under subsection (4); and • signed and dated after the person was informed by a medical practitioner or nurse practitioner they have a grievous and irremediable medical condition
241.2(3)(c)	Be satisfied the request was signed and dated by the person – or by another person under subsection (4) – before two independent witnesses who then also signed and dated the request
241.2(3)(d)	Ensure that the person has been informed they may, at any time and in any manner, withdraw their request
241.2(3)(e)	Ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all eligibility criteria
241.2(3)(f)	Be satisfied they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent
241.2(3)(g)	ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;
241.2(3)(h)	immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and
241.2(3)(i)	if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

In addition to the above, Bill C-14 required assessors to be independent, the collection of certain data for monitoring purposes, and the creation of an offence for failing to comply with the safeguards.²⁹⁸

²⁹⁸ Bill C-14, *supra* note 2.

Although a full review of how the House of Commons and Senate debated Bill C-14 is beyond the scope of this paper, it is important to identify a brief history of how the bill was considered and passed. First reading by the House of Commons was completed on April 14, 2016, and followed by the second reading which referred the matter to the Standing Committee on Justice and Human Rights.²⁹⁹ Notably, 228 briefs were submitted to the Standing Committee on Justice and Human Rights, resulting in amendments to Bill C-14, which subsequently passed third reading by the House of Commons on May 31, 2016. The briefs were submitted by individuals and organizations with various perspectives on the issue of physician assisted suicide.³⁰⁰ The number of interested parties, highlights the complexity involved in developing a MAID regime that accounts for the various interests and concerns. Senate conducted a pre-study by the Standing Senate Committee on Legal and Constitutional Affairs, and the bill passed first and second reading by June 3, 2016. The Standing Senate Committee on Legal and Constitutional Affairs concluded its consideration of the bill on June 7, 2016, and subsequently, following third reading on June 15, 2016, Bill C-14 passed Senate with amendments.³⁰¹ A further review of the debates before the House of Commons and Senate related to voluntariness are considered in chapter 3.

Next, *AB* is reviewed as it is an important evolution in the MAID jurisprudence as it interprets “natural death is reasonably foreseeable”, along with a clear articulation of the role of the courts in reviewing MAID eligibility assessments.

2.5.3 *AB v Canada (Attorney General)*

Although the *AB* decision does not discuss the voluntariness requirement, it is worthwhile highlighting this decision, in the context of MAID, as it interprets what was meant by “natural death is reasonably foreseeable”, impact of conflicting eligibility assessments and

²⁹⁹ Passed with 235 voting yea and 75 voting nay.

³⁰⁰ For a complete review of the work of the Standing Committee on Justice and Human Rights, including the written briefs, transcripts of the evidence of the witnesses, and report refer to: [JUST - Bill C-14, An Act to amend the Criminal Code \(medical assistance in dying\) \(ourcommons.ca\)](#).

³⁰¹ Bill C-14, *supra* note 2.

clearly identifies the role of the courts in assessing whether patients meet the MAID eligibility criteria. In this application, the Plaintiff was seeking a declaration that she met the *Criminal Code* eligibility criteria and, specifically, that her natural death was reasonably foreseeable. AB was almost 80 years old and suffering with severe osteoarthritis,³⁰² which was diagnosed in her 40s, and her condition continued to deteriorate to the point where she could no longer work due to excruciating pain.³⁰³ Eventually, AB required full time care and was placed in a nursing home. As her condition continued to deteriorate, and her pain became unbearable, she started to think about MAID, which at that time was being considered by the SCC.³⁰⁴ The evidence entered indicated AB was in an “advanced state of incurable, irreversible, inflammatory and erosive osteoarthritis...her medical condition is not imminently terminal”.³⁰⁵ AB proceeded with her MAID eligibility assessments in April 2017.

The first assessor found AB’s death was reasonably foreseeable “given her age and irreversible, incurable, debilitating illness that is causing her incredible suffering”.³⁰⁶ The second assessor concluded AB’s death was not reasonably foreseeable.³⁰⁷ Subsequently, AB sought a third assessor who found that she was eligible for MAID and she proceeded to ask the first assessor to provision.³⁰⁸ However, due to the second assessor concluding AB’s natural death was not reasonably foreseeable, the first assessor (and intended provisioner), would not provision her death as he was uncomfortable with the second assessor’s conclusion and concern with his understanding of the meaning of “reasonably foreseeable” in section 241.2(2)(d) of the *Criminal Code*.³⁰⁹

³⁰² *AB*, *supra* note 278 at para 8.

³⁰³ *Ibid* at para 18.

³⁰⁴ *Ibid* at para 20.

³⁰⁵ *Ibid* at para 31.

³⁰⁶ *Ibid* at para 34.

³⁰⁷ *Ibid* at para 35.

³⁰⁸ *Ibid* at paras 36–37.

³⁰⁹ *Ibid* at para 37.

The Ontario Superior Court of Justice (ONSC) concluded it was not the court's role to opine on whether AB met the eligibility criteria for MAID, as this was exclusively the responsibility of assessors.³¹⁰ The Court was willing, however, to make a declaration as a matter of statutory interpretation as to what it meant for natural death to be reasonably foreseeable. It held it was not necessary to identify a specific length of time the person had remaining³¹¹, as natural death “need not be connected to a particular terminal disease or condition and rather is connected to all of a particular person’s medical circumstances”³¹², but that the person be on a trajectory toward death.³¹³

The ONSC held, in accordance with the proper interpretation of the requirement that the persons natural death be reasonably foreseeable, that AB’s natural death was reasonably foreseeable.³¹⁴ This decision is important as it clarifies the role of the courts in reviewing cases related to MAID and highlights the assessment of whether a person meets the eligibility criteria falls within the scope of the medical practitioner. Further, it confirmed that differing opinions regarding a patient’s medical eligibility for MAID are not fatal and that a third assessment is appropriate when there are differing opinions on eligibility.

2.5.4 *Truchon v Procureur General Du Canada*

In *Truchon* the applicants, Jean Truchon and Nicole Gladu, who were both assessed as being ineligible for MAID as their natural death was not reasonably foreseeable, challenged the constitutional validity of the requirement that their natural death be reasonably foreseeable.³¹⁵ The Superior Court of Quebec (QCCS) held the requirement of natural death being reasonably foreseeable was found to infringe sections 7 and 15 of the *Charter* and could not be saved by section 1.

³¹⁰ *Ibid* at para 62. This was reiterated in *Sorenson v Swinemar*, 2020 NSCA 62, [2020] NSJ No. 319 [*Sorenson*], wherein the Court dismissed the applicant’s request for an injunction to prevent her husband from proceeding with MAID.

³¹¹ *Ibid* at para 80.

³¹² *Ibid* at para 81.

³¹³ *Ibid* at para 83.

³¹⁴ *Ibid* at para 89.

³¹⁵ *Truchon*, *supra* note 18.

Truchon was a 51-year-old man who suffered from spastic cerebral palsy with tripareisis since birth. As a result of this condition, he was completely paralyzed with the exception of his left arm, which was functional and, until 2012, allowed him to perform certain everyday tasks and to move around in a wheelchair. His cognitive and mental functions were completely intact and above normal. He had lived a full life, including graduating from university and living in a supervised apartment in Montreal. In and around 2012, Truchon's condition deteriorated significantly resulting full paralysis and no hope for improvement. Significant medical evidence was entered by several different experts that provided care and assessments of Truchon that clearly depicted a man that was enduring considerable suffering and concluded he could voluntarily consent to ending his life. Even though he met all the other legislative requirements, his degenerative illness would not cause or hasten his death.

The other Plaintiff, Gladu, was a 73-year-old female who survived poliomyelitis at the age of 4, which sent her into a coma and left her with significant sequelae, including residual paralysis of the left side and severe scoliosis caused by the gradual deformation of her spinal column.³¹⁶ At the age of 47, Gladu was diagnosed with muscular post-polio syndrome, an incurable degenerative neurological disease characterized by general fatigue, gradual or sudden muscular weakness, and mobility-reducing muscle pain.³¹⁷ In 1997 she developed thrombophlebitis and a hiatal hernia and life was increasingly more difficult, as her condition continued to deteriorate and was later diagnosed with a serious case of osteoporosis. Due to her various conditions, she was no longer able to hold herself up, she suffered severe restrictive lung disease making every breath a battle and her hiatal hernia made eating difficult.³¹⁸ At the time of the trial, Gladu was in constant pain, in a perpetual state of great discomfort and malaise and medication had been unable to provide relief.

Gladu joined forces with Truchon to bring about the application as she questioned the logic of the principle that she could starve herself in order to achieve a state where she is eligible

³¹⁶ *Ibid* at para 53.

³¹⁷ *Ibid* at para 55.

³¹⁸ *Ibid* at para 57.

for MAID, but she could not be assisted to do it humanely.³¹⁹ Gladu underwent many medical assessments for the purposes of determining whether she would be eligible for MAID under the existing criteria and was deemed to be eligible except for the requirement that her death be reasonably foreseeable and that she be at end of life.³²⁰

The AGC argued that the law should not be amended to permit persons whose natural death is not reasonably foreseeable from accessing MAID due to the “collective vulnerability” of this group of persons.³²¹ Generally, the AGC argued persons with disabilities face concerns with social determinants of health that may persuade them to access MAID for non-medical reasons. For example, this group of persons may be vulnerable as a result of reduced access to appropriate care, poverty, unemployment, abuse, and other socio-economic concerns.³²² The QCCS disagreed with the AGC and found that vulnerability arising from external factors, including the social determinants of health, should not prevent a group of persons from requesting MAID and that an individual case by case assessment is required.³²³

Significant evidence was produced during the trial and the Court, at paragraph 466, made important conclusions based on the evidence, including:

- Medical assistance in dying as practiced in Canada is a strict and rigorous process that, in itself, displays no obvious weakness;
- The physicians involved are able to assess the patients’ capacity to consent and identify signs of ambivalence, mental disorders affecting or likely to affect the decision-making process, or cases of coercion or abuse;
- The vulnerability of a person requesting medical assistance in dying must be assessed exclusively on a case-by-case basis, according to the

³¹⁹ *Ibid* at para 64.

³²⁰ *Ibid* at paras 66, 68.

³²¹ *Ibid* at para 309.

³²² *Ibid* at para 245 (footnote at 263).

³²³ *Ibid* at para 252.

characteristics of the person and not based on a reference group of so-called “vulnerable persons”. Beyond the various factors of vulnerability that physicians are able to objectify or identify, the patient’s ability to understand and to consent is ultimately the decisive factor, in addition to the other legal criteria;

- ...
- Neither the national data in Canada or Quebec nor the foreign data indicate any abuse, slippery slope or even heightened risks for vulnerable people when imminent end of life is not an eligibility criterion for medical assistance in dying.³²⁴

Notably, the second and third bullet relates to the ability of a physician to competently assess an individual for vulnerabilities that may vitiate the voluntariness of the request for MAID.

2.5.4.1 Section 7 analysis

The Plaintiffs argued the eligibility requirement that one’s natural death be reasonably foreseeable infringed upon their right to life, liberty and security of the person and their right to equality, which are guaranteed by sections 7 and 15 of the *Charter*.³²⁵ The AGC argued that Parliament’s response to *Carter*, Bill C-14, struck the right balance between the autonomy of persons who seek MAID, and the objective of section 241, which is to protect vulnerable persons.³²⁶ The AGC further argued that if there was an infringement it would be saved by section 1 of the *Charter* because it is a reasonable requirement that can be justified in a free and democratic society.³²⁷

The QCCS held the impugned provision violated section 7 as it was overbroad and disproportionate, making it inconsistent with the principles of fundamental justice.³²⁸ The

³²⁴ *Ibid* at para 466.

³²⁵ *Ibid* at para 6.

³²⁶ *Ibid* at para 9.

³²⁷ *Ibid* at para 10.

³²⁸ *Ibid* at para 587.

QCCS further held, based on the evidence adduced, the *Criminal Code* regime is “fully able, even without the challenged requirement, of screening and identifying persons who do not meet the other eligibility criteria...” and, accordingly, could not be saved by section 1.³²⁹

2.5.4.2 Section 15 analysis

The Plaintiffs argued the impugned provision creates an unjustifiable distinction based on physical disability. Canada agreed the impugned provision creates a distinction, but the distinction is not based on the nature of the health issues or disabilities and the timing of when MAID becomes available is not an enumerated or analogous ground. Further, the requirement does not exclude persons with severe disabilities and persons who do not meet the requirement are not forced to continue living as they have the ability to end their lives.³³⁰ The Court concluded the impugned provision did create a distinction based on physical disability, as due to their physical condition, they are unable to obtain MAID, despite meeting all the other eligibility criteria.³³¹ The impugned provision could not be saved by section 1 as it did not meet the standard of minimal impairment and proportionality of effects.³³²

The QCCS granted a six-month suspension of the declaration of constitutional invalidity³³³ to allow Parliament enough time to amend the *Criminal Code* within the parameters of the *Truchon* decision.³³⁴ The QCCS also granted a constitutional exemption for individuals to seek a court’s authorization to proceed with MAID despite not meeting the requirement for

³²⁹ *Ibid* at para 636.

³³⁰ *Ibid* at para 653.

³³¹ *Ibid* at para 654.

³³² *Ibid* at para 690.

³³³ The suspension was extended by four months in March 2020 as the election slowed the proposed changes to the MAID law. For a third time, the Attorney General of Canada requested an extension to the suspension of the declaration of invalidity from July 2020 to December 18, 2020 as a result of the impact of the COVID 19 pandemic.

³³⁴ *Truchon*, *supra* note 18. The suspension was extended in March 2020 for four additional months in, *Truchon c. Procureur général du Canada*, 2020 QCCS 772, [2020] QJ No. 1553. Subsequently the suspension of invalidity was extended to December 18, 2020, in *Truchon c. Procureur général du Canada*, 2020 QCCS 2019, [2020] JQ No. 4180.

the person’s natural death to be reasonably foreseeable. Neither of the Defendants appealed the decision and the AGC stated, “we decided not to appeal the *Truchon* decision because we agreed that medical assistance in dying should be available as a means to address intolerable suffering outside of the end-of-life context. To ensure the consistency of criminal law across the country, we committed to amending the *Criminal Code*”.³³⁵ The AGC also stated they thought the Court’s decision in *Truchon* was sound and they would lose on appeal.³³⁶

While the *Truchon* decision does not provide insight into the interpretation of what it means for a request to be voluntary and not the result of external pressures it does reference the need for it to be voluntary. Following *Truchon*, the legislature was required to amend the *Criminal Code* to permit access to eligible persons whose natural death was not reasonably foreseeable.

2.5.5 Bill C-7: *An Act to amend the Criminal Code (medical assistance in dying), 2021*

Bill C-7 was the Federal government’s response to *Truchon* and sought to create a second track of MAID for persons whose natural death was not reasonably foreseeable, along with other important amendments that addressed concerns raised with the existing law and application.³³⁷ The other proposed amendments to the *Criminal Code* addressed other critical matters. For example, the amendments expressly excluded persons where MD-SUMC as being eligible for MAID. The Federal Ministers of Justice and Health were required to organize an independent review by experts respecting MAID for MD-SUMC.³³⁸ They also created two sets of safeguards dependent on whether the person’s natural death was reasonably foreseeable or not. The amendment would also permit MAID

³³⁵ *House of Commons Debates*, 2-150, No. 013 (October 9, 2020).

³³⁶ *House of Commons Debates*, 2-150, No. 064 (February 23, 2021).

³³⁷ Bill C-7, *supra* note 280.

³³⁸ The repeal of the exclusion of mental illness as an illness, disease or disability in subsection 241.2(2.1) of the *Criminal Code* was set to come into force on March 17, 2023, but was delayed by one year, until March 17, 2024. On February 29, 2024, Bill C-62, *supra* note 281, received Royal Assent, delaying MAID MD-SUMC until March 17, 2027.

to be provided to a person who has been found eligible to receive it, whose natural death is reasonably foreseeable and who has lost the capacity to consent before MAID is provided, on the basis of a prior agreement they entered into with the medical practitioner or nurse practitioner (commonly referred to as the Final Waiver of Consent).³³⁹ MAID could also be provided to a person who lost the capacity to consent as a result of the self-administration of a substance that was provided to them under the provisions governing MAID in order to cause their own death. Finally, the amendments introduced new reporting requirements to permit the Minister of Health to develop new regulations³⁴⁰ to enhance the existing federal monitoring regime.³⁴¹

Similar to Bill C-14, Bill C-7 was referred by the House of Commons to the Standing Committee on Justice and Human Rights, and the Senate referred to the matter to the Standing Senate Committee on Legal and Constitutional Affairs.³⁴² The expansion of MAID to include persons whose natural death is not reasonably foreseeable created significant debate, which, in part, can be evidenced by the number witnesses from diverse backgrounds including legal, medical, ethics and disability advocates that appeared before the Standing Committees. Bill C-7 received royal assent on March 17, 2021.

2.5.6 Government Reports

Since the decision in *Carter SCC*, numerous government reports have been commissioned, including expert panels to consider ongoing contentious matters related to the expansion

³³⁹ Notably, a private member's bill Bill S-248, *An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 44th Parl, 2022 [Bill S-248], sought to extend the Final Waiver of Consent to those persons whose natural death was not reasonably foreseeable. Bill S-248 did not pass.

³⁴⁰ This resulted in the *Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying*, which allows for additional data collection regarding those persons whose natural death is not reasonably foreseeable, further demographic data sets (i.e. gender identity, race, Indigenous identity and disability of persons requesting MAID, if the person consents to providing this information) and expand reporting requirements for medical practitioners, nurse practitioners and pharmacists to also include preliminary assessors and pharmacy technicians. The rationale for the updated monitoring regulations is: to “support Canada’s MAID regime by allowing for enhancements to data collection and reporting through the federal MAID monitoring regime to provide a more comprehensive picture of how MAID, with expanded eligibility, is being implemented in Canada

³⁴¹ Bill C-7, *supra* note 280.

³⁴² *Ibid.*

of MAID in Canada. Specifically, these reports canvass the social, ethical and legal considerations for the expansion of MAID to mature minors, MD-SUMC, and the ability to include MAID in advance directives. These reports will be further considered in Chapter 3, and specifically as they relate to understanding the legal interpretation of a voluntary request for MAID.

2.6 Conclusion

The evolution of physician assisted suicide in Canada has occurred over more than 100 years and demonstrates conflicting opinions on the appropriate balancing of bodily autonomy and self-determination with the protection of vulnerable people. A common thread within the work is the concern for protecting vulnerable people and whether any regulatory framework can safeguard the vulnerable. In *Carter*, the SCC answered this in the affirmative, that a properly administered regime is capable of protecting the vulnerable from abuse or error.

From the above, we can identify key considerations that emerge from the caselaw, the legislative response and government reports as it relates to the interpretation of a voluntary request for MAID that is not the result of external pressures. As evidenced throughout this chapter, a universal concern has been the protection of vulnerable persons and the concern for the ‘slippery slope’ manifesting.³⁴³ These concerns can be addressed, in part, by requiring a request for MAID to be voluntary and not the result of external pressure. Voluntariness may consider coercion, undue pressure from individuals, and possible external pressures such as scarce financial or institutional resources. Coercion and undue influences are external pressures that individuals may experience from family, friends, authority figures or society at large. Influence will be “undue” “when it rises to the level of fraud, deceit, duress, or coercion”.³⁴⁴ Practitioners are able to assess whether a patient’s request for MAID is being affected by coercion or abuse, using existing skills and knowledge.

³⁴³ *Truchon*, *supra* note 18 at para 466; *Rodriguez SCC*, *supra* note 42 at 567.

³⁴⁴ First Report, *supra* note 22 at 69.

A discussion of the key considerations identified in this chapter, will be explored in chapter 5, along with the learnings from the following chapter which reviews how voluntariness has been considered by the courts and legislature since *Rodriguez SCC*, specific to the MAID context and within three other areas of law where voluntariness is germane.

Chapter 3

3 Understanding Voluntariness

A historical review of the criminalization of assisted suicide in Canada, which was followed by important jurisprudence and government reports that paved the way for the legalization of MAID, including its expansion, was reviewed in detail in Chapter 2. This included consideration of Bill C-14 and Bill C-7, legislation that amended the *Criminal Code*, creating an exception to the prohibition of assisted suicide, provided it is administered in accordance with the framework. Chapter 2 concluded by identifying considerations for interpreting what it means, within this framework, for an individual to make a voluntary request that is not the result of external pressure. This chapter serves to expand on these considerations by reviewing the MAID jurisprudence, legislation, practice guidelines, government reports and other areas of law.

The interpretation of the Voluntary Provision requires an exploration of the concern which the law seeks to remedy.³⁴⁵ As Professor Randal Graham helpfully states,

The exploration of legislative purpose does not involve an inquiry into the legislature’s views regarding the meaning or construction of specific words or phrases. On the contrary, a court that seeks to determine legislative purpose focuses its inquiry on the policies or problems that motivated a legislative body to enact a particular piece of legislation.³⁴⁶

To provide a robust understanding of voluntariness within the MAID context, I begin in the first part with consideration of how voluntariness has been addressed by the Courts, the legislature, and several government reports in response to *Carter SCC*, including the concerns in which the Voluntary Provision seeks to address. This will also entail a review of the Health Canada Model Practice Standard for MAID³⁴⁷ (the “**Model MAID Practice**

³⁴⁵ Cramm, *supra* note 28.

³⁴⁶ Graham, Randal. “Good Intentions” (2000) 12 SCLR 147 [Good Intentions].

³⁴⁷ Health Canada, *Model Practice Standard for Medical Assistance in Dying (MAID)* (Ottawa: Health Canada, 2023) [Model MAID Practice Standard].

Standard”). While the Model MAID Practice Standard explicitly contemplates the voluntariness of a request for MAID, it does not go far enough in framing the scope of the assessment of voluntariness. In this writer’s opinion the most informative source to interpret voluntariness arises from *Carter BCSC* and government reports on MAID.

To supplement this review, other areas of law that contemplate voluntariness are considered in part two. The term ‘voluntary’ has been well considered in law, and thus it is important to review how the term has evolved. Particular attention is paid to the confessions rule in the criminal law context, the principle of unconscionability in the law of contract, and informed consent, a foundational principle in health law. This part proceeds in three sections. The first is a review of the confessions rule, where voluntariness has perhaps been most considered.³⁴⁸ The confessions rule is relevant as it seeks to uncover the distinction between a voluntary and coercive statement, similar to the concerns brought forward in the MAID context. Next, we examine voluntariness as it relates to the doctrine of unconscionability in contract law, and specifically the concerns related to power imbalances and the potential influence of the stronger party compromising the other party’s free will. This will be followed in the third section is a more focused review of voluntariness as contemplated in health care and specifically within the concept of informed consent. The utility of this review is demonstrated by the confirmation that other areas of law have similar considerations when interpreting voluntariness and highlights the need for a case-by-case assessment of voluntariness, that cannot be presumed based on the identification of vulnerabilities. This chapter concludes by identifying how other areas of law have interpreted voluntariness and the application of these understandings to how best to interpret the requirement that a request for MAID be voluntary and not made as a result of external pressures. Following a discussion of the role of social workers in MAID in chapters 4 and 5, I will then rely upon these interpretations to consider how voluntariness can be understood and meaningfully assessed by social workers within the MAID context.

³⁴⁸ Lisa Dufraimont, “The Common Law Confessions Rule in the Charter Era: Current Law and Future Directions” (2008) 40 *Supreme Court Law Review* [Lisa Dufraimont].

3.1 Voluntariness as Contemplated in Medical Assistance in Dying

In Canada, MAID has now been legal for more than seven years and we have the benefit of both case law and government reports to help understand the interpretation of a voluntary request for MAID that is not the result of external pressures. This section of the chapter will provide a summary of how voluntariness is discussed in *Carter* and the subsequent drafting of the voluntary request provision in the *Criminal Code*. While voluntariness was considered by the SCC in *Rodriguez*, it did so narrowly. The SCC's analysis on voluntariness was related to McLachlin J.'s dissenting opinion that recommended a constitutional exemption be granted to Rodriguez and the requirement that the request for a physician assisted death be voluntary.³⁴⁹ Accordingly, the *Rodriguez* decision will not be considered further here. A review of MAID caselaw following *Carter* will be canvassed to determine how the Courts have considered voluntariness specific to the MAID regime. Cases that sought a constitutional exemption following the decision in *Carter SCC*, and prior to the passing of Bill C-14, are interpreting voluntariness as discussed in *Carter SCC* and not the *Criminal Code*. There have also been numerous government reports on MAID since *Carter* which helps to glean a greater understanding of how voluntariness has been applied in the context of MAID.

3.1.1 Voluntariness as Contemplated in *Carter*

In *Carter BCSC*, Justice Smith provides an excellent overview of the concerns related to ensuring a patient is not being coerced or unduly influenced into MAID and the importance of assessing the voluntariness of a MAID request.³⁵⁰ In *Carter SCC*, the Court affirmed Justice Smith's finding of fact as it related to the concerns with patient's being coerced or unduly influenced into accessing MAID and the assessment of voluntariness.³⁵¹ It is clear by reading the relevant portions of Justice Smith's decision that assessing voluntariness seeks to limit the potential effects of coercion and undue influence by acting as a

³⁴⁹ In *Rodriguez*, the British Columbia Supreme Court and Court of Appeal did not consider voluntariness.

³⁵⁰ *Carter BCSC*, *supra* note 6 at paras 799–815.

³⁵¹ *Carter SCC*, *supra* note 1 at para 7.

safeguard.³⁵² This safeguard attempts to balance the autonomy of individual's seeking MAID while protecting vulnerable persons from being coerced or pressured into accessing MAID.³⁵³ In *Carter BCSC*, Canada argued that for a request to be voluntary it must be free from coercion, pressure, undue inducement and psychological or emotional manipulations.³⁵⁴ It offered examples of external pressures to include illness (as it might impair one's perceptions of their circumstances), lack of information about options, concerns about burdening family or friends, physician influence and society's acceptance of physician assisted suicide.³⁵⁵

Several experts were called on behalf of the Plaintiffs and Defendants on the issue of how outside forces may influence a patient's desire for a hastened death. The experts in *Carter BCSC* opined influence or coercion can come from various sources, including family members, caregivers or a long-term abusive relationship.³⁵⁶ Coercion or influence may arise within the family unit as the patient seeks to avoid becoming a burden to their family. It may also arise for those without family or friends to give care to them, as they may feel that death is a reasonable option in the absence of available community resources.³⁵⁷

The decision in *Carter BCSC* highlights two areas of concern for physician influence and/or coercion of a patient. Dr. Gallagher, an expert called by the Defendant, opined that this sort of influence could come at an "unconscious level as a result of the dependency of patients on their doctor's knowledge and reliance on the doctor for clinical care".³⁵⁸ Further, Dr. Gallagher testified that "institutional culture and external factors can influence the options that are presented, and the way options are presented can influence the decision that is made".³⁵⁹ Dr. Rasmussen, a retired Oregon palliative care physician, a state that has a permissive regime for physician assisted death, was asked by the Plaintiffs to provide an

³⁵² *Ibid* at paras 799–814.

³⁵³ *Ibid* at paras 799–815.

³⁵⁴ *Ibid* para 1192.

³⁵⁵ *Ibid* at para 750.

³⁵⁶ *Ibid* at para 801.

³⁵⁷ *Ibid* at para 801.

³⁵⁸ *Ibid* at para 808.

³⁵⁹ *Ibid* at para 808.

opinion about some of the evidence tendered by the Defendants. Dr. Rasmussen describes the coercion issue arising from the physician-patient relationship in instances where the physician believes they know best and takes a paternalistic approach.³⁶⁰ Paternalism reflects the belief “the patient cannot be trusted to know his or her own mind, so the physician should do everything, even bully the patient, to get him or her to make the decision the physician believes is right”.³⁶¹ Whereas, to mitigate the coercive influence of the physician, the patient’s autonomy must prevail by the physician providing all options and to engage “the patient in a vigorous debate in which all options are explored and validated”.³⁶²

The concern highlighted above relates to the effect of paternalism and impact on a patient’s ability to voluntarily make health care decisions on their own behalf. Steps have been taken through the patient rights movement to address paternalism and the shift towards a patient-centered perspective to the delivery of health care, specifically the reinforcement of informed consent principles. Although this has not eliminated paternalism within health care, individual rights have progressed, and the resulting coercive influence of physicians has arguably been reduced. Although physician coercion was addressed in *Carter BCSC*, it was not seen as a significant issue that would be a hurdle to ensuring voluntariness.

The discussion of voluntariness in *Carter BCSC* suggests that although unconscious bias or influence may stem from a health care practitioner, the primary concern the Court had was how family members may influence a patient’s decision to request MAID. Ultimately, Justice Smith held that voluntariness can be accurately assessed by health care practitioners in such a way as to identify any coercion or undue influence and is primarily accomplished by way of a capacity assessment.³⁶³ Further, the Court held that evidence from both Oregon and the Netherlands, both permissive regimes, does not

³⁶⁰ *Ibid* at para 810.

³⁶¹ *Ibid* at para 810.

³⁶² *Ibid* at para 810.

³⁶³ *Ibid* at para 800.

support the conclusion that pressure or coercion is wide-spread or readily escapes detection.³⁶⁴ As Justice Smith observed:

...coercion and undue influence can be detected as part of a capacity assessment. To be accurate and reliable, clinicians who perform such assessments would have to be aware of the risks of coercion and undue influence, of the possibility of subtle influence, and of the risks of unconscious biases regarding the quality of the lives of persons with disabilities or persons of advanced age.³⁶⁵

In *Carter BCSC*, witnesses called by the AGC were concerned with how to assess ambivalence and ensure a patient has made an enduring and repeat request for assistance in dying.³⁶⁶ They suggested there was some evidence from Oregon that a large portion of individuals given lethal prescriptions for the purposes of physician assisted death do not follow through with ending their lives, suggestive of an inability to appropriately assess ambivalence.³⁶⁷ Witnesses called by the Plaintiffs disagreed that the evidence from Oregon supported that conclusion and that ambivalence, like coercion and undue influence, can be accurately assessed by physicians.³⁶⁸ Ultimately, the *BCSC* sided with the Plaintiffs, holding health care providers can assess ambivalence, similar to how they assess competence and voluntariness in the context of other end-of-life decision making.³⁶⁹

In summary, *Carter BCSC*, which was affirmed by the SCC, provides a meaningful review of voluntariness and the potential sources of coercion and undue influence. The lower court decision paid particular attention to the influence or coercive power of family, friends, physicians and societal acceptance of MAID, but did not consider the potential socio-economic pressures that may vitiate voluntariness. Concerns about ambivalence, while relevant, were not founded based on the evidence produced from permissive regimes and were deemed, at a minimum, to be able to be accurately assessed during a capacity assessment. *Carter BCSC* also highlighted that voluntariness is not a new concept within

³⁶⁴ *Ibid* at para 671.

³⁶⁵ *Ibid* at para 815.

³⁶⁶ *Ibid* at para 832.

³⁶⁷ *Ibid* at paras 832.

³⁶⁸ *Ibid* at paras 837, 843.

³⁶⁹ *Ibid* at para 1240.

health care decision making, reinforcing the idea that physicians are capable, with existing assessment tools, to appropriately assess the voluntariness of a patient's request for MAID. As will be discussed later in this chapter, the expert reports written after *Carter SCC*, demonstrate an evolution in how voluntariness is discussed in the context of MAID, and it is expected this will continue to evolve as MAID continues to expand.

3.1.2 *Criminal Code*

Following the *Carter* decision, Parliament was tasked with creating a legislative framework for MAID in Canada. In creating the framework, it included a specific provision to reinforce the importance of the legal obligation that any request for MAID is made voluntarily and not made as a result of external pressures. Specifically, the *Criminal Code* states:

Eligibility for medical assistance in dying

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:

...

(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure.³⁷⁰

When drafting section 241.2(1)(d) of the *Criminal Code*, Parliament went a step further than just requiring voluntariness as it requires the request to be voluntary and not made as a result of external pressure.

The modern approach to statutory interpretation supports the view that Parliament's intention is the relevant guide to the interpretation of statutes.³⁷¹ Parliament's intention can be, in part, understood by looking at *Carter BCSC* as it is argued that the language of Bill C-14 indicates that a part of the Bill's purpose is to "adopt or mirror the views expressed

³⁷⁰ *Criminal Code*, *supra* note 3 at ss 241.2(1)(d), 241.2(1)(e).

³⁷¹ *Driedger*, *supra* note 27; *Sullivan*, *supra* note 27 at 131; *Cramm*, *supra* note 28.

by the court in [Carter]’”.³⁷² In *Carter BCSC* the Court explains the intention behind ensuring a request for MAID is voluntary is to limit the potential effects of coercion and undue influence on a patient’s decision as to whether or not they seek MAID.³⁷³ *Carter BCSC* is helpful in understanding the purpose of the Voluntary Provision and can be further understood by reviewing the Hansard debates related to Bill C-14.

A review of the Hansard debates related to Bill C-14 clearly demonstrates concerns for persons with social vulnerabilities arising from poverty and access to health care services and provides insight into the drafting of the Voluntary Provision. At second reading, Wayne Stetski, NDP Parliamentarian and supporter of Bill C-14, recommended five areas of substantive amendments, as proposed by the Canadian Association for Community Living. This included that Bill C-14 is amended to specify that a voluntary request for MAID cannot be made “as a result of external pressure or any form of inducement”.³⁷⁴ The purpose of the amendment to the Voluntary Provision was to “look deeper into the situation, rather than just looking at the request” and to look at the context to determine the reason for the request, for example, whether there was an absence of proper palliative care.³⁷⁵ This proposed amendment was further considered at the Standing Committee of Justice and Human Rights, where Ted Falik recommended an amendment to the Voluntary Provision as follows:

a result of external pressure or lack of access to services required to address the underlying cause of the request, such as palliative care, chronic pain care, and geriatric care³⁷⁶

³⁷² Graham Memo, *supra* note 41. Examples of overlapping language include: (1) repeated references to “grievous and irremediable medical conditions” see paragraph 4, 14, 40, 66, 68, (2) “intolerable suffering” or “suffering intolerably” (16 occurrences in the judgment), the reference to protecting vulnerable persons from committing suicide “in moments of weakness” (paragraph 86).

³⁷³ *Carter BCSC*, *supra* note 6 at paras 799-814.

³⁷⁴ *House of Commons Debates*, 1-148, No. 046 (May 2, 2016) at 55.

³⁷⁵ *Ibid.*

³⁷⁶ Canada, Parliament, Senate, Standing Committee on Justice and Human Rights, *Minutes of Proceedings*, 42nd Parl, 1st Sess, No. 015 (May 9, 2016) at 18.

The suggestion was that if the Practitioner did not consider access to palliative care, a request for MAID could not be voluntary.³⁷⁷ In response, Colin Fraser, Liberal Parliamentarian, opposed the amendment on the basis the term “voluntary” was already included in the provision and unnecessary to amend the provision. Rather, Mr. Fraser reflected the decision as to whether a person’s request for MAID is voluntary should be assessed by the Practitioner, having regard to the other services that may help alleviate the persons suffering, such as palliative and/or chronic pain care and other relevant consultations.³⁷⁸ The Voluntary Provision was not amended and has remained the same since the drafting of Bill C-14.

There was a request for there to be a prior review process of non-medical social vulnerabilities for every patient, which was supported by “every single large organization within the persons with disabilities community.”³⁷⁹ Those who opposed the prior review argued it would create barriers to accessing assisted suicide, particularly in remote communities.³⁸⁰ This was ultimately defeated but the concerns with prior review process continue to be a contentious issue and recently raised, but not determined, in *WV v MV*, 2024.³⁸¹

While *Carter BCSC* indicates the requirement of voluntariness is intended to ensure a person is not coerced or unduly pressured into MAID, the debates around Bill C-14 provide a deeper understanding of the potential sources that may contribute to coercion or undue influence including socio-economic factors. Specifically, the various debates regarding Bill C-14 in the House of Commons and Senate, clearly identify concerns with the possibility of social determinants of health placing people in vulnerable situations, resulting in individuals requesting MAID for non-medical reasons.³⁸² It was argued

³⁷⁷ *Ibid.*

³⁷⁸ *Ibid.*

³⁷⁹ *House of Commons Debates*, 1-148, No. 039 (April 4, 2016) (Rachel Harder) at 48.

³⁸⁰ *House of Commons Debates*, 1-148, No. 045 (April 22, 2016) at 33.

³⁸¹ *WV*, *supra* note 26. This issue has also been raised in some of the Expert Reports.

³⁸² *Debates of Senate*, 42nd Parl, 1st Sess, Vol 150, No 46 (9 June 2016) at 977; *Debates of Senate*, 42nd Parl, 1st Sess, Vol 150, No. 49 (14 June 2016) at 1087-1088.

suffering may be increased for vulnerable persons where social determinants of health are impacted and further safeguards are necessary to ensure they are protected.³⁸³ This requires Practitioners to recognize the importance of the social determinants of health and the potential influence they may have on the request for MAID. The purpose, in part, of the Voluntary Provision is to identify how social determinants of health and other social conditions may influence or motivate a person to request MAID, and whether this vitiates voluntariness.

This provision does not require an absence of external pressure, rather it requires that a request for MAID not be the result *of* external pressures. This is an important part of the drafting in that it is arguable most individuals face some form of external pressure in their life, but the existence of those external pressures does not mean a request for MAID is involuntary. This writer will consider the role of the social worker in assisting with the assessment of voluntariness in chapter four.

3.1.3 Post-Carter Case Law

The case law since the decriminalization of assisted dying provides limited analysis on the requirement that a request for MAID be voluntary and not the result of external pressure. At the time of writing this paper, there were 19 individual cases, resulting in 32 court decisions, cited as having considered the eligibility provisions for MAID in the *Criminal Code*. Of the 19 cases that considered the MAID eligibility criteria, 14 came from Quebec, two from Ontario, and one from British Columbia, Alberta, and Nova Scotia. Of these cases, 12 sought authorizations for the provision of MAID for persons whose natural death was not reasonably foreseeable during the suspension of invalidity following *Truchon*.³⁸⁴

³⁸³ *Debates of Senate*, 42nd Parl, 1st Sess, Vol 150, No 46 (9 June 2016) at 977; *Debates of Senate*, 42nd Parl, 1st Sess, Vol 150, No 46 (9 June 2016) at 977 at 28.

³⁸⁴ *Payette v. Attorney General of Canada*, 2020 QCCS 1604, [2020] J.Q. no 3198 [Payette]; *Quenneville v. Attorney General of Canada*, 2020 QCCS 3397 [Quenneville]; *Labbé v. Attorney General of Canada*, 2020 QCCS 4314, [2020] J.Q. no 12374 [Labbé]; *Sinclair et Procureur général du Canada*, 2020 QCCS 3196, [2020] J.Q. no 7328 [Sinclair]; *Jacob c. Procureur général du Canada (Ministère de la Justice)*, 2021 QCCS 1086, [2021] J.Q. no 2708 [Jacob]; *C.V. et Trudel*, 2020 QCCS 1717, [2020] J.Q. no 3420 [CV]; *Hénaire c. Procureur général du Canada*, 2020 QCCS 4018, [2020] J.Q. no 11200 [Henaire]; *Delorme c. Procureur général du Canada*, 2020 QCCS 3935, [2020] J.Q. no 11120 [Delorme]; *Lessard et Procureur général du Canada*, 2020 QCCS 3189, [2020] J.Q. no 7329 [Lessard]; *Ménard c. Procureur*

In the cases that considered voluntariness, the following factors emerged: the duration of contemplation³⁸⁵, whether the patient was fully informed³⁸⁶, the repeat nature of the request³⁸⁷, influence or pressure of friends and family³⁸⁸, undue influence or coercion (including undue influence or coercion from family to discourage a patient to pursue MAID)³⁸⁹, whether there were any signs of ambivalence³⁹⁰ and the potential impact of depression or suicidal ideation on the request.³⁹¹ None of the decisions go into depth on how the Court assessed these various factors, and not every factor was considered in each case. These factors can be broadly categorized as being concerned with coercion, undue influence and ambivalence, similar factors that emerged from the review of how voluntariness has been considered in other areas of law and *Carter BCSC*.

3.1.4 Health Canada Model MAID Practice Standards

In 2023, Health Canada released the Model MAID Practice Standard³⁹² for the use by health care regulatory bodies, public authorities, and health professional organizations in drafting provincially based Practice Standards for MAID. The intention is to support a consistent approach to MAID across Canada and assist regulatory bodies in creating clear and consistent guidance on the assessment and provision of MAID. With respect to voluntariness, the Model MAID Practice Standard states:

C. Voluntariness

9.8 To find a person eligible for MAID, assessors and providers must be satisfied that the person's decision to request MAID has been made freely, without undue influence (contemporaneous or past) from family members, health care providers, or others.

général du Canada, 2020 QCCS 4460, [2020] J.Q. no 12649 [*Menard*]; *Laplante et Procureur général du Canada*, 2020 QCCS 4307, [2020] J.Q. no 12107 [*Laplante*].

³⁸⁵ *Sorenson*, *supra* note 310 at para 20.

³⁸⁶ *Payette*, *supra* note 384 at para 29.

³⁸⁷ *Menard*, *supra* note 384 at para 30.

³⁸⁸ *CV*, *supra* note 384 at para 17; *Sinclair*, *supra* note 384 at para 38.

³⁸⁹ *Sorenson*, *supra* note 310, at para 20; *Payette*, *supra* note 384, at para 29; *B. (A.) v. Canada (Attorney General)*, 2016 ONSC 1912, 129 O.R. (3d) 749 at para 50 [*BA*].

³⁹⁰ *Trudeau c. Procureur général du Canada*, 2020 QCCS 1863, [2020] J.Q. no 3786 at para 466 [*Trudeau*]; *BA*, *supra* note 369 at para 50.

³⁹¹ *Henaire*, *supra* note 384 at para 36; *CV*, *supra* note 384 at para 17; *Sinclair*, *supra* note 384 at para 38.

³⁹² Model MAID Practice Standard, *supra* note 347.

9.9 Assessors and providers must be familiar with and adhere to any [provincial/territorial] requirements relating to MAID for persons who are involuntarily hospitalized or under a Community Treatment Order. Similarly, they must be familiar with and adhere to any [provincial/territorial] or federal requirements re: MAID for persons who are being held under a Not Criminally Responsible order or are incarcerated.³⁹³

There is no guidance provided on how to assess voluntariness or what is meant that a request be made freely “without undue influence (contemporaneous or past) from family members, health care providers, or others”.³⁹⁴ Of significance, the Model MAID Practice Standards seem to be narrowly interpreting the requirement for voluntariness as it relates to the influence of others. As a result, the current framing of voluntariness in the Model MAID Practice Standard arguably does not go far enough to consider the potential of external factors such as social determinants of health that may motivate or influence a person’s request for MAID. The Model MAID Practice Standard is still new, and more time is necessary to determine how the medical community views and incorporates these standards into provincial guidance documents.

3.1.5 Government Reports on MAID

Since *Carter SCC*, there have been several parliamentary committees struck and requests by Parliament to engage the Council of Canadian Academies to assess and study a Canadian approach to MAID. This has included options for a legislative response to the *Carter SCC* decision and issue-specific reports that address controversial topics such as the expansion of MAID to permit advanced requests, access for mature minors MD-SUMC (collectively referred to as “**Expert Reports**”).³⁹⁵ These Expert Reports provide context to

³⁹³ *Ibid* at 12.

³⁹⁴ *Ibid*.

³⁹⁵ First Report, *supra* note 22; Canada, Parliament, Report of the Special Joint Committee on Physician Assisted Dying, *Medical Assistance in Dying: A Patient Centered-Approach* (2016); Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, *The State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018); Council of Canadian Academies, The Expert Panel Working Group on MAID for Mature Minors, *The State of Knowledge on Medical Assistance in Dying for Mature Minors* (2018); Council of Canadian Academies, The Expert Panel Working Group Where a Mental Disorder is the Sole Underlying Medical Condition, *The State of Knowledge on MAID Where a Mental Disorder is the Sole Underlying Medical Condition* (2018); Health Canada, *Final Report of the Expert Panel on MAID and Mental Illness* (Ottawa: Health Canada, 2022); Canada, Parliament,

the issues that have emerged related to creating a legislative framework for MAID in Canada and, further, highlight the ongoing importance of balancing interests and rights in the expansion of MAID. Specifically, among other things, the Expert Reports help to understand the interpretation of the MAID legislative provisions including the intent behind the Voluntary Provision. Each of the Expert Reports consider the meaning of a voluntary request and considers some of the concerns related to ensuring a request for MAID is voluntary. Following the first Expert Report in 2015, there has been an evolution in how voluntariness has been addressed in the Expert Reports and, specifically, the meaning of “external pressures”.

The following reviews how each of the Expert Reports considers voluntariness and how this understanding has evolved since the first report completed in 2015.³⁹⁶ As a detailed review of the Expert Reports is beyond the scope of this paper, the focus here is on discussions related to voluntariness.

3.1.5.1 Consultations on Physician-Assisted Dying: Summary of Results and Key Findings, Final Report, 2015

The first report requested post-*Carter* was by the Federal Ministers of Justice and Health and resulted in the *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings, Final Report*, published in 2015 (the “**First Report**”).³⁹⁷ The Panel’s mandate “was to hold discussions with the interveners in *Carter* and with relevant medical authorities, and to conduct an online consultation open to all Canadians and other stakeholders”.³⁹⁸ The First Report was used to inform the drafting of Bill C-14 and highlighted the fundamental need to develop an approach that balances personal autonomy with the protection of vulnerable people.³⁹⁹

Report of the Special Joint Committee on Medical Assistance in Dying, *Medical Assistance in Dying in Canada: Choices for Canadians* (2023).

³⁹⁶ First Report, *supra* note 22.

³⁹⁷ *Ibid.*

³⁹⁸ *Ibid* at 9.

³⁹⁹ *House of Commons Debates (Hansard)*, 1-148, No. 039 (April 4, 2016) (Rachel Harder).

With respect to voluntariness, the First Report was concerned with ensuring a person's request for MAID was evaluated for possible coercion, undue influence and ambivalence.⁴⁰⁰ Coercion and undue influence are external pressures that individuals may experience from family, friends, authority figures—potentially including health care providers—or society at large.⁴⁰¹ Influence will be seen as “undue” when it rises to the level of fraud, deceit, duress or coercion.⁴⁰² Ambivalence reflects the individual's own potentially conflicting thoughts on whether to proceed with MAID.⁴⁰³ The Canadian Medical Association (CMA) supported this understanding of voluntariness and expressed concerns with ensuring people were freely making a voluntary request for MAID and were not unduly influenced or coerced.⁴⁰⁴ The CMA went further to ensure there is “a clear and settled intention to end [one's] own life after due consideration” and that the request(s) come from an individual themselves “thoughtfully and repeatedly, in a free and informed manner”.⁴⁰⁵ The assessment of voluntariness requires a contextual assessment to examine the unique factors in each case.⁴⁰⁶

Professor Wayne Sumner, an expert called to testify during the Panel's hearings, suggested that a person's request for MAID should be deemed to be voluntary unless there is some reason to think it is not, which would then require further inquiry into the patient's motivations and decision-making process.⁴⁰⁷ This presumption is an interesting concept that will be considered in further detail in Chapter 5 but it is noteworthy to point out that there are certain presumptions at law relevant here, including the presumption an adult patient has capacity to consent to health care decisions.

The remaining issue addressed by the First Report in relation to voluntariness includes how a MAID assessor is to assess the voluntariness of a request. The First Report highlights the need for a framework or clear roles and responsibilities to ensure that persons who request

⁴⁰⁰ *Ibid.*

⁴⁰¹ *Ibid.*

⁴⁰² *Ibid.*

⁴⁰³ *Ibid.*

⁴⁰⁴ *Ibid.*

⁴⁰⁵ *Ibid.*

⁴⁰⁶ *Ibid* at 70.

⁴⁰⁷ *Ibid* at 69.

MAID do so voluntarily.⁴⁰⁸ Suggestions to accomplish this included requiring two physicians to assess and attest that the request was made voluntarily without coercion, the involvement of a multi-disciplinary team in voluntariness assessments to ensure no sources of coercion, and exploration of voluntariness and possible undue influence or “suspicious circumstances” during a capacity assessment.⁴⁰⁹ Both proponents and opponents of MAID raised concerns with the assessment of voluntariness and whether it is possible to ever be entirely sure whether coercion is present. The majority of the concerns were raised in specific contexts, in particular, where mental illness is present, situations with language or cultural barriers, and where “other social vulnerabilities and oppression exist.”⁴¹⁰ The First Report does not identify what is meant by social vulnerabilities, but this idea is explored further in subsequent Expert Reports.

The First Report was mainly focused on ensuring a person’s request for MAID is not unduly influenced or coerced by others, and to ensure consistent and repeat messaging from the patient related to their MAID request (this addresses ambivalence). The First Report also canvassed the role of multi-disciplinary teams in the assessment of voluntariness and the contextual nature of these assessments. It recommends that responsibilities and procedures are developed to ensure voluntariness has been considered and reiterated the contextual nature of these assessments.

3.1.5.2 Medical Assistance in Dying: A Patient-Centered Approach, Report of the Special Joint Committee on Physician-Assisted Dying, 2016

Following the release of the First Report, motions were passed in the House of Commons and the Senate to establish a special joint committee whose purpose was to “review the [First Report] and other relevant consultation activities and studies, to consult with Canadian experts and stakeholders, and make recommendations on the framework of a federal response on physician-assisted dying that respects the *Constitution*, the *Charter of*

⁴⁰⁸ First Report, *supra* note 22 at 69–70.

⁴⁰⁹ *Ibid* at 70–71.

⁴¹⁰ *Ibid* at 70.

Rights and Freedoms, and the priorities of Canadians” (the “**Second Report**”).⁴¹¹ In addition, the motions also stated that “the Committee be directed 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”.⁴¹² The Second Report expanded the scope of how voluntariness and external pressures are discussed, who could be vulnerable, and safeguards that may be utilized to ensure a request for MAID is voluntary.

The Second Report expanded the discussion of voluntariness and the nature of the potential external pressures that may vitiate the voluntariness of a request for MAID. It raised concerns about the vulnerabilities associated with those living in poverty and/or with mental health concerns and how these vulnerabilities may be seen as external pressures impacting a request for MAID.⁴¹³ Interestingly, a disability advocate that testified before the special committee recognized the concern with socio-economic vulnerabilities may be increased for persons living with disabilities but at the same time she highlighted the concern with further limiting or restricting the choices and autonomy of those with disabilities based on presumed vulnerabilities.⁴¹⁴ In other words, the disability advocate’s concern was with *presuming* vulnerabilities and, in turn, the potential presumption of assessors that a request for MAID from an individual with a disability is the result of external pressure and not a voluntary request. That is to say, they were concerned with presuming someone with a disability is at a greater risk of being unduly influenced or coerced by external pressures simply by reason of being identified as someone with a disability. This concern led to a new framing of the vulnerabilities and a focus on “who” may be impacted by external pressures.

The new attention paid to “who” may be impacted by external pressures sought to consider that vulnerability was not simply a characteristic of an individual or group, “but rather a

⁴¹¹ Canada, Parliament, Report of the Special Joint Committee on Physician Assisted Dying, *Medical Assistance in Dying: A Patient Centered-Approach* (2016) at 2 [Second Report].

⁴¹² *Ibid.*

⁴¹³ *Ibid* at 28.

⁴¹⁴ *Ibid.*

state that any one of us could be in under certain circumstances.”⁴¹⁵ The committee heard testimony that people can be made vulnerable in particular contexts and “situations when personal autonomy, status, wealth, and well-being are compromised in any significant way.”⁴¹⁶ These ideas can be categorized as social, economic and other environmental factors that increase the vulnerability of persons. That is to say, in the context of MAID all persons are potentially vulnerable and an individual assessment is required.⁴¹⁷ Further, it cannot be assumed that a vulnerable person is automatically ineligible but that those nuances must be considered, and an assessor must put their minds to the potential impact of the vulnerability on the voluntary nature of the request for MAID.⁴¹⁸ This work requires a balance to protect vulnerable persons while respecting autonomy⁴¹⁹ – this was a large portion of the discussion in *Carter BCSC*, which concluded this balancing can be done well and effectively with a robust regulatory scheme with adequate safeguards.⁴²⁰

The committee concluded safeguards and oversight measures would ensure that “individuals who do not really want to die are identified, that the vulnerable are protected and that individuals who satisfy the criteria and with a genuine and enduring desire to die are provided with MAID to end their suffering.”⁴²¹ The committee endorsed recommendations to provide more supports and services to reduce the vulnerabilities of those seeking MAID and further that oversight and safeguards are the best way to ensure informed consent and voluntariness while not being too restrictive and refusing access to those who qualify.⁴²²

The Second Report expands the concerns related to voluntariness from possible coercion or undue influence from others to the potential impact of socio-economic factors on voluntariness. The authors of the Second Report concluded that these concerns could be appropriately addressed with safeguards and oversight measures. Confidence in this

⁴¹⁵ *Ibid* at 15–16.

⁴¹⁶ *Ibid*.

⁴¹⁷ *Ibid*.

⁴¹⁸ *Ibid*.

⁴¹⁹ *Ibid* at 17.

⁴²⁰ *Carter BCSC*, *supra* note 6 at paras 800-815; *Carter SCC*, *supra* note 1 at para 3.

⁴²¹ Second Report, *supra* note 411 at 18.

⁴²² *Ibid* at 17.

approach was expressed because of the conclusions made in *Carter BCSC*, specifically how physicians are already trained to assess voluntariness.⁴²³ Concerns related to presuming vulnerabilities were raised and how generalizations should not occur based on one's vulnerabilities as this could lead to certain patients being deemed illegible simply based on presumptions and not evidence.

3.1.5.3 The State of Knowledge on Medical Assistance in Dying for Mature Minors, Advance Requests and Where Mental Disorder is the Sole Underlying Medical Condition, 2018⁴²⁴

Following the passing of Bill C-14, the debate about the MAID regime continued and specifically three topic areas were identified as requiring further research and consideration, including: permitting access to MAID to mature minors; the ability to give advance consent through an advance request (i.e., personal directive or health care directive); and access to MAID for individuals with MD-SUMC. Bill C-14 included a provision that required the Ministers of Justice and Health, no later than 180 days after the day on which Bill C-14 received royal assent, to initiate one or more independent reviews of issues relating to the three topic areas.⁴²⁵ The Council of Canadian Academies (the "CCA"), at the request of the Ministers of Health and Justice and AGC, assembled the Expert Panel on Medical Assistance in Dying to undertake an evidence-based assessment of the state of knowledge surrounding these three topics.

Three comprehensive reports were prepared that canvassed the unique issues in relation to each of the topic areas and were summarized in a summary report.⁴²⁶ The objective of the

⁴²³ *Carter BCSC supra* note 6 at para 1240.

⁴²⁴ Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, *The State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018); Council of Canadian Academies, The Expert Panel Working Group on MAID for Mature Minors, *The State of Knowledge on Medical Assistance in Dying for Mature Minors* (2018) [Third Report]; Council of Canadian Academies, The Expert Panel Working Group Where a Mental Disorder is the Sole Underlying Medical Condition, *The State of Knowledge on MAID Where a Mental Disorder is the Sole Underlying Medical Condition* (2018).

⁴²⁵ Bill C-14, *supra* note 2 at cl 9.1.

⁴²⁶ Council of Canadian Academies, The Expert Panel Working Group on MAID, *The State of Knowledge on Medical Assistance in Dying for Mature Minors*, *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, and *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition: A Summary of Reports* (2018) [Summary of Reports].

reviews, “[...] was to gather and assess information and evidence relevant to the three topic areas in order to inform a national dialogue among the Canadian public, and between the public and decision makers.”⁴²⁷ The CCA assembled a multi-disciplinary panel of 43 experts from Canada and abroad and divided the experts into three working groups. The issues related to voluntariness are similar for mature minors and advance requests, while MD-SUMC presents a unique circumstance whereby voluntariness may be increasingly concerned with situational vulnerability, which refers to vulnerability that is “context specific”.⁴²⁸ For example, geographic isolation and financial constraints may limit access to health care services and render individuals vulnerable.⁴²⁹ Importantly, vulnerability includes two aspects: protection from exploitation and protection from exclusion.⁴³⁰

3.1.5.3.1 Mature Minors

The State of Knowledge on Medical Assistance in Dying for Mature Minors (the “**Third Report**”) determined that for a patient to make a voluntary choice it needs to be free from duress or coercion.⁴³¹ In the committee’s view, the requirement for voluntariness is closely tied to life experiences and social environments and, due to minors’ limited life experiences, this may impact their ability to make autonomous decisions.⁴³² Other concerns were raised about minors being particularly vulnerable to pressure, duress and manipulation from authority figures such as parents or health care teams. As a result of the minor’s limited life experience and the increased risk of minors being impressionable, some witnesses suggested it is questionable whether a minor has sufficient freedom to make voluntary decisions.⁴³³ On the contrary, concerns were also raised with trying to protect mature minors from what is perceived as a vulnerable situation and creating a new vulnerability by not respecting their wishes or decisions. In addition, the idea that mature

⁴²⁷ *Ibid* at 1.

⁴²⁸ Council of Canadian Academies, *The Expert Panel Working Group on Advance Requests for MAID, The State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018) at 55 [Fourth Report].

⁴²⁹ *Ibid* at 55.

⁴³⁰ Summary of Reports, *supra* note 426 at 5.

⁴³¹ Third Report, *supra* note 424 at 45.

⁴³² *Ibid* at 47.

⁴³³ *Ibid* at 70.

minors may be influenced by their family does not necessarily mean their decisions are not voluntary as, in comparison, many adults consult with family members before making significant health care decisions and this does not necessarily negate the voluntariness.⁴³⁴

3.1.5.3.2 Advance Requests

In *The State of Knowledge on Advance Requests for Medical Assistance in Dying* (the “**Fourth Report**”) the Expert Panel identifies a consideration arising in the provisioning of MAID based on the authority of an advanced request – for example, the contemplation of MAID in an advance directive, health care directive or personal directive.⁴³⁵ In particular, concern was raised that the provisioner is not privy to the conversation when the advance request was created and it becomes difficult, if not impossible, to ascertain whether the request for MAID was, in fact, voluntary.⁴³⁶ Based on the Belgium experience, it was highlighted that most physicians feel the need to personally communicate with the patient to assess the nature of their suffering and the voluntariness of their request.⁴³⁷ Ultimately, based on the eligibility criteria for MAID, it would seem difficult to ascertain whether the person was informed of their current situation when they wrote their advance request, particularly if they completed the advance request without assistance from a health care provider, witness or before any diagnosis was made.⁴³⁸ Currently, the *Criminal Code* does not allow for an advance directive to contemplate MAID, but the discussion is helpful in understanding how voluntariness is to be established – by way of discussion with the patient.

3.1.5.3.3 Mental Disorder as the Sole Underlying Medical Condition

A significant portion of the discussion in *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition* (the “**Fifth**

⁴³⁴ *Ibid* at 70, 147.

⁴³⁵ The term used to identify the legal document outlining a person’s health care wishes once they lack capacity differs based on province.

⁴³⁶ Fourth Report, *supra* note 428 at 55.

⁴³⁷ *Ibid* at 123.

⁴³⁸ *Ibid* at 171

Report”) surrounds concerns of the potential increased vulnerability of the population living with mental disorders.⁴³⁹ Concerns related to vulnerability largely relate to voluntariness and ensuring MAID requests are autonomous.⁴⁴⁰ There is often overlap in the discussion of voluntariness with the concept of autonomous decision making. A person is acting autonomously when they have the “capacity for self-determination and the ability to make decisions according to their own values and beliefs, free from coercion and outside interference”.⁴⁴¹

The impact of, and potential vulnerability to, social factors may affect this population differently. The presence of mental disorders is strongly correlated with social, economic, and environmental inequalities.⁴⁴² The relationship between social factors and mental disorders was identified as bi-directional, meaning, social factors may increase an individual’s risk factor of developing a mental illness, and at the same time, mental illness may increase a person’s exposure or vulnerability to social factors that are detrimental to their mental health.⁴⁴³ This can be demonstrated by higher rates of homelessness and incarceration, inequity in access to educational and employment opportunities, limited social supports to aid in recovery and an increased risk for chronic physical health conditions such as diabetes, heart disease, stroke and respiratory disease.⁴⁴⁴ Concerns were raised that this population may seek MAID as a means to escape chronically difficult circumstances such as homelessness, poverty and unemployment.⁴⁴⁵ The expert panel reviewed evidence from the Netherlands, as it is a permissive regime, and found some evidence that individuals requesting MAID on the basis of a psychiatric condition, cite socio-economic factors, as contributing to their suffering.⁴⁴⁶ These factors could include poverty, poor access to health care and community supports, housing and income stability,

⁴³⁹ For the purposes of this paper, this writer uses this term to capture all mental illnesses.

⁴⁴⁰ Council of Canadian Academies, The Expert Panel Working Group Where a Mental Disorder is the Sole Underlying Medical Condition, *The State of Knowledge on MAID Where a Mental Disorder is the Sole Underlying Medical Condition* (2018) at 160 [Fifth Report].

⁴⁴¹ Fourth Report, *supra* note 428 at 97.

⁴⁴² *Ibid* at 44.

⁴⁴³ *Ibid* at 45.

⁴⁴⁴ *Ibid*.

⁴⁴⁵ *Ibid*.

⁴⁴⁶ *Ibid* at 49.

among other things. In some cases, these factors could be seen as external pressures motivating the request for MAID and, thus, to ensure voluntariness of a request would require further exploration by an assessor to determine the degree of influence these factors have on the request for MAID.

In summary, although there are unique considerations for each of these populations related to voluntariness, a general theme reflects the importance of considering whether an individual's decision is being influenced by others or by coercive factors such as socio-economic pressures. This includes considering protection from exploitation and protection from exclusion. This will be addressed further in Chapter 5. If MAID expands to include these populations, there are unique considerations that will arise when addressing voluntariness; however, these considerations cannot be presumed and require a case-by-case assessment. For example, if the patient is requesting MAID on the basis of MD-SUMC, and the patient is experiencing socio-economic pressures, consideration might be given to how those factors may be influencing their motivations and, if they are, whether their suffering arises from their medical condition or from their socio-economic status.

3.1.5.4 Final Report of the Expert Panel on MAID and Mental Illness, 2022

As identified above, the MD-SUMC population has unique characteristics that may expose them to greater socio-economic inequality and poses unique challenges for assessors in the MAID context. The *Final Report of the Expert Panel on MAID and Mental Illness* (the “**Sixth Report**”) identifies structural vulnerability as a particular concern and refers to the “impacts of the interaction of demographic attributes (i.e., sex, gender, socioeconomic status, race/ethnicity), with assumed or attributed statuses related to one’s position in prevailing social, cultural, and political hierarchies”.⁴⁴⁷ These circumstances can influence suffering and contribute to viewing death as the only option.⁴⁴⁸ While this population is at heightened risk of experiencing structural vulnerability, this vulnerability should not be

⁴⁴⁷ Health Canada, *Final Report of the Expert Panel on MAID and Mental Illness* (Ottawa: Health Canada, 2022) at 11 [Sixth Report].

⁴⁴⁸ *Ibid* at 11.

used to generally exclude this population from MAID.⁴⁴⁹ Rather, assessors need to consider the impact of the structural vulnerability on the person’s request for MAID by addressing these vulnerabilities, offering means available to relieve the suffering and make all reasonable efforts to ensure the patient has access to these means.⁴⁵⁰ The expert panel offered a recommendation in this regard as follows:

Recommendation 6: Means Available to Relieve Suffering

To ensure all requesters have access to the fullest possible range of social supports which could potentially contribute to reducing suffering, we recommend that ‘community services’ in Track 2 Safeguard 241.2(3.1)(g) should be interpreted as including housing and income supports as means available to relieve suffering and should be offered to MAID requesters where appropriate.⁴⁵¹

Of considerable significance is the expert panel’s recommendation that the interpretation of “community services” within the safeguards of the *Criminal Code* extends to include housing and income supports.⁴⁵² Practically, this may result in significant additional work in determining what supports are available, especially in a situation where the assessor is a sole Practitioner without the support of allied health professionals. Further, it is possible these supports are difficult to access and, even if the patient is eligible for services or supports, there is likely to be a delay in the commencement of the supports. The necessary knowledge required to identify appropriate community supports, and the subsequent facilitation of referrals, is a skill that allied health care providers maintain, such as social workers.⁴⁵³ This will be further explored in Chapter four.

The Sixth Report highlights the possibility of situations of involuntariness, including involuntary detainment in both the civil and criminal context and internal pressure through

⁴⁴⁹ *Ibid* at 62.

⁴⁵⁰ *Ibid*.

⁴⁵¹ *Ibid* at 61.

⁴⁵² *Ibid*.

⁴⁵³ Model MAID Practice Standard, *supra* note 347 at s. 10.3.5.3; Canadian Association of Social Workers Federation, *Scope of Practice Statement* (2020) at 1-2 [Scope of Practice]; Miller PJ et al., “Social work Assessment at End of Life: Practice guidelines for suicide and the terminally ill” (1998) 26(4) *Soc Work Health Care* 23 at 32-33 [Miller PJ]; Alberta College of Social Workers, *Standards of Practice* (March 2023) at B.2(b)(ii) [Standards of Practice].

symptoms of their condition such as delusions.⁴⁵⁴ Given the concerns that these situations may vitiate a voluntary request, the expert panel made the following recommendation:

Recommendation 9: Situations of Involuntariness

Persons in situations of involuntariness for periods shorter than six months should be assessed following this period to minimize the potential contribution of the involuntariness on the request for MAiD. For those who are repeatedly or continuously in situations of involuntariness, (e.g., six months or longer, or repeated periods of less than six months), the institutions responsible for the person should ensure that assessments for MAiD are performed by assessors who do not work within or are associated with the institution.⁴⁵⁵

This report raises similar concerns identified in the Fifth Report related to the impact of structural vulnerabilities such as those arising from socio-economic disadvantage. This Sixth Report goes a step further in how to address those vulnerabilities by including an expansion of the interpretation of “community services” to include housing and income supports.⁴⁵⁶ In addition, the Sixth Report provides useful guidance on how to address situations of involuntary detention in both the civil and criminal context. This is especially helpful for health care providers who are tasked with assessing an incarcerated patient for MAiD and the impact of the incarceration on the voluntariness of the request.⁴⁵⁷ This report leaves questions unanswered about the extent to which an assessor is required to explore the structural vulnerabilities and the potential remedies that may relieve some of the patient’s suffering.

3.1.5.5 MAiD and Mental Disorder as the Sole Underlying Condition: An Interim Report, 2022 and MAiD in Canada: Choices for Canadians, Report of the Special Joint Committee on MAiD, 2023

MAiD and Mental Disorder as the Sole Underlying Condition: An Interim Report (the “**Seventh Report**”) was released in May 2022 and was followed by *MAiD in Canada:*

⁴⁵⁴ Sixth Report, *supra* note 447 at 73.

⁴⁵⁵ *Ibid* at 67.

⁴⁵⁶ *Ibid* at 61.

⁴⁵⁷ *Ibid* at 67.

Choices for Canadians, Report of the Special Joint Committee on MAID (the “**Eighth Report**”)⁴⁵⁸, in February 2023. Bill C-7 required that a parliamentary committee review the MAID law specifically regarding five issues: (1) the state of palliative care in Canada; (2) protections for Canadians with disabilities; (3) MAID MD-SUMC; (4) MAID for mature minors; and (5) advance requests for MAID. The Seventh and Eighth Report reflect the resulting review of the parliamentary committee.

The Seventh Report has minimal discussion on voluntariness except for reiterating the recommendation provided in the Sixth Report specific to addressing situations of involuntariness.⁴⁵⁹

The Eighth Report provides further commentary on the potential concern for socio-economic factors influencing a person to request MAID and the appropriate balancing of autonomy in the face of structural inequality.⁴⁶⁰ Many of the witnesses raised concerns with the ability of persons with disabilities to exercise meaningful choice when burdened with socio-economic disadvantages.⁴⁶¹ However, on the contrary, a witness highlighted the importance of not holding individuals “hostage to fixing systemic problems” and further reducing their autonomy.⁴⁶² The members reiterated the perspective that voluntariness must be assessed on a case-by-case basis.⁴⁶³ One witness had concerns related to the “systemic coercion” the expansion of MAID has caused persons with disabilities in so far as they may not see themselves as welcomed and valued citizens.⁴⁶⁴

With respect to voluntariness, the Eighth Report canvassed similar issues as those raised in the Fifth and Sixth Reports, such as the concern with potential impact of structural

⁴⁵⁸ The Eighth Report made significant recommendations that fall outside of the discussion on voluntariness. These recommendations relate to the potential evolution of MAID as it relates to mature minors and advance requests. For a full listing of the recommendations, refer to pages 5-9 of the Eighth Report.

⁴⁵⁹ Canada, Parliament, Report of the Special Joint Committee on Medical Assistance in Dying, *MAID and Mental Disorder as the Sole Underlying Condition: An Interim Report* (June 2022) at 23 [Seventh Report].

⁴⁶⁰ Canada, Parliament, Report of the Special Joint Committee on Medical Assistance in Dying, *Medical Assistance in Dying in Canada: Choices for Canadians* (February 2023) at 35 [Eighth Report].

⁴⁶¹ *Ibid* at 36.

⁴⁶² *Ibid*.

⁴⁶³ *Ibid* at 35.

⁴⁶⁴ *Ibid* at 36.

vulnerabilities on the voluntariness of a MAID request. The Eighth Report reinforced the need to ensure a case-by-case assessment is undertaken so not to presume vulnerabilities that may vitiate voluntariness. This report addressed a common thread in the evolution of physician assisted suicide, the balancing of autonomy with a duty to protect vulnerable persons.

3.2 Review of Voluntariness in Law

The decision in *Carter* and the subsequent Expert Reports have directly interpreted and applied the voluntariness requirement to some degree, and, as such, are the most informative in understanding the meaning of voluntariness and the development of a framework to assess voluntariness in the MAID context. However, there are several areas of law that consider voluntariness. While it is beyond the scope of this paper to conduct an exhaustive review of voluntariness in other areas of law, three examples will be considered to supplement how voluntariness was considered in *Carter*, MAID jurisprudence and the Expert Reports. These three examples are deliberately chosen as they are areas of law where voluntariness is germane, making them informative to understanding voluntariness in the MAID context. Here I do not consider secondary sources, as I am concerned with how the court has interpreted voluntariness and not the consideration in academic literature. I start this review by looking at the confessions rule as it has a long history of interpreting voluntariness and arises in the criminal law context, like the MAID law. Additionally, the confessions rule has similar concerns related to power imbalances and the impact of coercion on decision making. This is followed by a review of the principle of unconscionability in contract law, which also raises concerns related to power imbalances and coercion and the potential of offering a remedy based on social policy. I conclude this section by considering voluntariness in the informed consent context, which provides a considerable amount of insight into voluntariness in the health care context. Arguably, the requirement for informed consent to be given voluntarily offers the greatest guidance in applying voluntariness in the MAID context. Statutory interpretation demands that terms and concepts are interpreted similarly and consistently in the legal sphere, lending support

for the importance of considering how voluntariness has been considered in the confessions rule and informed consent in this analysis.⁴⁶⁵

3.2.1 Confessions Rule

The confessions rule provides that “any out-of-court statement made by an accused person to a person in authority is inadmissible against the accused unless the prosecution proves beyond a reasonable doubt that the statement was voluntary”.⁴⁶⁶ Both the confessions rule and the MAID law are found within the context of criminal law, and the presumption of consistent usage suggests that each time the term “voluntary” is used within the *Criminal Code*, it should be interpreted in a way that is consistent with the way the term is interpreted in other parts of the statute.⁴⁶⁷ The principle of *in pari materia* is of assistance in this instance, as it confirms that, “[s]tatutes, or portions of a statute, that deal with the same subject or contribute to an integrated scheme are said to be *in pari materia*”.⁴⁶⁸ As Gonthier J. explains in *Re Therrien*: “interpretations favouring harmony between the various statutes by the same government should indeed prevail. This presumption is even stronger when the statutes relate to the same subject matter”.⁴⁶⁹ The confessions rule is a helpful legal doctrine to review as it (1) falls within the jurisdiction of criminal law, and therefore *in pari materia* is applicable, and (2) it clarifies the distinction between a voluntary and coercive statement.

In *Ibrahim v The King (1914)* (“**Ibrahim**”), the confessions rule was determined by the Privy Council to be narrow in scope, excluding statements only where the police held out explicit threats or promises to the accused.⁴⁷⁰ Meaning, confessions were deemed voluntary

⁴⁶⁵ R. Graham 2001, *supra* note 36 at 101; Cramm, *supra* note 28.

⁴⁶⁶ Lisa Dufraimont, *supra* note 348.

⁴⁶⁷ R. Graham 2001, *supra* note 36 at 101.

⁴⁶⁸ Ruth Sullivan, *Statutory interpretation*, 2d ed (Ottawa: Canadian Electronic Library, 2010) at 149-150 [Sullivan, 2010].

⁴⁶⁹ *Re Therrien* [2001] 2 SCR 3 at para 121; Cramm, *supra* note 28.

⁴⁷⁰ *Ibrahim v The King*, [1914] AC 599 (PC) [*Ibrahim*]. The SCC adopted the Ibrahim rule in numerous subsequent SCC decisions prior to being widened by the SCC in *Hobbins v The Queen*, [1982] 1 SCR 533.

unless they were obtained as a result of explicit threats or promises. The confessions rule widened in scope in *Hobbins v The Queen*, (1982) (“**Hobbins**”) wherein the SCC held that when determining voluntariness of a confession courts should be alert to the coercive effect of an “atmosphere of oppression”.⁴⁷¹ This broader approach to the confessions rule was reiterated in 1990 by the SCC in *R v Hebert*⁴⁷² (“**Hebert**”). Here the court identified the approach in *Ibrahim*⁴⁷³ and described the *Hobbins* approach, according to which, “the absence of violence, threats and promises by the authorities does not necessarily mean that the resulting statement is voluntary, if the necessary mental element of deciding between alternatives is absent.”⁴⁷⁴ In *R v Oickle*, (2000) (“**Oickle**”) the SCC took the opportunity to clarify the proper test for ascertaining the voluntariness of statements.⁴⁷⁵

In *Oickle*, the SCC was tasked with determining whether or not a confession made by the accused was obtained by way of coercion or undue influence, as argued by the accused.⁴⁷⁶ Here the Court stated that the confessions rule embraces more than the narrow *Ibrahim* formulation, and is instead concerned with voluntariness broadly understood.⁴⁷⁷ The dominant reason for this concern is that involuntary confessions are more likely to be unreliable.⁴⁷⁸ The burden is therefore on the prosecution to show beyond a reasonable doubt that the confession was voluntary.⁴⁷⁹ The application of the confessions rule is based on context and necessitates a case-by-case analysis in determining whether a confession is voluntary.⁴⁸⁰ Therefore, “hard and fast rules”⁴⁸¹ cannot account for the varied circumstances that vitiate the voluntariness of a statement, necessitating a context-based analysis. The SCC identifies four occurrences that may arise to vitiate the voluntariness of a statement, namely: threats or promises made by the police and an offering of quid quo

⁴⁷¹ *Hobbins v The Queen*, [1982] 1 SCR 533 at 556-557 [*Hobbins*].

⁴⁷² *R v Hebert*, [1990] 2 SCR 151, [1990] ACS No. 64 [*Hebert*].

⁴⁷³ *Ibrahim*, *supra* note 470.

⁴⁷⁴ *Hebert*, *supra* note 472 at para 166.

⁴⁷⁵ *R v Oickle*, 2000 SCC 38, [2000] ACS No. 38 [*Oickle*].

⁴⁷⁶ *Ibid*.

⁴⁷⁷ *Ibid* at para 27.

⁴⁷⁸ *Ibid* at para 32.

⁴⁷⁹ *Ibid* at para 30.

⁴⁸⁰ *Ibid* at para 47.

⁴⁸¹ *Ibid*.

pro,⁴⁸² oppression⁴⁸³, the lack of an operating mind⁴⁸⁴, or police trickery⁴⁸⁵. The first three of these occurrences are relevant and will be considered further.

The concern with police using threats, promises or offering quid pro quo is that they may have a coercive effect on the person and raises the concern the person is simply confessing to gain a benefit from the interrogator.⁴⁸⁶ A form of threats or promises can be the use of moral or spiritual inducements to obtain a confession.⁴⁸⁷ However, these inducements will generally not produce an involuntary confession for the “simple reason that the inducement offered is not in the control of the police officers”.⁴⁸⁸ The court stressed that if a police officer convinces a suspect that he or she will feel better as a result of a confession the officer has not offered anything; and as a general rule confessions that result from “spiritual exhortations or appeals to conscience and morality, are admissible in evidence, whether urged by a person in authority or by someone else”.⁴⁸⁹

In the case of an “oppressive atmosphere” the Court is concerned with police creating conditions distasteful enough that it should be no surprise that the suspect would make a stress-compliant confession to escape those conditions.⁴⁹⁰ The concern here is that oppressive circumstances could overbear the suspect’s will to the point that he or she, “comes to doubt his or her own memory, believes the relentless accusations made by the police, and gives an induced confession”.⁴⁹¹ Ultimately, this is concerned with the effects of inhumane treatment on the voluntariness of a confession and can include, but not limited to, deprivation of food, clothing, water, sleep or medical attention, denying access to

⁴⁸² *Ibid* at para 48.

⁴⁸³ *Ibid* at para 58.

⁴⁸⁴ *Ibid* at para 63.

⁴⁸⁵ *Ibid* at para 65. Unlike the previous three considerations used to assess voluntariness, police trickery while concerned with voluntariness has a more specific objective, that is, it seeks to maintain the integrity of the criminal justice system.

⁴⁸⁶ *Ibid* at paras 51, 56.

⁴⁸⁷ *Ibid* at para 56.

⁴⁸⁸ *Ibid*.

⁴⁸⁹ *Ibid* at para 56.

⁴⁹⁰ *Oickle, supra* note 475 at para 35.

⁴⁹¹ *Ibid* at para 58.

counsel, and excessively aggressive, intimidating questioning for a prolonged period of time.⁴⁹²

The operating mind requirement only demands that the accused has the knowledge and awareness of what he or she is saying and recognition that is being said to a police officer who can use it to their detriment.⁴⁹³

More recently, in *R v Spencer, 2007 SCC*⁴⁹⁴, the police withheld a visit between the accused and his girlfriend, who was also being investigated, until the accused partially confessed to a string of robberies. The accused partially confessed and subsequently requested leniency for his girlfriend, which the officer indicated he could not offer. The accused was permitted to visit his girlfriend and subsequently the accused confessed to further robberies after being permitted to speak with his girlfriend. The SCC considered whether the Court of Appeal erred in determining the confessions were involuntary and the majority (Fish and Abella JJ. dissenting) restored the trial judge's conviction of the accused and found the confessions were voluntary. The Court found the police did not offer leniency to the accused's girlfriend and the withholding of the visit was not a strong enough inducement to render the confession involuntary.⁴⁹⁵ While withholding of the visit was an inducement, the accused's free will was not overborne by that action. The SCC referred to the test in *Oickle* and highlighted the need for the application of the rule to be contextual and not based on hard and fast rules that are unable to account for the variety of circumstances that may vitiate the voluntariness of a confession. This would ultimately lead to a rule that is both "over- and under-inclusive".⁴⁹⁶

In summary, the confessions rule seeks to ensure the inevitable power imbalance between police and an accused, along with the tactics engaged by the police during an investigation, do not override the will of the accused, making a confession involuntary and consequently, unreliable. Tactics that may be engaged by police and vitiate the voluntariness of an

⁴⁹² *Ibid* at para 60.

⁴⁹³ *Ibid* at para 63.

⁴⁹⁴ *R v Spencer*, 2007 SCC 11, [2007] SCJ. No. 11 [*Spencer*].

⁴⁹⁵ *Ibid* at para 20.

⁴⁹⁶ *Ibid* at para 11.

accused's confession include threats or promises made by the police and an offering of quid quo pro,⁴⁹⁷ oppression⁴⁹⁸, or the lack of an operating mind⁴⁹⁹. This is a contextual assessment that considers a variety of factors and not based on "hard and fast rules"⁵⁰⁰ due to the risk of creating a rule that is both over and under inclusive.⁵⁰¹

The most relevant considerations from the confessions rule for interpreting voluntariness in the MAID context, include consideration of whether there is an oppressive atmosphere, whether the patient has an operating mind and ensuring they are aware of alternatives. In other words, an assessment of whether a person's request for MAID is voluntary must consider whether there are any external oppressive or coercive factors that may compromise the person's operating mind, such that free will is compromised, and ensure they are informed of the alternative treatment options other than MAID.

3.2.2 Unconscionability

There is limited discussion of voluntariness in relation to the doctrine of unconscionability. In contract, an unconscionable transaction arises where there is an "overwhelming" power imbalance between the parties.⁵⁰² The doctrine of unconscionability has arisen to protect the vulnerable when they are in a relationship of unequal power.⁵⁰³ In *Uber*, the SCC confirmed the doctrine of unconscionability has two elements: "inequality of bargaining power, stemming from some weakness or vulnerability affecting the claimant and...an improvident transaction."⁵⁰⁴ Pleading unconscionability may result in a remedy for one party against an unfair advantage gained by an "unconscientious use of power by a stronger

⁴⁹⁷ *Oickle*, *supra* note 475 at para 48.

⁴⁹⁸ *Ibid* at para 58.

⁴⁹⁹ *Ibid* at para 63.

⁵⁰⁰ *Ibid* at para 47.

⁵⁰¹ *Spencer*, *supra* note 494 at para 11.

⁵⁰² *Uber v Heller*, 2020 SCC 16 at para 60 [*Uber*]; *Morrison v Coast Finance*, [1965] B.C.J. No. 178, 55 D.L.R. (2d) 710 at 716 [*Morrison*]; *Norberg v Wynrib* [1992] SCJ No. 60, [1992] ACS No. 60 at para 30 [*Norberg SCC*].

⁵⁰³ *Norberg SCC*, *supra* note 502 at para 28.

⁵⁰⁴ *Uber*, *supra* note 502 at para 62-63.

party against a weaker”.⁵⁰⁵ To prove this claim, one must demonstrate an inequality between the parties “arising out of the ignorance, need or distress of the weaker, and proof of substantial unfairness of the bargain obtained by the stronger”.⁵⁰⁶ Interestingly, although one may argue a transaction to be unconscionable it does not necessarily vitiate consent. On the basis of social policy, the law may provide relief if it can be shown there was such a disparity in the positions of the parties that the weaker party could not “choose freely”.⁵⁰⁷ In the MAID context, the suggestion that a patient has not chosen freely would necessitate a pause in the process to determine the voluntariness of the request.

Unconscionability is concerned with the effect of unequal bargaining power that may arise such that a person is vulnerable and unable to choose freely.⁵⁰⁸ Generally, in health care there is a presumed power imbalance in the patient-physician relationship, and, in part, the risk is the patient submits to the authority of the physician.⁵⁰⁹ The analysis of unconscionability clarifies the role of a power-imbalance in “power dependency”⁵¹⁰ relationships, such as patient-physician, and reinforces the need to assess the potential influence of the power imbalance on voluntariness. The law of contract goes a step further to recognize that even in situations where consent is not vitiated there may be a strong social policy reason for offering a remedy.

3.2.3 Informed Consent

In health care, voluntary informed consent is a requirement prior to the provision of treatment, with a limited exception for the provision of emergency treatment when informed consent cannot be readily obtained. For informed consent to be valid it must be voluntary.⁵¹¹ The *Constitution Act, 1867*, grants the provinces and territories jurisdiction

⁵⁰⁵ *Morrison*, supra note 502 at para 713; *Norberg SCC*, supra note 502 at para 30.

⁵⁰⁶ *Morrison* supra note 502 at para 713; *Norberg SCC*, supra note 502 at para 30.

⁵⁰⁷ *Norberg SCC*, supra note 502 at para 34.

⁵⁰⁸ *Ibid* at para 28.

⁵⁰⁹ *Ibid* at para 39.

⁵¹⁰ *Ibid*. “Power dependency” relationship: common element is an underlying personal or professional association which creates a significant power imbalance between the parties.

⁵¹¹ *Ibid* at para 29.

over health care⁵¹², and some provinces and territories have enshrined the common law concept of informed consent into legislation, while others have not.⁵¹³ For application purposes, this writer refers to the Alberta context as an examination of all provincial informed consent is beyond the scope of this paper. In Alberta, there is no provincial legislation that governs informed consent and therefore the only relevant legal authority on informed consent to treatment is the common law, along with the Practice Standards from the various health care provider regulatory Colleges.⁵¹⁴ The following outlines the requirements of informed consent and pays particular attention to the meaning of voluntariness.

The principle of informed consent is foundational to the provision of health care and respect for self-determination and bodily autonomy.⁵¹⁵ Treatment is prohibited without the health care provider being satisfied that the patient has given informed consent for the treatment. Generally, there are four elements to obtaining a proper informed consent. These are: a patient must have capacity, they shall be informed about the risks and benefits of a treatment, the information provided shall be specific to the treatment or procedure, and lastly, the consent shall be given voluntary.⁵¹⁶ Informed consent operates on the presumption of individual autonomy and free will, and the ability of the individual to be free to provide or not provide informed consent. However, this presumption becomes untenable in some circumstances where a significant power imbalance exists and interferes with the persons free will.⁵¹⁷ In such circumstances, one must consider whether the patient is in a position to truly make a free choice, taking into account the context in which the choice arises.⁵¹⁸ The contextual nature of the analysis may consider a variety of

⁵¹² *Constitution*, *supra* note 8, at ss 92(7), 92(13), 92(16).

⁵¹³ For example, Ontario has enshrined the common law principle of informed consent in the *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A s 11(2) [*HCCA*].

⁵¹⁴ There are relevant Standards of Practice and Code of Ethics that apply to health care providers pursuant to their regulatory College (i.e. College of Physicians and Surgeons of Alberta) but those Standards are beyond the scope of this paper.

⁵¹⁵ *Carter SCC*, *supra* note 1; *Reibl v. Hughes*, [1980] 2 SCR, 1980 CanLII 23 [*Reibl*]; *Starson v Swayze*, 2003 SCC 32, [2003] 1 SCR [*Starson*].

⁵¹⁶ Leanne E. Tran, *The Canadian Law of Consent to Treatment*, 4th Edition (Lexis Nexis, 2023) at 6 [Leanne E. Tran].

⁵¹⁷ *Norberg*, *supra* note 502 at paras 27–28.

⁵¹⁸ *Ibid* at para 41.

considerations such as the possible use of threat or force, the age of the person, the urgency of the decision, and the gravity of the decision.

The requirements of voluntariness and being informed are closely tied in the informed consent context. The SCC has held in a number of decisions, including *Norberg v Wynrib (1992)* and *Reibl v Hughes (1980)*, that consent to treatment is informed, if before giving it, the person received the information pertaining to the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, alternative courses of action, and the likely consequences of not having the treatment.⁵¹⁹ What counts as “material” will depend on the particular facts of the case and includes those risks which the health care provider knows, or ought to know, that a reasonable person in the patient’s position would consider in deciding whether to proceed with the treatment.⁵²⁰ In making this determination, the law uses the reasonable person standard. That is to say, it asks what a reasonable person in the same circumstances would require in order to make a decision about the treatment. To make a voluntary decision, the patient must have the necessary information to be able to make an informed decision.

For consent to be valid, it requires the choice to be exercised voluntarily, where the patient provides it freely, without coercion, undue influence or misrepresentation regarding the nature of the treatment.⁵²¹ Influence will be undue “when it rises to the level of fraud, deceit, duress, or coercion”.⁵²² If pressure from any person is present, one must consider the degree of pressure brought to bear upon a patient and whether it was sufficient to affect

⁵¹⁹ *Reibl*, *supra* note 515; *Norberg*, *supra* note 502; *Arndt v. Smith*, 1997 CanLII 360 (SCC), [1997] 2 S.C.R. 539; *Hopp v. Lepp*, 1980 CanLII 14 (SCC), [1980] 2 S.C.R. 192; *Bauer (Litigation Guardian of) v. Seager*, 2000 MBQB 113, [2000] 11 W.W.R. 621; *Mangalji (Next Friend of) v. Graham* (1997), 1997 CanLII 14728 ABKB, 47 Alta. L.R. (3d) 19 (Q.B.); *Rhine v. Millan*, 2000 ABQB 212, [2000] 7 W.W.R. 13

⁵²⁰ *Ciarlariello v. Schacter*, 1993 CanLII 138 (SCC), [1993] 2 S.C.R. 119 [*Ciarlariello*].

⁵²¹ *Norberg*, *supra* note 502 at para 29; *Reibl*, *supra* note 515 at para 11.

⁵²² First Report, *supra* note 22 at 69.

the decision-making process.⁵²³ Misrepresentation requires that there was a false representation as to a matter of present or past fact.⁵²⁴

Informed consent arises in discussion between the patient and health care provider and, with a few exceptions⁵²⁵, is not legally required to be documented in writing, although the physician is required to document the informed consent discussion in the patient's health record.⁵²⁶ Notwithstanding informed consent being documented on a consent to treatment form, when determining whether proper informed consent was obtained, the analysis will focus on the discussion between the physician and patient.⁵²⁷ The documentation provides evidence of the conversation but does not conclusively prove informed consent was obtained.⁵²⁸ The process of obtaining informed consent may occur over the course of multiple appointments with a patient and may require further appointments to ensure the patient is informed. Arguably, determining the voluntariness of a person's request for a particular health care service may occur over several appointments to ensure the request is prolonged, repeated, and well-considered.

For completeness purposes, it is prudent to consider informed refusals in the health care context. Canadian courts have long recognized a common law right of patients to refuse consent to medical treatment, or to withdraw medical treatment that has been commenced.⁵²⁹ The right of a competent patient to assume risks that others would deem foolish or unadvisable must be respected.⁵³⁰ This right extends to circumstances where

⁵²³ John Irvine et al., *Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professionals*, 4th ed (Toronto: Carswell, 2013) at 32.

⁵²⁴ *Markowa v. Adamson Cosmetic Facial Surgery Inc.*, 2012 ONSC 1012, [2012] OJ No. 762 at para 158.

⁵²⁵ There are instances where informed consent must be written such as the use of blood and blood by-products, medical assistance in dying and human tissue and organ donation.

⁵²⁶ The requirement related to documentation of informed consent arises from the health care provider's regulatory College Standard of Practice. For physicians this would be: CPSA Standard of Practice: Patient Record Content; Consent: A Guide for Canadian Physicians, June 2016 retrieved online at [CMPA - Consent: A guide for Canadian physicians \(cmpa-acpm.ca\)](http://cmpa-acpm.ca);

⁵²⁷ Consent: A Guide for Canadian Physicians, June 2016 retrieved online at [CMPA - Consent: A guide for Canadian physicians \(cmpa-acpm.ca\)](http://cmpa-acpm.ca)

⁵²⁸ Consent: A Guide for Canadian Physicians, June 2016 retrieved online at [CMPA - Consent: A guide for Canadian physicians \(cmpa-acpm.ca\)](http://cmpa-acpm.ca); *Complainant v. College of Physicians and Surgeons of British Columbia (No. 1)*, 2020 BCHPRB 56 at para 74

⁵²⁹ *Ciarlariello*, *supra* note 520.

⁵³⁰ *Starson*, *supra* note 515 at para 76.

death will occur because of withdrawing the medical treatment.⁵³¹ The Ontario Court of Appeal in *Malette v Shulman* speaks to the importance of the doctrine of informed consent and respect for self-determination:

The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment.⁵³²

While some academics, lawyers, and advocates argue there is a difference between the withholding or withdrawal of life sustaining treatment from a more “active” form of assisted dying such as MAID, both decisions result in the same outcome: death.⁵³³ The law has evolved to accept that patients have the right to bodily autonomy and self-determination, which extends to not only choosing how to live but how to die, provided certain criteria are met. Based on my professional experience, in contexts of withholding or withdrawing life sustaining care, it is an alternate decision maker who is involved in the decision making and not the patient. Whereas, in MAID, the patient must have capacity to consent to MAID and do so voluntarily. Arguably, there are greater concerns with ensuring voluntariness of the withdrawal and withholding of life sustaining treatment as the patient is often times not engaged in the conversation by reason of medical issues.

To summarize, informed consent requires the physician to be satisfied the patient has the requisite capacity to consent to the specific treatment or procedure being proposed, informed of risks, benefits, consequences, and alternatives of the treatment, and ensure the patient is voluntarily providing informed consent. Voluntariness requires the patient to freely, without coercion, undue influence, or misrepresentation, to provide informed

⁵³¹ *B(N) v Hotel-Dieu de Quebec* (1992), 86 DLR (4th) 385 (CS Que).

⁵³² *Malette v Shulman* (1990), 72 OR (2d) 417, 67 DLR (4th) 321 (Ont CA) at paras 61–62, 65.

⁵³³ Carter, *supra* note 6 at paras 235 to 253.

consent and must have sufficient information to do so. In the context of informed consent, voluntariness is concerned with the potential influence and pressure of other people such as family or health care providers, interfering with the patient's decision making.

3.3 Conclusion

Throughout this chapter, this writer reviewed how voluntariness has been considered in the jurisprudence arising mainly from *Carter BCSC* and the subsequent MAID case law interpreting the eligibility criteria. Additionally, it provided a comprehensive review of relevant government reports tasked with studying and putting forth recommendations related to the development of the MAID regime in Canada, and the subsequent evolution of the law. This review was supplemented by considering how voluntariness has been reviewed in other areas of law, specifically, the confessions rule, unconscionability in contract, and informed consent. The universal themes that have emerged highlight voluntariness must be assessed on a case-by-case basis, that is contextual in nature, and specifically considers whether there is undue influence from any person or coercive factors that may be influencing or motivating a person's request for MAID, and ambivalence. Coercive factors may include social and economic concerns.

There were a few important considerations that were not universally considered but will be used to inform the analysis of voluntariness specific to the MAID context including that a framework, with clearly established roles and responsibilities of a multidisciplinary team, cannot be over or under restrictive, and vulnerabilities cannot be presumed based on a group or individual characteristics. Some of the factors are universally required in the jurisprudence and government reports, while other factors are unique in the context in which they arise. Regardless, read together, they provide a strong foundation on how voluntariness should be interpreted in the MAID context and, further, provide guidance on the application of assessing voluntariness. These factors will be used to identify a framework for the legal interpretation of voluntariness and the role of the social worker in this assessment. The next chapter turns to examine the role of social workers.

Chapter 4

4 The Role of the Social Worker in MAID

Social work within the health care context is one of the oldest forms of social work practice in Canada.⁵³⁴ It dates back to 1910, when the first social service department was established in Canada at the Winnipeg General Hospital.⁵³⁵ The social work profession has a particular interest in the “needs and empowerment of people who are vulnerable, oppressed, and/or living in poverty.”⁵³⁶ Social workers that practice within health care are increasingly encountering clients who wish to die by way of MAID.⁵³⁷ The learnings from Chapters 2 and 3 highlight that assessing voluntariness may be best achieved with the involvement of other health care professionals, which this Chapter argues should include social workers.

In *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings, Final Report*, 2015, as referenced in Chapter 3, suggests a need for a framework with clear roles and responsibilities on how voluntariness is to be assessed.⁵³⁸ The First Report suggests two physicians (or Practitioners) should attest that the request was made voluntarily without coercion and, further, a multidisciplinary team approach should be utilized to assess voluntariness and ensure no sources of coercion.⁵³⁹ In addition, it suggests that where vulnerability is present, the person is assessed for possible coercion or inducement, which may include a social worker or psychologist speaking with the patient to determine whether any unmet needs have compromised the request for MAID.⁵⁴⁰ This team based approach was viewed as possibly offering distinct advantages by offering

⁵³⁴ Canadian Association of Social Workers, *Social Workers in Health: Working Conditions and Related Topics Literature Review* (2006) at 2 [CASW Social Work in Health].

⁵³⁵ *Ibid* at 2.

⁵³⁶ Canadian Association of Social Workers, *Code of Ethics, Values and Guiding Principles* (2024) at 3 [CASW Code of Ethics].

⁵³⁷ Gina Bravo et al, “Social workers’ experiences with medical assistance in dying: Survey findings from Quebec, Canada” (2023) 62:5 *Social Work in Health Care* at 194 [Gina Bravo].

⁵³⁸ First Report, *supra* note 22 at 69–70.

⁵³⁹ *Ibid* at 70–71.

⁵⁴⁰ *Ibid* at 87–88. Unmet needs are not well defined; however, unmet needs are largely understood to include needs that may be met by way of medical or socio-economic services. It is acknowledged that many people have some unmet needs but in the MAID context this is specific to needs that may be reasonably met by way of medical or socio-economic services. Palliative care is often referenced as an unmet need for end-of-life patients due to resources.

comprehensive voluntariness assessments.⁵⁴¹ A 2023 Canadian research study that looked at the roles of social workers, nurses and pharmacists in the delivery of MAID, underscores the unique importance of a multi-disciplinary team.⁵⁴² In 2016, the Canadian Association of Social Workers (the “CASW”) identified social workers as having a “unique perspective and expertise” and should be an “integral member” of a multi-disciplinary team involved in the delivery of MAID.⁵⁴³

Clinical social workers are uniquely qualified to work in the fields of palliative care and end-of-life care.⁵⁴⁴ It is the commonality of the values and practice approach taken by social workers, which considers individuals in the full context of their lives⁵⁴⁵, that supports this view. This Chapter begins by providing a definition for a clinical social worker and a review of the regulation of social workers. As a result of the provincial and territorial regulation of social workers, this section will specifically look at the Alberta context and the Alberta College of Social Workers (the “College”) as a reference point for the discussion of the regulation of social workers. This is followed by identifying specific provisions of the *Criminal Code*⁵⁴⁶ and the Model MAID Practice Standard⁵⁴⁷ that contemplate a role for social workers in assisting practitioners with the delivery of MAID. This includes consideration of how specific ethical principles, as identified in the CASW *Code of Ethics*,⁵⁴⁸ including self-determination,⁵⁴⁹ social justice,⁵⁵⁰ and recognition of the impact of social exclusion on vulnerability⁵⁵¹, uniquely equip social workers for working within the MAID context. Further, the scope of clinical social work practice is addressed

⁵⁴¹ *Ibid* at 82.

⁵⁴² Debbie Selby et al, “Perception of roles across the interprofessional team for delivery of medical assistance in dying” (2023) 37:1 *Journal of Interprofessional Care* 39, DOI: 10.1080/13561820.2021.1997947 at 43 [Debbie Selby].

⁵⁴³ Canadian Association of Social Workers, *Position Statement on Physician Assistance in Dying* (2016) at 2 [CASW Position Statement].

⁵⁴⁴ Lisa P Gwyther et al., “Social Work Competencies in Palliative and End-of-Life Care” (2005) Vol. 1(1) *Journal of Social Work in End-of-Life & Palliative Care* at 90.

⁵⁴⁵ Bosma, H, et al, *Canadian Social Work Competencies for Hospice Palliative Care: A Framework to Guide Education and Practice at the Generalist and Specialist Levels* (2008) at 2.

⁵⁴⁶ *Criminal Code*, *supra* note 3 at ss 241(3), 241(5.1).

⁵⁴⁷ Model MAID Practice Standard, *supra* note 347.

⁵⁴⁸ CASW Code of Ethics, *supra* note 536.

⁵⁴⁹ *Ibid* at 1.2.

⁵⁵⁰ *Ibid* at 2.1

⁵⁵¹ *Ibid* at 2.3.

and informed by the College’s Standards of Practice⁵⁵² and the experiences of Canadian social workers in MAID, which identifies their scope of practice to include a variety of services, and specifically biopsychosocial assessments.⁵⁵³ Biopsychosocial assessments are used to explore context (physical, emotional, social, economic, and spiritual) of the MAID request.⁵⁵⁴ Although there are different ways in which social workers may be involved in the MAID process, for the purposes of this paper, I consider their role related to assessing voluntariness of a request for MAID. This chapter concludes social workers are thus uniquely positioned to assist Practitioners with assessing the voluntariness of a request for MAID as a result of their professional ethics and scope of practice.

4.1 Definition and Regulation of Social Workers in Alberta

For the purposes of this paper, a social worker is defined as a registered social worker with the College.⁵⁵⁵ While an accredited bachelor of social work education is considered the first professional practice degree, preparing social workers as generalist practitioners,⁵⁵⁶ for specialized practice, including clinical social work, an advanced degree is required.⁵⁵⁷ A regulated member may use the term “clinical social worker” if they have a minimum of a master’s degree in social work from a university approved by the College Council, along with other various experiential requirements.⁵⁵⁸ While the CASW does not provide a definition of clinical social worker, the National Association of Social Workers (“NASW”) defines clinical social work practice as “the professional application of social work theory

⁵⁵² Standards of Practice, *supra* note 453.

⁵⁵³ Kelsey Antifaeff, “Social Work Practice with Medical Assistance in Dying” (2019) 2;44(3) Health Soc Work 185 at 186 [Kelsey Antifaeff]; Gina Bravo, *supra* note 537, at 194; Standards of Practice, *supra* note 453 at B.2(b)(ii).

⁵⁵⁴ Kelsey Antifaeff, *supra* note 553 at 186.

⁵⁵⁵ *Social Workers Profession Regulation*, Alta Reg 82/2003 at s 10 [Social Workers Regulation].

⁵⁵⁶ Scope of Practice, *supra* note 453.

⁵⁵⁷ This is typically a graduate degree (Masters or PhD levels). Scope of Practice, *supra* note 453.

⁵⁵⁸ *Social Workers Regulation*, *supra* note 555 at s 10(2): minimum of a master’s degree in social work; has been registered for at least two years on the general registrar; has two years of post-master’s degree clinical work experience that includes 1600 client hours under the supervision of a clinical social worker or a practitioner from another profession as approved by Council; and provides two letters of references from a clinical social worker, psychologist, psychiatrist or other provider of health services who has direct knowledge of the applicant’s practice.

and methods to the diagnosis, treatment, and prevention of psychosocial dysfunction, disability, or impairment, including emotional, mental, and mental disorders.”⁵⁵⁹ A survey completed by the Canadian Council of Social Work Regulators found that entry level social workers do not have adequate clinical practice training and are also lacking in clinical knowledge and skills.⁵⁶⁰ For our purposes here, the role of the social worker in MAID is specific to the role of clinical social workers, with advanced education and training. That is to say, advanced training should be a requirement for any social worker involved in MAID assessments. Advanced training may be offered in the employment environment and specific to the MAID context.

In Canada, social work practice is regulated by provincial law. In Alberta the profession is regulated by the *Health Professions Act*⁵⁶¹ and associated *Social Workers Profession Regulation (Social Work Regulation)*.⁵⁶² The *CASW Code of Ethics* sets forth values to guide social workers’ professional conduct, namely self-determination, autonomy and social justice.⁵⁶³ The *CASW Code of Ethics* serve as the “foundation of the ethical practice of social work in Canada” and reflect similar ideas in the MAID jurisprudence, government reports and legislation – namely, a balancing of self-determination and bodily autonomy with the concern for, and protection of, vulnerable people. The ethical basis of social work practice compels social workers to respect the autonomy and self-determination of clients, while identifying the external factors that may be impacting their wellbeing and quality of life. The social worker’s scope of practice includes the assessment of social determinants of health⁵⁶⁴ and competency to complete biopsychosocial assessments.⁵⁶⁵ These skills uniquely situated the social work profession to assist with the assessment of voluntariness.

⁵⁵⁹ National Association of Social Workers, *NASW Standards for Clinical Social Work in Social Work Practice* (2005) at p 9 [NASW Standards for Clinical Practice].

⁵⁶⁰ Canadian Council of Social Work Regulators, *Entry level competency profile for the social work profession in Canada* (2013) at 36; Toulia Kourgiantakis et al, “Clinical Social Work Practice in Canada: A Critical Examination of Regulation” 33(1) *Research on Social Work Practice* 15 at 16.

⁵⁶¹ *Health Professions Act*, RSA 2000, c H-7 [Health Professions Act].

⁵⁶² *Social Workers Regulation*, *supra* note 555.

⁵⁶³ *CASW Code of Ethics*, *supra* note 536 at 2.

⁵⁶⁴ *ibid* at 10.

⁵⁶⁵ Kelsey Antifaeff, *supra* note 553 at 186.

4.2 Criminal Code and Model MAID Practice Standard

Recommending a role for social workers within MAID is consistent with the legislative framework that emerged after *Carter*. In accordance with the following review of social work ethics and scope of practice, it is not difficult to see why the legislature and Health Canada agree there is a role for social workers within MAID. Although the *Criminal Code* requires the Practitioner to personally opine on whether a person is eligible for MAID⁵⁶⁶, Parliament intended there to be a role for social workers in the delivery of MAID services. This is contemplated by sections 241(3) and 241(5.1) of the *Criminal Code* which states:⁵⁶⁷

Exemption for person aiding practitioner

(3) No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a Practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

Clarification

(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, Practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.

Social workers are afforded protection from criminal liability, provided their impugned actions are in accordance with the MAID provisions. In addition, the *Regulations for the Monitoring of Medical Assistance in Dying* (the “*Monitoring Regulation*”), also contemplates a role for social workers in the delivery of MAID.⁵⁶⁸ The *Monitoring Regulation* requires prescribed health care providers involved in the MAID process to provide information related to requests for, and the provision of, MAID.⁵⁶⁹ The *Monitoring Regulation* stipulates both mandatory and discretionary data collection that seeks to

⁵⁶⁶*Criminal Code*, *supra* note 3 at ss 241.2(3), 241.2(3.1).

⁵⁶⁷ *Ibid* at ss 241(3), 241(5.1).

⁵⁶⁸ *Regulations for the Monitoring of Medical Assistance in Dying*, SOR/2018-166 at s. 13(2)(h) [*Monitoring Regulation*].

⁵⁶⁹ *Ibid*

understand the demographic profile of individuals who have requested, been assessed and received MAID, to assist with oversight and monitoring of MAID in Canada.⁵⁷⁰ The *Monitoring Regulation* requires the reporting of “information as to whether Practitioners consulted with other health care professionals or social workers regarding requests”.⁵⁷¹ Social workers are also contemplated at Schedule 3 of the *Monitoring Regulation*, which requires the preliminary assessor or the Practitioner to report whether they consulted with other health care professionals or social workers in order to determine whether the person who made the request for MAID met the eligibility criteria.⁵⁷² Social workers have been specifically identified as a professional who may be consulted with respect to eligibility criteria for which the Voluntary Provision is considered.

A specific area in which social workers are contemplated in assisting a Practitioner is in offering services and referrals to health care and community supports that may relieve a person’s suffering. The *Criminal Code* requires that a patient whose natural death is not reasonably foreseeable is informed of the means available to relieve the persons suffering and ensure they are offered consultations with relevant professions who provide those services or care.⁵⁷³ These services include, where appropriate, counselling services, mental health and disability support services, community services, and palliative care.⁵⁷⁴ Community services have been interpreted to include housing and income supports as possible means available to relieve suffering and should be offered to MAID requesters where appropriate.⁵⁷⁵ The Model MAID Practice Standard suggests social workers and other healthcare providers, with the relevant knowledge, can assist with informing and offering consultations about the means available to relieve a patient’s suffering.⁵⁷⁶ The Model MAID Practice Standard interprets “means available” as available means that are

⁵⁷⁰ *Ibid.*

⁵⁷¹ *Ibid* at s 13(2)(h).

⁵⁷² *Ibid* at Schedule 3 para 1.

⁵⁷³ *Criminal Code*, *supra* note 3, at s 241.2(3.1)(g).

⁵⁷⁴ *Ibid* at s 241.2(3.1)(g).

⁵⁷⁵ Sixth Report, *supra* note 447 at 61.

⁵⁷⁶ Model MAID Practice Standard, *supra* note 347 at s 10.3.5.4.

reasonable and recognized.⁵⁷⁷ The services identified above are services in which social workers are well trained to either perform or provide a referral, while addressing any potential barriers in accessing the services.⁵⁷⁸

Due to the nature of social work practice, social workers typically spend considerably more time with their clients than do physicians⁵⁷⁹, which can provide increased opportunity and context for the social worker to understand the specifics that may be informing a person's request for MAID.⁵⁸⁰ For example, an existing role for social workers in MAID includes biopsychosocial assessments, which allows social workers an opportunity to canvass any unmet needs an individual may have that could be influencing or motivating a request for MAID.⁵⁸¹ The particular skill set of social workers will be further canvassed below. The next section considers how specific ethical principles originating from the *CASW Code of Ethics* uniquely situates social workers in how they approach their scope of practice.

4.3 The CASW Code of Ethics

The *CASW Code of Ethics* sets forth the ethical responsibilities of social workers as developed by members of the College and service users.⁵⁸² It articulates the values, principles, and guidelines of social work practice for the social work profession.⁵⁸³ Specifically, the *Code of Ethics* emphasizes self-determination and autonomy,⁵⁸⁴ informed

⁵⁷⁷ *Ibid* at s 10.3.5.3.

⁵⁷⁸ Scope of Practice, *supra* note 453 at 1-2; Miller PJ, *supra* note 453 at 32–33; Standards of Practice, *supra* note 453 at B.2(b)(ii).

⁵⁷⁹ Ogden, R.D., & Young, M.G., “Euthanasia and assisted suicide: A survey of registered social workers in British Columbia” (1998) 28(2) *British Journal of Social Work* 161 at 163 [Ogden].

⁵⁸⁰ Gina Bravo, *supra* note 537 at 194; Miller PJ, *supra* note 453 at 32–33; Kelsey Antifaeff, *supra* note 553 at 186.

⁵⁸¹ Gina Bravo, *supra* note 537 at 197; Jamie K. Fujioka et al., “Implementation of Medical Assistance in Dying: A Scoping Review of Health Care Providers’ Perspectives” (2018) Vol. 55 No. 6 *Journal of Pain and Symptom Management* at 6 [Jamie K. Fujioka]; Miller PJ, *supra* note 453.

⁵⁸² *CASW Code of Ethics*, *supra* note 536 at 3.

⁵⁸³ *Ibid* at 4.

⁵⁸⁴ *Ibid* at 1.2.

consent⁵⁸⁵, and social justice (including impacts of social exclusion on vulnerability).⁵⁸⁶ With these guiding ethical principles, clinical social workers are uniquely qualified to assist in the MAID process, and, specifically, to assist a Practitioner with the assessment of voluntariness. These ethical principles equip the clinical social worker to assess voluntariness because of: (1) the social worker's professional obligation to uphold a patient's right to self-determination and informed decision making; and (2) special regard to vulnerable and oppressed persons and the impact of the environment on a person's decision making. These principles and their importance to the role of clinical social workers in the MAID process are discussed below.

The CASW *Code of Ethics* emphasizes the inherent dignity and worth of persons and the expectation social workers uphold each person's right to self-determination and respect the client's right to make choices based on voluntary informed consent, consistent with their capacity.⁵⁸⁷ The *Code of Ethics* defines self-determination as:

A core social work value that refers to the right to self-direction and freedom of choice without interference from others. Self-determination is codified in practice through mechanisms of informed consent. Social workers may be obligated to limit self-determination when a client lacks capacity or in order to prevent harm.⁵⁸⁸

To make an autonomous decision, an individual must have capacity for self-determination.⁵⁸⁹ Self-determination means a person has the freedom of choice without interference of others, which, as discussed above, is a fundamental consideration when assessing whether a request for MAID is voluntary and not the result of external pressures. Respect for self-determination means social workers take necessary steps to ensure the person has access to all the information and resources necessary to participate in decision making.⁵⁹⁰ This is a critical step to ensuring a person has made a voluntary request for

⁵⁸⁵ *Ibid.*

⁵⁸⁶ *Ibid* at 2.1.

⁵⁸⁷ *Ibid* at 6.

⁵⁸⁸ *Ibid* at 33.

⁵⁸⁹ Fifth Report, *supra* note 441 at 97.

⁵⁹⁰ CASW Code of Ethics, *supra* note 536 at s 1.2.7.

MAID and based on an informed decision, having been advised of the other means that may be available to alleviate their suffering or address other external factors that may be influencing a person to request MAID. The *CASW Code of Ethics* requires social workers to “uphold a person’s right to self-determination insofar as they do not pose a threat of harm to themselves or others”.⁵⁹¹ In the context of MAID, respecting the self-determination of a patient requires the social worker to consider the person’s capacity for self-determination and whether the person has the requisite information to make an informed decision that is not going to lead them to harm themselves. Social workers have always been involved with clients making difficult decisions and will continue to do so in the MAID context.⁵⁹²

The *Code of Ethics* also highlights social justice as a core value for social workers, who as a profession have a particular regard for persons who are marginalized, disadvantaged and vulnerable.⁵⁹³ The pursuit of social justice requires social workers “seek to understand the social determinants of health to understand the ways in which educational, racial, socioeconomic and other social inequities influence the wellbeing of all people”.⁵⁹⁴ This also means social workers pursue fair and equitable access to services.⁵⁹⁵

In addition, social workers are concerned about social exclusion and the potential impact on vulnerable persons. Social exclusion is defined in the *Code of Ethics* as,

People who are socially excluded are more economically and socially vulnerable and tend to have diminished life experiences. Social exclusion describes a state in which individuals are unable to participate fully in economic, social, political and cultural life, as well as the process leading to and sustaining such a state. Indigenous social exclusion resulting from colonialism and current social policies impacts education, income and employment and the inequitable distribution of resources.⁵⁹⁶

⁵⁹¹ CASW Position Statement, *supra* note 543 at 6.

⁵⁹² *Ibid* at 7.

⁵⁹³ CASW Code of Ethics, *supra* note 536 at 9.

⁵⁹⁴ *Ibid* at 11.

⁵⁹⁵ *Ibid* at 11.

⁵⁹⁶ *Ibid* at 33.

As discussed in Chapter 3, the Voluntary Provision is intended to protect vulnerable persons from being coerced or unduly influenced into MAID.⁵⁹⁷ The clinical social worker, who is attuned to viewing a person in the full context of their environment, is alert to the potential external factors that may be influencing a person's decision-making, while ensuring they are not presuming vulnerabilities based on characteristics of an individual or group.⁵⁹⁸ Social workers actively work to reduce barriers and expand choice for individuals, which is critical in all settings but especially when determining whether an individual is making an informed and voluntary request for MAID.⁵⁹⁹ It is inevitable that barriers will exist for some individuals to access health care services or other community supports, and these barriers will need to be considered when an individual is informed of the means to relieve their suffering and are offered potential consultations to assist with those means.

The ethical principles of the social work profession help to ensure that social workers do not impose personal biases, values or religious beliefs onto their clients.⁶⁰⁰ By encouraging and respecting self-determination, social workers are inclined to support an individual's autonomy and freedom of choice, subject only to concerns with respect to a client's capacity and voluntariness to make decisions.⁶⁰¹ This support for individual choice is present even when social workers fundamentally disagree with their client's decisions.⁶⁰² The client's needs and interests remain paramount when the social worker is able to clearly distinguish between her interests and those of the client.⁶⁰³ This is important in the MAID context as voluntariness may be vitiated by undue influence or coercion by health care providers, social workers included.⁶⁰⁴ All of these ethical principles suggest that social

⁵⁹⁷ *Carter BCSC*, *supra* note 6 at para 799–814.

⁵⁹⁸ First Report, *supra* note 22 at 15–16 and 28.

⁵⁹⁹ Scope of Practice, *supra* note 453 at 1; Standards of Practice, *supra* note 453 at B.2(b)(ii).

⁶⁰⁰ Standards of Practice, *supra* note 453 at 24; CASW Code of Ethics, *supra* note 536.

⁶⁰¹ *Oxford Textbook of Palliative Social Work* (Oxford: Oxford University Press, 2011) at 654 [Oxford Textbook].

⁶⁰² *Ibid.*

⁶⁰³ Standards of Practice, *supra* note 453 at 24; CASW Code of Ethics, *supra* note 536.

⁶⁰⁴ *Carter BCSC*, *supra* note 6 at paras 801, 810.

workers are invaluable in assessing the reasons for which a person is requesting MAID and have the ability to identify the external factors that may vitiate voluntariness.⁶⁰⁵

4.4 Unique Skills and Practice Areas

The social work profession respects diversity of beliefs and lifestyles of individuals and their social systems.⁶⁰⁶ The CASW has recognized the unique social work perspective in MAID, which considers the person-in-environment perspective, as integral to the support of Canadians considering MAID.⁶⁰⁷ Person-in-environment perspective in social work practice is a guiding principle that highlights the “importance of understanding an individual and individual behaviour in light of the environmental contexts in which that person lives and acts”.⁶⁰⁸ The environmental context includes social, political, familial, economic, spiritual, and family.⁶⁰⁹ This perspective has been accepted by the profession as “uniquely defining and differentiating social work” from related disciplines such as psychology, which is more person focused, and sociology, which is more structurally oriented.⁶¹⁰ This perspective may also increase the range of interventions that may be used to assist a client by intervening directly with the client or with aspects of their environment.⁶¹¹ Clinical social workers have experience in assessing all factors that might impact a client’s wellbeing, including physical, emotional, social, economic⁶¹² and spiritual.⁶¹³ The social factors are often referred to as the social determinants of health and are recognized as playing an important role in achieving health and well-being of

⁶⁰⁵ CASW Position Paper, *supra* note 516 at 7; Gina Bravo, *supra* note 537 at 194.

⁶⁰⁶ CASW Code of Ethics, *supra* note 536 at Preamble.

⁶⁰⁷ CASW Position Paper, *supra* note 516 at 3.

⁶⁰⁸ Mary Ellen Kondrat, “Person in Environment, Encyclopedia of Social Work” (June 11, 2013) *National Association of Social Workers Press and Oxford university*, <https://doi.org/10.1093/acrefore/9780199975839.013.285>

⁶⁰⁹ Mary Ellen Kondrat, Person in Environment, May 5, 2017, Introduction DOI: 10.1093/OBO/9780195389678-0092: [Person-in-Environment - Social Work - Oxford Bibliographies \(uwo.ca\)](#) [Person in Environment].

⁶¹⁰ *Ibid.*

⁶¹¹ *Ibid.*

⁶¹² Kathy Faber-Langendoen, MD, and Jason H.T. Karlawish, “Should Assisted Suicide Be Only Physician Assisted?” (2000) 132(6) *Annals of Internal Medicine* 482 at 484 [Kathy Faber].

⁶¹³ CASW Position Paper, *supra* note 516 at 4; Kelsey Antifaeff, *supra* note 553 at 186.

Canadians⁶¹⁴ and include a broad range of issues, including income, employment, and access to adequate housing, among others.⁶¹⁵ The social determinants of health are well known by social workers⁶¹⁶ and social workers are equipped to identify the social determinants that may be impacting an individual and offer resources to address these issues. The resulting impact on one's quality of life and suffering may motivate or influence a person to request MAID.

Evidence suggests that social workers have already been recognized as providing a valuable resource on clinical teams in a variety of ways, including providing consultative support to other social workers and other professionals involved in the facilitation of MAID.⁶¹⁷ As members of an multidisciplinary team, social workers provide the following services within the MAID context: therapeutic counselling services, information, biopsychosocial assessments, supports to clients and clients' families and networks, and referrals to services.⁶¹⁸ These services form the basis of social work practice in the MAID context; however, further analysis is required to understand the nuances and complexity of the role of social workers within this context, including their involvement in assisting with assessing the voluntariness of a request for MAID. Although beyond the scope of this paper, the CASW highlights the involvement of social workers in MAID extends to include psychosocial support to families, caregivers and other professionals involved in the assessment and treatment of the patient.⁶¹⁹

Social workers are able to assist with assessing the voluntariness of a MAID request by conducting a thorough biopsychosocial assessment, which identifies patient concerns and unmet needs that may contribute to a person's request for MAID.⁶²⁰ Through these assessments, significant information is elicited and can identify potential barriers to

⁶¹⁴ Canadian Association of Social Workers, *The Canada Social Transfer and The Social Determinants of Health Final Report* (2013) at page 8 [CASW Social Determinants of Health].

⁶¹⁵ Mikkonen, J., & Raphael, D., *Social Determinants of Health: The Canadian Facts* (Toronto: York University School of Health Policy and Management, 2010).

⁶¹⁶ Canadian Association of Social Workers, *Safety, Community and Social Work: Possibilities for Canadians* (2022) at 20.

⁶¹⁷ CASW Position Paper, *supra* note 516 at 5.

⁶¹⁸ *Ibid.*

⁶¹⁹ *Ibid.*

⁶²⁰ Kelsey Antifaeff, *supra* note 553 at 186; CASW Social Work in Health, *supra* note 534 at 2.

addressing unmet needs.⁶²¹ If unmet needs are identified, further steps would be required to determine the possible solutions to meeting those needs, and the extent to which those unmet needs may be influencing or motivating an individual's request for MAID. Although Practitioners are aware of the potential impact of the social determinants of health on the wellbeing of a patient, generally, they are not well positioned to be able to identify the community supports available. This can be demonstrated by the role of social workers in discharge planning. Although it is a physician decision to discharge a patient, the social worker plays a critical role in developing discharge plans and involves assisting with social assistance applications (i.e., disability support payments), housing applications and contacting service providers.⁶²² Precarious housing and access to social assistance are external pressures that could influence a person to request MAID.

The impact of unmet needs cannot be presumed as each person's unique context will need to be evaluated to determine the actual impact on the person's request for MAID. The biopsychosocial assessment can also help screen for coercive factors that may be influencing or motivating a person.⁶²³ Coercive factors may include family dynamics, inadequate housing, economic pressures, food insecurity, poor access to health care services and mental health concerns.⁶²⁴ Confronting potential coercive factors and undue influence are best addressed by those who have expertise in biopsychosocial assessments, including clinical social workers, and physician involvement alone is insufficient.⁶²⁵ A survey of social workers' experiences with MAID in Quebec was completed in 2023, and found social workers are increasingly encountering clients who wish to die with assistance.⁶²⁶ This study suggested social workers may help clients by distinguishing care options and make decisions based on their values, and investigate the impact of personal

⁶²¹ Kelsey Antifaef, *supra* note 553 at 186; Kathy Faber, *supra* note 612 at 484; CASW Standards of Practice, *supra* note 453 at B.2(b)(ii).

⁶²² Centre for Addiction & Mental Health, *A Typical Day for a CAMH Inpatient Social Worker*, [A Typical Day for a CAMH Inpatient Social Worker | CAMH](#)

⁶²³ Kathy Faber, *supra* note 612 at 484.

⁶²⁴ CASW Position Paper, *supra* note 516 at 3.

⁶²⁵ Kathy Faber, *supra* note 612 at 484.

⁶²⁶ Gina Bravo, *supra* note 537 at 194.

and contextual factors on motivations for an assisted death.⁶²⁷ Notably, 59.6% of the survey respondents reported they were involved in the assessment of a patient’s “social functioning”.⁶²⁸ Unfortunately, “social functioning” is not further explained but it is reasonable to presume this includes, at least in part, an assessment of the social determinants of health. In another recent research project, social workers viewed their roles as beginning earlier and extending after the provisions, compared to nurses.⁶²⁹ Further, they found the MAID context afforded a “unique opportunity to employ the full gamut of their skills”.⁶³⁰ Given the duration for which social workers are engaged with the patient, along with the number of touch points, they are well positioned to be able to complete thorough assessments for voluntariness. For example, ambivalence is concerned with ensuring a consistent and enduring request. Multiple touch points from the beginning of the process to the day of provision, would allow the social worker to confirm the request was consistent and enduring during that period of time. The role of clinical social workers in the context of MAID is further supported by Kelsey Antifaeff’s recent journal article, which highlights the “integral role” of social workers in providing psychosocial care and are trained to understand the personal and contextual factors informing a request for MAID.⁶³¹ To assess the personal and contextual factors, a biopsychosocial assessment is conducted and begins early on in the process.⁶³² Early commencement of the assessment affords time for unmet needs to be addressed or to determine that despite having an unmet need, there are no reasonable means to address it. There is limited literature on the role of social workers in MAID as the research has largely focused on the role of the Practitioner. Despite the limited literature, the role of the social worker is made clear based on their existing skill, knowledge and training in other health care contexts, along with the emerging literature specific to MAID.

⁶²⁷ *Ibid.*

⁶²⁸ *Ibid* at 198.

⁶²⁹ Debbie Selby, *supra* note 542 at 44.

⁶³⁰ *Ibid.*

⁶³¹ Kelsey Antifaeff, *supra* note 553 at 185.

⁶³² *Ibid* at 186.

4.5 Conclusion

The role of clinical social work in the MAID context has been contemplated by the legislature, in the Expert Reports, the Model MAID Practice Standards and the CASW. The importance of their role has also been demonstrated in practice by identifying the unique skills and scope of clinical social work practice in health care generally, and specifically within the MAID context. The person-in-environment perspective provides a lens to the assessment of voluntariness that is unique to the social work profession and may increase the range of interventions available to assist with external pressures impacting a patient. The environmental context is a critical factor when assessing voluntariness, and social workers are trained to consider the social determinants of health and whether they are influencing a person's request for MAID. The social determinants of health, along with other factors, can be assessed using the biopsychosocial assessment, which social workers are well versed in. Social work is concerned with the protection of vulnerable persons, but it is also concerned with upholding the patient's right to self-determination and bodily autonomy. These values guide social work practice and supports an approach that is neither over or under restrictive, whereby individuals are assessed on a case-by-case basis and vulnerabilities are not presumed.

The assessment of voluntariness should be started as soon as possible to provide adequate time for the patient to have an opportunity to access services that have been identified as potentially able to help alleviate their suffering, by addressing external pressures. The first step in the assessment is to identify the possible sources of external pressure, followed by consideration of the extent to which the external pressures are influencing decision-making. In complex MAID matters, where there may be a significant environmental context, the assessment of voluntariness may take multiple meetings with the patient to identify the external pressures and whether the patient has any unmet needs, for which may be met with further referrals to community and health care supports. If the patient accesses further support services, the clinical social worker needs to assess the effect of those services on alleviating the patient's suffering and provide a recommendation on the voluntariness of the patient's request for MAID. The nature of social work practice often means social work is engaged over a period of time, with multiple touch points, making

them well positioned to complete thorough assessments. Voluntariness is intricately connected to the patient's access to health care and community services, the extent to which the patient has unmet needs, whether social, physical, emotional, economic, and spiritual, and undue influence from friends, family or health care providers, all of which could be considered coercive factors that may vitiate the voluntariness of a person's request for MAID. As evidence above, social workers are well positioned to do this work and provide invaluable information and recommendations to the Practitioners with respect to the voluntariness of the patient's request for MAID. In the following chapter, the role of the social worker will be further explored in the context of a framework for assessing voluntariness.

Chapter 5

5 A Framework for Assessing the Voluntariness of a MAID Request

The preceding chapters provide a comprehensive review of how voluntariness has been considered in the MAID jurisprudence and related government reports, as well as other areas of law where voluntariness is contemplated. Important information was gleaned from this review that helps inform the key considerations that must be taken into account when assessing whether a request for MAID has been made voluntarily and is not the result of external pressures. This project contends that voluntariness is best assessed within a framework that identifies clear roles and responsibilities for a multidisciplinary team.⁶³³ In addition to the multi-disciplinary team involved in the administration of MAID, ethical and legal perspectives are also important to consider on a consultative basis. This Chapter formulates this framework to assess the voluntariness of a MAID request by identifying the specific factors that require consideration to ensure coercion or undue influence are not impacting a person's decision making, while also assessing ambivalence. This includes consideration of the contextual nature of these assessments, whereby voluntariness is not presumed but independently assessed on a case-by-case basis. Within this framework, social workers play an important role, as they are well positioned to complete an assessment of voluntariness by way of a biopsychosocial assessment. This assessment can identify factors that may compromise the autonomy of a person and provides a protective layer to those who may be vulnerable to abuse, coercion, or undue influence.⁶³⁴ Specifically, the biopsychosocial assessment can identify a person's unmet needs, potential resources to meet their needs, and vulnerability that, if addressed, may impact their decision to pursue an assisted death. The proposed legal framework can provide confidence

⁶³³ First Report, *supra* note 22 at 70–71; Canadian Psychiatric Association Committee on Professional Standards and Practice, (2023). Position Paper, *Capacity Assessments, and the Assessment of Voluntariness in the Context of MAID Legislation: The Role and Responsibility of Psychiatrists* at 9 [Canadian Psychiatric Association].

⁶³⁴ *Ibid* at 11.

to Practitioners when formulating an opinion on whether a request for MAID is voluntary. For clarity, this framework does not provide clinical practice direction on how to complete the clinical assessment but rather provides the legal factors that must be considered when completing the clinical assessment for voluntariness.

This Chapter starts by contending with the conflation of capacity and voluntariness assessments. The current framing of the voluntariness assessment falling within the capacity assessment is inaccurate, and the importance of each criterion is watered down as a result. Instead, here a clear framework for assessing voluntariness is formulated and identifies three prongs that must be considered, namely: vulnerability, coercion and undue influence, and ambivalence. The framework guides the assessment of vulnerability, coercion and undue influence by identifying a variety of external pressures that ought to be considered when determining the voluntariness of a request for MAID. Ambivalence, the third prong, requires the patient to provide an enduring and consistent request for MAID. Each is addressed in turn. Highlighted throughout each of these prongs is the role of the social worker and the biopsychosocial assessment that supports compliance with the Voluntary Provision and safeguards vulnerable persons.

5.1 Conflation of Capacity and Voluntariness Assessments

In the BCSC's decision in *Carter*,⁶³⁵ and the First Report⁶³⁶, it was suggested that voluntariness could be accurately assessed by way of capacity assessment. However, this conflation of capacity and voluntariness assessments does not seem to have been translated into the *Criminal Code*, as the legislature separated the requirements for capacity and voluntariness and created two independent eligibility criteria, namely section 241.2(2)(b), which requires the patient to be at least 18 years of age and capable of making decisions with respect to their health, and section 241.2(2)(d), which is the Voluntary Provision. Although the assessment of voluntariness may be partly informed by information gathered

⁶³⁵ *Carter BCSC*, *supra* note 6 at para 800.

⁶³⁶ First Report, *supra* note 22 at 70–71.

during the capacity assessment, a determination of voluntariness is not the same as an assessment of capacity to consent to MAID. This part of the Chapter identifies three significant concerns with this conflation: (1) there are conflicting legal presumptions; (2) the potential for inaccurate assessments due to failing to consider the right factors; and (3) although Practitioners have the requisite skill set to assess capacity, social workers have a more appropriate skill set to thoroughly assess voluntariness. Practitioners and social workers are both necessary members of the multidisciplinary team for the delivery of MAID, which reinforces the need for clear roles and responsibilities.⁶³⁷ Whether a person's request for MAID is voluntary is a separate issue from whether they have the requisite capacity to consent to treatment and conflating the two issues increases the risk of inaccurate assessments of capacity and voluntariness.

5.1.1 Conflicting Legal Presumptions

It is inaccurate to conflate the capacity and voluntariness assessments due to conflicting presumptions. In its 2003 decision *Starson v Swayze*, the SCC confirmed the law presumes an adult is capable to decide to accept or reject medical treatment.⁶³⁸ The presumption is founded in the respect of fundamental societal values, namely: autonomy and self-determination.⁶³⁹ The SCC found the “right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy” and unwarranted findings of incapacity “severely infringes upon a person’s right to self-determination.”⁶⁴⁰ Thus, the presumption of capacity is concerned with respecting the person’s bodily autonomy and self-determination and can only be displaced by evidence to the contrary, placing the burden of proof on the party that seeks to infringe on these rights. In other words, it is the responsibility of the health care provider (or whomever is challenging the presumption) to adduce evidence that a person lacks the requisite capacity. This is necessarily a contextually based decision, as capacity is a fluctuating concept, with the requisite capacity

⁶³⁷ *Ibid.*

⁶³⁸ *Starson*, *supra* note 515 at para 77.

⁶³⁹ *Ibid* at para 7.

⁶⁴⁰ *Ibid* at para 75.

needed being determined by the type of decision being made.⁶⁴¹ Similar to the presumption of capacity, which honors the fundamental values of self-determination and autonomy, the requirement to assess voluntariness is a safeguard to ensure that a decision is being made freely in furtherance of self-determination and bodily autonomy.

Akin to the confessions rule, there is no presumption that a request for MAID is voluntary, and the Practitioner must consider specific factors to determine voluntariness.⁶⁴² These assessments necessitate a context-based analysis that can account for the varied circumstances of the individual and requires a conversation between the health care provider and the patient.⁶⁴³ A presumption of voluntariness would not reflect the need for a conversation to assess whether coercion or undue influence are influencing a patient's request for MAID. Dependent on the nuances of the case, the assessment of voluntariness may be more comprehensive and require multiple appointments to tease apart potential external pressures that may be influencing a request. For example, a Practitioner completes a MAID eligibility assessment for an individual who is unhappy in their supportive living facility, and they advise the Practitioner they are awaiting a transfer to their preferred facility. Based on the initial assessment, the Practitioner thinks the patient's less than desirable living situation may be influencing their request for MAID and determines to put the eligibility assessment on hold until the patient is transferred to their preferred living facility. Three weeks pass and the Practitioner connects with the patient and learns they have been moved to their preferred facility and they are enjoying their co-residents and the social activities. The patient advises the Practitioner they want to stop their MAID application as their sense of suffering has reduced since being transferred. Indeed, this has been my professional experience and I have seen the potential benefit of pausing or slowing the process to account for an anticipated change in circumstance that may improve the patient's sense of suffering.

⁶⁴¹ Leanne E. Tran, *supra* note 516 at 6; *Starson*, *supra* note 515 at para 118.

⁶⁴² Lisa Dufraimont, *supra* note 348.

⁶⁴³ Fourth Report, *supra* note 428 at 123; Canadian Psychiatric Association, *supra* note 633.

Again, similar to the confessions rule, the stakes of a MAID request are high, and the decision irreversible. It thus warrants a heightened responsibility for ensuring the decision to proceed is voluntary. This interpretation is particularly persuasive considering the confessions rule arises in the criminal context, and so does the Voluntary Provision.⁶⁴⁴

5.1.2 Consideration of Different Factors

At law, capacity speaks to the patient's *ability* to understand the information related to the proposed treatment and to *appreciate* the reasonably foreseeable consequences of the decision or lack of one.⁶⁴⁵ These do not speak to *why* a patient is making a decision. Capacity is not typically understood as something that depends on the socio-economic factors or that takes into account external pressures that may place a person in a vulnerable situation. Rather, a person may have the capacity to make a decision and yet still be subject to coercion or undue influence arising from external pressures that renders the decision involuntary. A person without capacity, however, can never be *subject to* external pressures rendering a decision involuntary, as they are not making any decisions but are entirely in the hands of an alternate decision maker. *Why* a decision is being made by a patient is different than *if* a patient can make a decision in the first place. Here the voluntariness of the request is only a relevant consideration after the *if* is determined; that is, only after it has been determined that a patient has the requisite capacity to make a decision is it necessary to consider the voluntariness of that decision.

The determination that a person lacks capacity regarding personal matters can have significant implications for a person's autonomy and self-determination. For example, in the health care context, when an adult is determined to lack capacity with respect to health care, they no longer have the legal authority to make health care decisions. In these situations, an alternate decision maker is appointed and effectively steps into the shoes of the incapable adult and assumes all legal decision making over matters related to health care.

⁶⁴⁴ R. Graham 2001, *supra* note 36 at 101.

⁶⁴⁵ *Starson*, *supra* note 515.

As reviewed above, voluntariness has been interpreted within various areas of law to require the assessment of the possible impact of coercion and undue influence on the decision-making process and does not intertwine this was the assessment of capacity. Coercion and undue influence are understood as *external pressures* that individuals may experience from a variety of sources.⁶⁴⁶ Influence will be seen as undue when it rises to the level of fraud, deceit, duress, or coercion.⁶⁴⁷ The extensive review of the jurisprudence in chapters two and three identified the possible external pressures that may be seen as coercive or unduly influencing. These external pressures can be summarized to include socio-economic⁶⁴⁸, scarce institutional resources⁶⁴⁹, friends, family and authority figures⁶⁵⁰, power imbalances⁶⁵¹, misrepresentation⁶⁵², lack of information⁶⁵³, mental disorder and suicidality⁶⁵⁴, and situations of involuntariness.⁶⁵⁵ Further, the assessment of voluntariness must consider ambivalence by determining whether the request for MAID is enduring and consistent.⁶⁵⁶ In order to assess these factors, it is necessary to step outside of a purely medical model and identify the environmental context that may be impacting a patient's wellbeing. One of the questions being asked by the Voluntary Provision is, whether there are any external pressures that may be influencing the patient's decision making. Social workers have the ability to identify these external pressures based on their unique patient-in-environment perspective and experience working with vulnerable persons. Ambivalence requires an assessment of any potential internal conflict regarding whether the proceed with MAID. In the absence of a consistent and enduring request for MAID, the voluntariness of the request for MAID is questionable. Although a Practitioner may have the skill to identify ambivalence, it is important that the assessment of

⁶⁴⁶ First Report, *supra* note 22 at 69.

⁶⁴⁷ *Ibid.*

⁶⁴⁸ *Ibid.*; Second Report, *supra* note 411 at 28; Fifth Report, *supra* note 441 at 11, 62.

⁶⁴⁹ Special Senate Committee, *supra* note 57 at 28.

⁶⁵⁰ Second Report, *supra* note 411 at 28; *Reibl*, *supra* note 515 at 11.

⁶⁵¹ *Hobbins*, *supra* note 447 at paras 556–557; *Oickle*, *supra* note 475 at para 27; *Morrison*, *supra* note 502.

⁶⁵² *Norberg*, *supra* note 502 at para 29; *Reibl*, *supra* note 515 at para 11.

⁶⁵³ *Reibl*, *supra* note 515 at para 11; *Payette*, *supra* note 384 at para 29;

⁶⁵⁴ First Report, *supra* note 22 at 70; Fifth Report, *supra* note 441 at 45; *Henaire*, *supra* note 384 at para 36; *CV*, *supra* note 384 at para 17; *Sinclair*, *supra* note 384 at para 38.

⁶⁵⁵ Model MAID Practice Standard, *supra* note 347; Fifth Report, *supra* note 441 at 67.

⁶⁵⁶ *Menard*, *supra* note 384 at para 30; First Report, *supra* note 22 at 70–71.

voluntariness is not piecemeal, but rather holistic in nature whereby all factors, external and internal, that may be influencing a patient's decision, are considered and assessments made based on the totality of the information before the social worker. To complete an assessment of the legal factors to determine voluntariness, requires significant time that may require multiple appointments. Social workers, in comparison to Practitioners, typically spend more time with the patient affording the necessary time and space to identify, address and mitigate concerns related to potential vulnerability.⁶⁵⁷

5.1.3 Different Skill Sets

The *Criminal Code* requires Practitioners to formulate opinions on eligibility and to ensure all safeguards are met prior to the provisioning of MAID.⁶⁵⁸ Although the accountability rests with the Practitioner to form an opinion on eligibility, it does not preclude others from being involved in the assessment process. In Alberta, capacity assessors are professionals who are qualified to evaluate an adult's ability to make decisions, and, provided they are trained and meet certain requirements, social workers can be designated as capacity assessors.⁶⁵⁹ Prior to conducting a capacity assessment, the capacity assessor must obtain confirmation that a medical evaluation of the adult was conducted within the three month period preceding the capacity assessment and the results did not indicate the adult was suffering from a reversible temporary medical condition that appeared likely to have a significant impact on the adult's capacity to make personal matters (including health care decisions).⁶⁶⁰ Although the medical evaluation falls within the scope of the Practitioner, it falls within the scope of the social worker to consider the ability of the adult to understand the information that is relevant to a decision, and appreciate the reasonably foreseeable consequences of a decision, and a failure to make a decision.⁶⁶¹ Meaning, a Practitioner must play a role in completing the first step of the capacity assessment, namely the medical

⁶⁵⁷ Ogden, *supra* note 579 at 163.

⁶⁵⁸ *Criminal Code*, *supra* note 3, at ss 241.2(3), 241.2(3.1).

⁶⁵⁹ *Adult Guardianship and Trusteeship Regulation*, Alta Reg 219/2009 section 6(f) [AGTA Regulation].

⁶⁶⁰ *Ibid* at s 4(2)(b).

⁶⁶¹ *Ibid* at s 4(6).

evaluation; however, they social worker is able to conduct a portion of the assessment that could then be relied upon by the Practitioner.

Social workers have been identified as having the ability to assess unmet needs that may impact the voluntariness of the request for MAID.⁶⁶² These assessments require an in-depth consideration of psychosocial and family factors by a “team of professionals well beyond medicine”.⁶⁶³ The importance of including a multi-disciplinary team in the MAID context cannot be understated and acts as an important safeguard, recognizing the complexity of the MAID context.

Through the biopsychosocial assessment, social workers are capable of identifying unmet needs, potential health care and community supports to meet those needs, and vulnerability⁶⁶⁴, all of which help to inform whether a person’s request for MAID is voluntary. From the beginning, there has been ongoing discourse related to the potential vulnerability of individual’s accessing MAID. As outlined in the review of the Expert Reports, for the purposes of this paper, vulnerability can be understood in two ways: structural vulnerability, which refers to the “impacts of the interaction of demographic attributes (i.e., sex, gender, socioeconomic status, race/ethnicity), with assumed or attributed statuses related to one’s position in prevailing social, cultural, and political hierarchies”,⁶⁶⁵ and situational vulnerability, which refers to “vulnerability that is context specific”.⁶⁶⁶ Justice Smith made it clear in *Carter BCSC* that vulnerability is not unique to the MAID context and is “implicitly condoned” for life-and-death decision-making.⁶⁶⁷ The SCC affirmed Smith’s J. finding that a “permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error” and vulnerability could be assessed using existing procedures and assessment tools.⁶⁶⁸

⁶⁶² First Report, *supra* note 22 at 87–88.

⁶⁶³ Canada, Parliament, Senate, Standing Committee on Justice and Human Rights, 42nd Parl, 1st Sess, No. 013, (May 4, 2016) at page 6.

⁶⁶⁴ Gina Bravo, *supra* note 537 at 197; Jamie K. Fujioka, *supra* note 581; Miller PJ, *supra* note 453.

⁶⁶⁵ Fifth Report, *supra* note 441 at 11.

⁶⁶⁶ Fourth Report, *supra* note 428 at 55.

⁶⁶⁷ *Carter SCC*, *supra* note 1 at para 116.

⁶⁶⁸ *Carter SCC*, *supra* note 1 at para 115.

The following builds on the utility of the biopsychosocial assessment in assessing voluntariness by exploring the unique considerations for social workers when assessing unmet needs, supports and vulnerability.

5.1.4 Benefits of Separating the Capacity and Voluntariness Assessments

The result of intertwining the assessment of capacity and voluntariness could unreasonably restrict a patient's decision-making capacity with respect to health care decisions. If we included voluntariness within the capacity assessment, there is the risk that one is found to lack capacity because they are not making a voluntary choice. In other words, the decision to request MAID may be used to justify a finding of incapacity solely on the basis of the effects of external pressures on decision making, rather than organic physiological issues that impair one's *ability* to understand the information related to the proposed treatment and to *appreciate* the reasonably foreseeable consequences of the decision or lack of one.⁶⁶⁹ That would lead to absurd results in that a capable patient could be found not to be capable on the basis their request is not voluntary.

The assessment of voluntariness should be treated separately from the assessment of capacity. An assessment of capacity asks if a person has the requisite ability to understand the relevant information and to appreciate the reasonably foreseeable consequences.⁶⁷⁰ Whereas, voluntariness is seeking to determine the influence, if any, of external pressures on decision making. An example helps to demonstrate how voluntariness is seeking to address something different than a capacity assessment. An adult patient attends a unit with their significant other and when the partner leaves the room the patient discloses they are being coerced by their partner to have an abortion. Upon learning this, the health care provider's reaction is not to deem the patient as lacking capacity, rather the health care provider would seek to address the external pressure and the impact on the patient's

⁶⁶⁹ Starson, *supra* note 515.

⁶⁷⁰ *Ibid* at para 13.

decision-making autonomy. In effect, the remedy provided in the circumstances are very different. If a patient is determined to lack capacity, their decision-making authority is removed and a substitute decision maker is identified to step into the patient's shoes. However, if a patient's request for a health care service is considered not to be voluntary as a result of coercion, the remedy is not to remove the person's decision-making authority but rather to support them in addressing the external pressure and honoring the patient's right to self-determination and autonomy by alleviating or attempting to alleviate, the influence of the external pressure. Conflating the two, risks undermining these fundamental values.

5.2 Framework: Voluntariness Assessment

In Canada, MAID is still relatively new and has received little judicial consideration since the passing of Bill C-14. Bill C-7 further expanded MAID to include persons whose natural death is not reasonably foreseeable and thus opened the door to individuals who present with different complexities than those whose natural death is reasonably foreseeable.⁶⁷¹ This expansion was, in part, the catalyst for questions related to what it means to make a voluntary request for MAID that is not the result of external pressure.⁶⁷² This was also reflected in my professional practice and the types of fact scenarios that were arising. For example, some Practitioners would identify cases where patients requesting MAID have lived with a chronic health issue for numerous years that has disadvantaged them in the workplace, with consequential impacts on housing, food security, access to pharmaceuticals, etc. The legal issue in these cases was whether the Practitioner can satisfy themselves that the patient meets the eligibility criteria for a grievous and irremediable medical condition in that their intolerable suffering arose from their underlying medical condition and not external pressures.⁶⁷³

⁶⁷¹ Second Report, *supra* note 411 at 17. This is also based on my professional experience practicing as a health lawyer and specializing in MAID.

⁶⁷² Jocelyn Downie, *supra* note 19 at 665.

⁶⁷³ *Criminal Code*, *supra* note 3 at s241.2(2)(c).

In some cases, it was increasingly difficult to identify what was driving the request for MAID and how to determine the extent to which one's social circumstances were contributing to their intolerable suffering. At the same time, restricting choice of an individual that meets the eligibility criteria raises considerable ethical questions about the appropriateness of that restriction of autonomy, which is not based on capacity concerns but the subjective assessment of what may constitute vulnerability, such that voluntariness is vitiated. Throughout these matters, it became clear that a legal framework that identifies legal considerations for assessing voluntariness would afford the appropriate balancing of autonomy and self-determination, in alignment with the purpose of the Voluntary Provision, which is to protect vulnerable persons from coercion, undue influence and potential effects of ambivalence.⁶⁷⁴

It is necessary work to tease apart what external pressures are merely present, from those that may be the motivation for the MAID request. The mere existence of external pressures does not automatically infer the patient's request for MAID is involuntary, and the degree to which those external pressures are influencing a person's decision must be considered.⁶⁷⁵ A good starting place for this assessment is, but for the external pressures, would the patient request MAID? The legislation only requires the request for MAID to not be the result of external pressures but does not require there to be an absence of external pressures. Indeed, most people have some form of external pressure, but this does not automatically mean the external pressure vitiates voluntariness.

The framework for assessing voluntariness must consider the legal factors and identify *who* is skilled or competent for completing the assessment. Although it is beyond the scope of this paper to explain *how* to conduct the assessments – a determination that would be influenced by each province's regulatory environment and standards of care – it is posited here that social workers can conduct these assessments from a person-in-environment

⁶⁷⁴ *Carter BCSC*, *supra* note 6 at paras 800–815.

⁶⁷⁵ *Oickle*, *supra* note 475 at para 32; *Morrison*, *supra* note 502; *Norberg*, *supra* note 502 at para 29; *Sorenson*, *supra* note 310 at para 20; *Payette*, *supra* note 384 at para 29; *BA*, *supra* note 384 at para 50; Canadian Psychiatric Association, *supra* note 633 at 8.

perspective that is keenly aware of the biopsychosocial factors that may influence an individual to pursue MAID.⁶⁷⁶

5.2.1 Vulnerability Requires a Case-by-Case Assessment

It is recognized that individuals may be motivated to request MAID by a range of factors that are unrelated to their medical diagnosis. These factors may make some individuals vulnerable to request MAID when their desire stems from a failing of the social system to meet their basic needs such as access to health care, stable housing and food security.⁶⁷⁷ You'll recall from chapter 2, coercion and undue influence are external pressures that arise from "society at large" including the various vulnerabilities being addressed here.⁶⁷⁸ Vulnerability cannot be presumed based on characteristics of the patient or the patient's identification with a group or illness; recall the objection to presumptions about this, as discussed above. Rather, someone may be vulnerable in particular situations when "personal autonomy, status, wealth, and well-being are compromised in any significant way".⁶⁷⁹ Meaning, the assessment of vulnerability requires an individual assessment with particular attention paid to biopsychosocial factors that are not simply present but are *impacting* or *influencing* a person's request for MAID. The Second Report highlighted concerns with vulnerabilities associated with those persons living in poverty and/or living with mental health concerns.⁶⁸⁰ These concerns were reiterated by the Council of Canadian Academies, with specific attention given to persons whose sole underlying medical condition is mental disorder, that they might seek MAID as a means to escape chronically difficult circumstances such as homelessness, poverty and unemployment.⁶⁸¹ In 2016, a disability advocate testified before the Special Joint Committee on Physician-Assisted

⁶⁷⁶ CASW Position Statement, *supra* note 543 at 3–4; Kathy Faber, *supra* note 612 at 484; Kelsey Antifaeff, *supra* note 553 at 186.

⁶⁷⁷ There have been a number of recent news articles that speak to how poverty has influenced some individuals to access MAID: [How poverty, not pain, is driving Canadians with disabilities to consider medically-assisted death - National | Globalnews.ca](#)

⁶⁷⁸ First Report, *supra* note 22 at 69.

⁶⁷⁹ Second Report, *supra* note 411 at 15–16.

⁶⁸⁰ *Ibid* at 28.

⁶⁸¹ Fifth Report, *supra* note 441.

Suicide, and recognized the concern with socio-economic vulnerabilities, which may be increased for persons living with disabilities, but also highlighted the concern of further limiting or restricting their choices and autonomy based on presumed vulnerabilities.⁶⁸² Similar to presuming vulnerabilities, one cannot presume involuntariness as a consequence of existing vulnerabilities (which are, arguably, socially defined⁶⁸³) without first considering the extent to which those vulnerabilities are influencing or motivating a person's request for MAID. This is a contextual assessment that may be difficult in some cases to tease apart and requires a balance to protect vulnerable persons while respecting self-determination and autonomy.⁶⁸⁴

The Voluntary Provision requires Practitioners to balance the autonomy of the individual seeking MAID, while recognizing voluntariness may be vitiated by external pressures; however, there is a balancing required where this assessment is not too restrictive.⁶⁸⁵ Vulnerability includes two aspects: protection from exploitation and protection from exclusion,⁶⁸⁶ and we must be mindful not to be over or under inclusive.⁶⁸⁷ In most cases, vulnerabilities will exist, and we should not set a standard that requires ideal social circumstances where no vulnerabilities exist – this is not a reasonable interpretation.

Further, an individual's autonomy should not be restricted simply due to the failings of the social system that has been unable to adequately support them. Vulnerabilities should not be used to generally exclude a group from MAID, rather social workers and Practitioners must consider the impact of the vulnerability on the persons request for MAID by addressing them, offering reasonable means available to relieve the suffering, and to make all reasonable efforts to ensure the patient has access to those means. What this means in practice will vary, just as the needs of individuals will vary. As discussed above, social

⁶⁸² Second Report, *supra* note 411 at 17.

⁶⁸³ Disability is a social construct. By accepting that a person is vulnerable simply by reason of labelling them "disabled" is patronizing and infringes on the fundamental values of social determination and bodily autonomy.

⁶⁸⁴ Second Report, *supra* note 411 at 17.

⁶⁸⁵ *Ibid.*

⁶⁸⁶ Summary of Reports, *supra* note 426 at 5.

⁶⁸⁷ *Spencer*, *supra* note 494 at 11.

workers are already positioned in ways that Practitioners may not be to assist with this assessment. This may result in an iterative process whereby an individual may be offered supports to determine if it improves their suffering, followed by a re-assessment within a certain amount of time. Practitioners should work with social workers to determine, as required, the context that informs questions of the voluntariness of a request.

Voluntariness requires a contextual assessment that addresses various sources of vulnerability that may unduly influence a person's request for MAID. The jurisprudence and Expert Reports have largely identified these sources of vulnerability in broad strokes as coercion and undue influence, and to a lesser extent ambivalence. Ambivalence is largely seen as an individual's conflicting thoughts, and, although conflicts may arise due to external pressures, this also seeks to address internal dissonance regarding the decision to proceed with MAID. The following outlines each of these areas of external pressure.

5.2.2 Coercion and Undue Influence

From a legal perspective, the jurisprudence and government reports, often refer to coercion and undue influence together and do not distinguish the terms. In the First Report, Professor Wayne Sumner testified influence will be "undue" "when it rises to the level of fraud, deceit, duress, or coercion".⁶⁸⁸ In other words, it could be said that undue influence is coercion. It is acknowledged that there may be nuances between these terms in the field of ethics and clinical practice; however, considering this paper is focused on the legal interpretation of voluntariness, I have not reviewed the ethical perspective on coercion and undue influence.

To help clarify the meaning of coercion and undue influence, definitions from a position paper of the Canadian Psychiatric Association are used.⁶⁸⁹ The following definitions are not relied upon to legally interpret the Voluntary Provision as they are from a clinical

⁶⁸⁸ First Report, *supra* note 22 at 69.

⁶⁸⁹ Canadian Psychiatric Association, *supra* note 633.

perspective; however, there is utility in using these definitions to help tease apart the two terms for practical purposes:

Coercion: is the practice of persuading someone to do or to not do something by using force, pressure or threats, or by unjustly curtailing their options.

Undue Internal Influence: are the psychological processes by which a person's free will is constrained such that it causes the individual to act in a manner that is not consonant with their longstanding will and preferences.

Undue External Influence: is when a third party (e.g., family, friends, others) manipulates, pressures or uses excessive persuasion that causes the individual to act (or refrain from acting) in a manner that would benefit the influencer. The benefit is often financial but could also relate to other material or psychological gains, or to preserve the status quo.⁶⁹⁰

It is important to flag that the clinical definition for undue influence identifies two forms including external and internal undue influence. From a clinical assessment, teasing apart undue influence in this way may assist in the way questions are framed and the analysis of the responses. This falls within the clinical assessment domain but are instructive in formulating a legal opinion on whether undue influence is the driving force behind a request for MAID.

If unmet needs are identified and determined to be the sole or partial reason for the person's request for MAID, further steps will need to be taken to discuss these concerns with the patient. A patient will not be forced to consent to receiving services or supports to meet their unmet needs, however, if the unmet needs are influencing the decision to request MAID, it is unlikely a Practitioner will determine the request for MAID to be voluntary and not the result of external pressures. However, a person's unmet needs should be balanced with the reasonableness of meeting those needs as individuals should not be held "hostage to fixing systemic problems" and further reducing their autonomy.⁶⁹¹ These

⁶⁹⁰ *Ibid* at 8 to 9.

⁶⁹¹ Eighth Report, *supra* note 460 at 36.

situations will give rise to challenging ethical and legal considerations and warrant the involvement of clinical ethicists and health lawyers to assist.

The Model MAID Practice Standard suggests that undue influence includes past undue influence,⁶⁹² and is not further explained. The role of past undue influence in assessing a current request for MAID is unclear but could be used to suggest a person's potential susceptibility to undue influence. However, this approach could lead to very presumptuous and inaccurate outcomes that are not based on a present-day assessment of undue influence. This writer is cautious in how past undue influence is being used to inform an assessment of voluntariness. That said, depending on the facts of the case, a pattern of undue influence may be informative to a present concern. This reinforces the need for a case-by-case assessment of voluntariness.

Individuals who consult with trusted persons such as family members or friends on their decision to proceed with MAID should not automatically be seen as coerced or unduly influenced. It is common and often encouraged for patients to consult with trusted persons when making significant health care decisions, including MAID, and this does not necessarily negate the voluntariness of the request.⁶⁹³ Involving family members or friends in discussions, upon the consent of the patient, may help determine whether undue influence or coercion are a concern. If so, additional steps will need to be taken to consider the extent the influence or coercion is influencing or motivating an individual to request MAID. This may take place over several conversations with a patient. Subtle nuances may be picked up during informal conversations between the patient and the social worker, such as the patient conveying a sense of being a burden to family members or familial concerns about finances to care for the patient.

That said, these are all valid concerns that do not necessarily mean the patient's request is not voluntary but may invite an opportunity for further dialogue to ensure there is no coercion or undue influence. As identified in chapter 4, this may take multiple meetings

⁶⁹² Model MAID Practice Standard, *supra* note 347 at s 9.8.

⁶⁹³ Third Report, *supra* note 424 at 70, 147.

with a patient and, in matters with significant external pressures identified, it is likely to be an iterative assessment to ensure the patient is afforded the opportunity to access services that may alleviate their suffering. The social workers skill set is to address the individual concerns but also how the social determinants of health, or other social conditions, may be influencing an individual. The social worker also has the knowledge to identify unmet needs that fall outside of the clinical domain and into the social determinants of health. Specifically, social workers are trained at identifying resources and making referrals to social services that may be able to meet a patient's needs. Due to the nature of the social worker's role, they are able to spend more time with the patient affording the necessary time and space to identify address and mitigate concerns related to potential vulnerability.

While a patient will not be forced to access further treatment or support services to address unmet needs or other external pressures, depending on the assessed level of influence of the external pressures on the patient's request for MAID, the social worker may be unable to determine the request for MAID is voluntary.⁶⁹⁴ Section 241.2(1)(c) of the *Criminal Code* requires the patient to have a grievous and irremediable medical condition.⁶⁹⁵ A grievous and irremediable medical condition is defined as requiring the person to have a serious and incurable illness, disease, or disability; are in an advanced state of irreversible decline in capability; and the illness, disease, disability or advanced state of irreversible decline in capability causes the patient enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider appropriate.⁶⁹⁶ Despite there being a subjective element of the definition of a grievous and irremediable medical condition this writer suggests the patient must have attempted reasonable treatment and care options, in order for the Practitioner to clinically determine

⁶⁹⁵ *Criminal Code*, *supra* note 3.

⁶⁹⁶ *Criminal Code*, *supra* note 3 at s 241.2(2).

the patient’s grievous and irremediable medical condition is “incurable” and “irreversible”.⁶⁹⁷

5.2.3 Ambivalence

Ambivalence is an individual’s own potentially conflicting thoughts on whether to proceed with a decision.⁶⁹⁸ Ambivalence includes the duration of contemplation,⁶⁹⁹ along with the repeat nature of the request.⁷⁰⁰ Ambivalence may be flagged when a patient changes their mind about proceeding with MAID or their decision conflicts with fundamental values and belief systems, whereas non-ambivalence may be exhibited by an enduring and repeated request for MAID.⁷⁰¹ This assessment may require query of a patient’s belief and value system, such as religious beliefs and their views of what constitutes a good quality of life. For clarity, the rescheduling of a MAID provision for a later date does not in and of itself mean the patient is ambivalent. Rather, it invites another opportunity to have a conversation with the patient to address the issue. The study completed by Gina Bravo, and reviewed in chapter 4, suggests that social workers may help clients by distinguishing care options and make decisions based on their values. The identification of the patient’s values can also inform the social workers perspective on whether ambivalence is a concern by determining any inconsistency or conflict between the patient’s values and their request for MAID.⁷⁰² Another source of information to determine ambivalence is the patient’s family or close friends, and collateral information can be obtained from these sources to inform the assessment.⁷⁰³ The identification of ambivalence would certainly raise concerns about

⁶⁹⁷ Model MAID Practice Standard, *supra* note 347 at sections 9.4, 9.5, 9.6 and 9.7.

⁶⁹⁸ First Report, *supra* note 22 at 69.

⁶⁹⁹ *Sorenson*, *supra* note 310 at 20.

⁷⁰⁰ *Menard*, *supra* note 384 at 30.

⁷⁰¹ *Carter BCSC*, *supra* note 6 at 832.

⁷⁰² Gina Bravo, *supra* note 537 at 194.

⁷⁰³ From a patient centered perspective and health privacy law, consent for speaking with friends and family should be obtained from the patient. If the patient refuses to provide consent, it may be that there is not enough information to complete a MAID eligibility assessment generally, and specifically within the context of voluntariness. This is especially true when seeking to determine whether a family member or close friend is an external pressure unduly influencing or coercing a patient to request MAID (or not request MAID). The Model MAID Practice Standard also supports the collection of collateral information at s 10.3.4.2.

whether the patient wishes to proceed with MAID. In considering ambivalence, this writer suggests it is not fatal to a determination of voluntariness that a patient has concerns or conflicting thoughts about the decision to proceed with MAID. As in other end-of-life health care contexts, the stakes are high, and it is an emotionally charged situation. It is to be expected that patient's will struggle with these hard decisions while weighing their options.

The assistance of social workers is advantageous as they often have multiple points of contacts with the patient as they go through the assessment process for MAID. The collection of information may occur over the course of multiple encounters, providing a greater degree of assurance that there would be ample opportunity to identify ambivalence.

5.2.4 Framework Distilled

The following is a quick reference chart that outlines the legal framework for the assessment of voluntariness:

Legal Framework: Assessment of Voluntariness		
Guiding Principles:		
<ul style="list-style-type: none"> - Voluntariness requires an individual assessment that is contextual in nature. - Voluntariness shall not be presumed. - The legal framework is not intended to be rigid. Various factors may fit under multiple considerations. - The assessment of voluntariness may need to be paused to provide an opportunity for the person to access additional medical or community services that may improve their suffering. - The assessment must not be under or over inclusive. - Self-determination and bodily autonomy are fundamental values in Canadian society that are to be respected. - Individuals who are assessed as experiencing vulnerability must not have additional barriers to access MAID. - Inclusion of other perspectives such as nursing, clinical ethics, psychology, spiritual care, etc. is an important consideration. 		
Step	Key Consideration	Possible factors (not an exhaustive list)
1	Vulnerability: <ul style="list-style-type: none"> - Structural vulnerability impacts of the interaction of demographic 	<ul style="list-style-type: none"> - Social determinants of health (e.g., income, access

	<p>attributes (i.e., sex, gender, socioeconomic status, race/ethnicity), with assumed or attributed statuses related to one's position in prevailing social, cultural, and political hierarchies.</p> <ul style="list-style-type: none"> - Someone may be vulnerable in particular situations when personal autonomy, status, wealth, and well-being are compromised in any significant way. 	<p>to health care, food insecurity, homelessness).</p>
2	<p>Coercion and Undue Influence</p> <ul style="list-style-type: none"> - External undue influence is when a third part manipulates, pressures or uses excessive persuasion that causes the individual to act (or refrain from acting) in a manner that would benefit the influencer. - Internal undue influence are the psychological processes by which a person's free will is constrained such that it causes the individual to act in manner that is not consonant with their longstanding will and preferences. - Coercion is persuading someone to do or to not do something by using force, pressure or threats or by unjustly curtailing their options. 	<ul style="list-style-type: none"> - Family, friends, and health care providers. - Hopelessness, self-loathing. - Involuntary detainment. - Subtle pressures from family about the cost of caregiving or burden of care. - Threats of placing a person in a nursing home.
3	<p>Ambivalence</p> <ul style="list-style-type: none"> - Consider the enduring nature of the request. - Consider the patient's values, beliefs and goals and the request for MAID. 	<ul style="list-style-type: none"> - Repeat cancellation of MAID provision date - Inconsistency between values, beliefs and goals and the request for MAID - Constant reconsideration of pursuing MAID

5.3 Conclusion

A framework for the assessment of voluntariness that identifies a key role for social workers, along with factors that must be considered, helps to inform practice, increase confidence of health care providers in their assessment of a MAID request, improves compliance with the law, and helps maintain the trust of the public in the MAID regime.

Ensuring public confidence in the MAID regime has recently been exhibited by a court challenge I am presently involved in, wherein a patient's father was granted an injunction preventing the patient, from provisioning MAID the day before her scheduled provision. In part, the injunction was granted due to alleged concerns with deficiencies in both the eligibility assessments and the MAID process. The allegations of the father, in part, generally relate to the patient's vulnerability and susceptibility to undue influence and coercion arising from her alleged disability.

The development of the framework has highlighted that many of the MAID eligibility criteria and safeguards overlap, and it is hard, and largely unnecessary, to create firm boundaries between the criteria. For example, the social determinants of health can be used to guide a biopsychosocial assessment that identifies unmet needs that may increase a person's vulnerability such as to vitiate voluntariness. At the same time, this assessment assists with identifying potential other sources impacting a person's intolerable suffering. If the person's intolerable suffering arises not as a result of the underlying medical condition but as a result of a potential socio-economic issue, this criterion has not been met. By reasonably addressing the social determinants of health, the health care team can satisfy themselves that the criteria have been met and the person is not accessing MAID for non-medical reasons.

This writer acknowledges there are ethical arguments related to why a patient ought not be excluded from MAID as a result of external pressures for which the individual has no control over.⁷⁰⁴ However, for the purposes of this paper, this writer is strictly speaking to the legal considerations that are based on the current iteration of the MAID law. Further, as a lawyer that provides advice to Practitioners, social workers and administrators, my duty is to my client and ensuring their rights and interests are protected. In some cases, this may conflict with the position or stance of advocates in this domain who are solely looking at the issue from a patient centered perspective.

⁷⁰⁴ Wiebe K, Mullin A. J Med Ethics Epub ahead of print: April 2, 2024. doi:10.1136/jme-2022-108871

Chapter 6

6 Conclusion

6.1 Summary

Throughout the evolution of MAID in Canada, the common theme has been the balancing of competing interests of respect for bodily autonomy and self-determination with the protection of vulnerable persons. The development of the MAID regime reflects these interests and, dependent on the nature of the MAID request, the Voluntary Provision acts as a critical safeguard to ensure the request for MAID is a result of intolerable suffering that arises from the underlying illness, disability, disease, or state of decline in capability, and not as a result of external pressures. The expansion to include Track 2 patients, those patients whose death is not reasonably foreseeable, has increased concerns about how to confidently identify the motivations for the MAID request and the potential sources of external pressure that may vitiate voluntariness. The development of a framework that identifies key legal factors to be considered when assessing voluntariness, along with the unique skill set of social workers to inform this assessment, is a means to ensure the lawful provision of MAID. Further, it invites an opportunity to identify possible other services to address unmet needs, with the hopes of alleviating intolerable suffering.

This paper provides a historical review of the decriminalization of MAID in Canada, and of the jurisprudence and legislative debates leading to the creation of Bill C-14 and the subsequent MAID jurisprudence, to inform this writer's interpretation of the Voluntary Provision. This review was supplemented by considering how the court has interpreted voluntariness in other areas of law including the confessions rule, unconscionability in contract, and informed consent. By way of this review, key legal factors were identified that were used to inform a framework for the assessment of voluntariness by addressing vulnerability, coercion, undue influence, and ambivalence. The legal factors are to be considered on a case-by-case basis and vulnerabilities must not be presumed based on a patient's identification with a group or characteristics. The unique role of the social worker in informing the voluntariness assessment, was highlighted in consideration of their Code of Ethics and scope of practice. The social work profession has a particular interest in the

needs of vulnerable persons and have the skill and knowledge to identify unmet needs, using a biopsychosocial assessment, and subsequently offering means available to address unmet needs.

To determine the voluntariness of a request for MAID requires a contextual assessment that reflects the person-in-environment perspective, recognizing the impact of the environmental context on a person's behaviour. With this perspective, social workers are well positioned to complete a biopsychosocial assessment, which explicitly considers various external pressures that may influence a person's request for MAID. This approach requires a reasonable balancing of the expectations of patients to address the influence of external pressures, with the acknowledgement that the current social system is not able to meet all needs and forcing an individual to be "hostage to fixing systemic problems,"⁷⁰⁵ further reduces autonomy and self-determination. In addition, it is important to recognize that the mere existence of external pressures does not necessitate a conclusion that a request for MAID is not voluntary. If external pressures are identified, it is important to then consider the extent to which, if at all, the external pressures are influencing the decision to request MAID. This paper concludes that social workers have an integral role in the MAID process, and specifically as it relates to the assessment of voluntariness.

6.2 Recommendations

This paper recommends health care authorities and individuals involved in assessing eligibility for MAID, incorporate a framework for the assessment of voluntariness. The framework proposed identifies the legal factors to be considered, and the scope of the assessment, along with the important role of the clinical social worker. However, further development of clinical practice tools and standards in completing these assessments is necessary. This writer suggests this can be developed using existing skills, knowledge and tools utilized by clinical social workers and enhanced by contextualizing the practice

⁷⁰⁵ Eighth Report, *supra* note 460 at 36.

within MAID. In addition, further training, and education of clinical social workers on their role in MAID is needed and demonstrated in the literature.

The *Regulations for the Monitoring of Medical Assistance in Dying*, currently requires certain data elements to be collected and provided to Health Canada to help Health Canada monitor the characteristics of persons who are seeking and those who access MAID.⁷⁰⁶ The reporting helps Health Canada determine whether the *Criminal Code* provisions are meeting their objectives.⁷⁰⁷ This writer recommends an expansion of data collection on the presence of external pressures and whether external pressures were found to vitiate voluntariness.⁷⁰⁸ The collection and assessment of this data can help inform how voluntariness is currently being assessed and identify whether further practice guidance from regulatory college is necessary. This data can also be used to inform a standard of care required in this context, with the goal of ensuring consistent practice across the country.

6.3 Limitations

There are limitations to this research as a result of the nature of the questions asked and scope of literature reviewed. This was not a comparison research project and therefore it did not consider how voluntariness has been considered in international permissive regimes where assisted dying was legalized before Canada. The review and consideration of secondary resources was limited due to the nature of the research question. Future research should consider the clinical and ethical interpretations on the legal factors such as coercion and undue influence and develop tools on the clinical assessment of voluntariness, within a legal framework. Further, the paper does not address the provincial legislation regulating the delivery of MAID in Quebec and may limit the application of this research to Quebec.

⁷⁰⁶ Health Canada, *Guidance Document: Reporting Requirements under the Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying* (December 2022) at page 16.

⁷⁰⁷ *Ibid.*

While the use of the Hansard is helpful to inform the interpretation of the Voluntary Provision, it is not determinative and should not be viewed as capturing the full intent of the Voluntary Provision. The qualifications of the clinical social worker require further consideration and consultation with the regulatory authorities to determine, with certainty, whether a social worker that does not have a graduate degree in social work is capable of assisting with the voluntariness assessments. Last, the paper does not address the unique vulnerabilities that arise in the context of involuntary detention, including within the civil and criminal contexts.

6.4 Next Steps

There is a need for further qualitative research on the role of social workers, along with other allied health care providers, in the assessment of voluntariness. A legal perspective is helpful in assessing compliance of an approach with the *Criminal Code*, while a clinical social work perspective would be critical in identifying further recommendations on how to complete the assessment.

Further education and training of social workers would be a reasonable next step to contextualize existing skills, knowledge and tools to the MAID context. This will also instill confidence in the clinical social worker to be able to practice competently in this area of health care. The Canadian Association of MAID Assessors or Providers or the regulatory College may be good options to consider for providing the education and training.

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