

Abstract - Establishing the Right to Palliative Care in Canada

This article is a preliminary exploration of two approaches for establishing an enforceable legal right to access to palliative care in Canada. A final version of the article will appear in a forthcoming volume of the *Supreme Court Law Review*. It is recognized that palliative care and physician-assisted dying are interrelated. Palliative care can alleviate immense suffering, and for some individuals, eliminate the need to avail themselves of physician-assisted dying. This was recognized in the Supreme Court of Canada's 2015 decision of *Carter v Canada*, which concluded that informed consent to choose MAiD involves making a patient aware of alternative options to reduce their suffering, namely, palliative care. Bill C-14 subsequently required that patients be made aware of palliative care options as a prerequisite to receiving MAiD. However, access to palliative care in Canada is not universal, which has important implications for accessing MAiD. With no meaningful access to palliative care, individuals may at times opt for MAiD as the only means to end their suffering, which belies a lack of independence and agency in their decision. The first approach we explore is to establish a right to palliative care by making this form of care a necessary medical service under the *Canada Health Act*. The second approach involves establishing a right to palliative care as part of the MAiD provisions in the Criminal Code. This second approach would seek to have meaningful access to palliative care, not just being informed of the option, made a prerequisite to receiving physician-assisted dying. We conclude by assessing the relative strengths of each approach as to lay the groundwork for future legal advocacy around improving access to this important form of care.

Establishing the Right to Palliative Care in Canada

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Palliative care and physician-assisted dying are interrelated. Palliative care can alleviate immense suffering and eliminate the need to resort to physician-assisted death due to intolerable suffering. The Court in *Carter v Canada* recognized the relation between palliative care and physician-assisted dying and its role in regulatory safeguards around medical assistance in dying. In turn, Bill C-14 requires that patients be made aware of palliative care options as a prerequisite to receiving MAiD. However, access to palliative care in Canada is not universal, which has important implications for accessing MAiD. Where there is no meaningful access to palliative care, individuals may at times opt for MAiD as the only means to alleviate their suffering, even though palliative treatment may have adequately relieved their suffering. Meaningful access to palliative care is crucial in the wake of Bill C-14 and is an important safeguard to prevent unnecessary resort to MAiD.

Establishing a right to palliative care in Canada is an avenue to ensuring meaningful access to palliative care services. In this article, we canvass two approaches for establishing an enforceable legal right to access to palliative care in Canada. First, a right to palliative care may be established by making this form of care a necessary medical service under the *Canada Health Act*.¹ Second, a right to palliative care may be established as part of the MAiD provisions in the *Criminal Code*.² These options are outlined as groundwork for future legal advocacy around improving access to this important form of care.

Defining Palliative Care

Palliative care (“PC”) is an important form of care for anyone experiencing a life-limiting illness.³ Justice Lynn Smith of the British Columbia Supreme Court in *Carter v Canada* defined PC as: “care provided to people of all ages who have a life-limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life. The treatment is aimed at alleviating suffering – physical, emotional, psychological, or spiritual – rather than curing. It aims neither to hasten nor to postpone death, but affirms life and regards dying as a normal process. It recognizes the special needs of patients and families at the end of life, and offers a support system to help them cope.”⁴ Smith, J.’s definition is very similar to the definition provided by the World Health Organization.⁵

¹ *Canada Health Act*, R.S.C., 1985, c. C-6; The approach we discuss for this first option is influenced by previous academic work, Henteleff, Shariff & MacPherson, “Palliative Care: An Enforceable Canadian Human Right?” (2011) 5:1 *McGill JL & Health*.

² *Criminal Code*, R.S.C., 1985, c. C-46, at s. 241.1 online at: <http://laws-lois.justice.gc.ca/eng/acts/C-46/page-54.html#h-79> [*Criminal Code*].

³ Chochinov, H. M. “Dying, Dignity, and New Horizons in Palliative End-of-Life Care” (2006) 56 *CA Cancer J Clin*, at 85.

⁴ *Carter v Canada*, 2012 BCSC 1587, at para 41 [*Carter (BCSC)*].

⁵ The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of

PC is designed to minimize pain and maximize comfort for individuals, raising quality-of-life in the terminal stages.⁶ The vast majority of individuals require and would benefit from this form of care at the end of their life.⁷ Rather than trying to cure an individual's condition, care focuses on maintaining his or her quality of life. The benefits of PC are numerous: improved quality of life, better pain and symptom management, longer life span, greater involvement in treatment decisions, and often lower rates of hospitalization.⁸ Further, the support it can provide for caregivers is invaluable.

Delivery of PC occurs in a variety of forms. Services are offered in a range of settings, including hospital, hospice, respite, long-term care facilities, and in-home.⁹ Individuals may receive palliative services exclusively or concurrently with other forms of care, and intensity of care can be progressively increased in accordance with disease trajectory.¹⁰

Access to Palliative Care in Canada

Access to PC in Canada is far from universal. Smith, J. in *Carter (BCSC)* acknowledged the general lack of availability.¹¹ Many Canadians in need of PC are either unable to access appropriate services or cannot access services in a timely manner.

There are significant gaps in the data on availability and quality of PC in Canada. Data is inconsistently collected around Canada and not comprehensive.¹² This makes it difficult to precisely show gaps in availability and access to PC, as well as state the percentage of Canadians who have access. For instance, the commonly cited figure that only 16-30% of Canadians have access to PC is not grounded in available healthcare data.

Despite the data limitations, it is generally accepted that there are great disparities in access to PC in Canada. In particular, disparities are observed among provinces, between urban and rural areas, and by diagnosis and terminal condition.¹³ Certain provinces offer generally superior services to other provinces. Within provinces, regional variation result in certain areas (typically urban) enjoying widely accessible services, while other regions (typically rural) remain severely

suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual.” World Health Organization, *WHO Definition of Palliative Care*, online at: <http://www.who.int/cancer/palliative/definition/en/>

⁶ McMaster Health Forum, *Citizen Brief: Improving Access to Palliative Care in Ontario* (2013) at 2 [McMaster Health Forum].

⁷ McMaster Health Forum, *supra* note 6, at 6.

⁸ McMaster Health Forum, *supra* note 6, at 4; Canadian Society of Palliative Care Physicians, *Highlights from the National Palliative Medicine Survey* (2015) at 2.

⁹ Department of Justice, *Consultations on Physician-Assisted Dying – Summary of Results and Key Findings*, online at: <http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/p9.html>.

¹⁰ Canadian Cancer Society, *Right to Care: Palliative Care for All Canadians* (2015) at 3.

¹¹ *Carter (BCSC)*, *supra* note 4, at para 192.

¹² Downie, J, and Loyd-Smith, G., “The making of a myth: unreliable data on access to palliative care in Canada” (2014) *Health Law Review*.

¹³ Canadian Institute for Health Information, *Health Care Use at the End of Life in Atlantic Canada* (2011); Canadian Institute for Health Information, *Health Care Use at the End of Life in Western Canada* (2007); Canadian Institute for Health Information, *End of Life Hospital Care for Cancer Patients*; Auditor General of Ontario (2014); Auditor General of Ontario, *2014 Annual Report of the Office of the Auditor General of Ontario* (2014) [Auditor General of Ontario].

underserved.¹⁴ Additionally, an individual's diagnosis will influence their access to care, with cancer patients more likely to receive PC when required than patients with other conditions and disease trajectories.¹⁵

A significant service gap is the timing of when a patient is admitted to PC. In Ontario, for example, the majority of individuals receiving PC begin care in the last month or second last month of their life.¹⁶ The date as to when an individual can access service will be an important factor in their end-of-life decision making. Accessing services only in the last month of life, when one's illness has progressed, may be inappropriate for individuals facing intolerable suffering. Waiting for months to access service may not be an option.

With the introduction of Bill C-14, gaps in access to PC increase the vulnerability of individuals with life-limiting illnesses to error and abuse in the delivery of MAiD, in the form of premature death. Physicians around Canada have reported observing patients resort to physician-assisted death due to a lack of PC.¹⁷

Palliative Care in *Carter v Canada*

The Supreme Court in *Carter* acknowledged the interrelation between PC and physician-assisted dying. Ultimately, the Court upheld Smith, J.'s finding that proper informed consent to physician-assisted death can be obtained where particular safe guards are in place, including being made aware of PC interventions.

Smith, J. had before her an incomplete record, which is regrettable in such an important case. The Supreme Court of Canada allowed the AGC to adduce new evidence in the form of 1 affidavit which was not cross-examined upon, and which was no substitute for a more fulsome record.¹⁸

No level of Court in the *Carter v Canada* proceedings engaged in robust analysis of the role of meaningful access to PC in a regulatory scheme for MAiD.

Despite the incompleteness of the record, there was evidence was before the Court that: 1) access to PC can eliminate an individual's resort to physician-assisted dying; and 2) high levels of access to PC exist in both the Benelux countries and Oregon. Together, this evidence suggests that meaningful access to PC is an important aspect of the MAiD schemes in these jurisdictions, protecting against error and avoidable death.

¹⁴ 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* (2015).

¹⁵ Canadian Institute for Health Information, *End of Life Hospital Care for Cancer Patients* (2013); Auditor General of Ontario, *supra* note 13.

¹⁶ Health Quality Ontario, *Palliative Care at the End of Life* (2016) Toronto: Queen's Printer for Ontario, at 8 [*Health Quality Ontario*].

¹⁷ See online at: <http://www.cbc.ca/news/canada/new-brunswick/pam-mansfield-palliative-care-new-brunswick-1.4088066>.

¹⁸ The *Carter* trial was expedited, resulting in an underdeveloped responding record. When the AGC attempted to correct the record before the British Columbia Court of Appeal, the request was denied because it had failed to adduce the evidence it was prevented from adducing at trial. See *Carter v Canada (Attorney General)*, 2013 BCCA 435, at paras. 183-199. Rather than attempt to correct this oversight before the SCC, the AGC sought and Rothstein J. granted the right to file new affidavit evidence from a Professor Montero.

The receipt of PC's influence on requests for physician-assisted dying was noted in *Carter (BCSC)*. Smith, J. stated unequivocally that "[a]dequate palliative care can reduce requests for euthanasia or lead to their retraction."¹⁹ Research on Oregon's MAiD scheme was conclusive that "substantive palliative care interventions" could lead some patients to either not request or retract their request for physician-assisted dying.²⁰ Although the Court did find that in some cases suffering cannot be alleviated by palliative care,²¹ the point should be emphasized that in many cases it does sufficiently relieve suffering. This is crucial when considering effective safeguards in MAiD schemes.

The high levels of availability of PC in all comparator jurisdictions relied upon was acknowledged by the Court in *Carter (BCSC)*. For Oregon for example, it was noted that virtually all individuals who died by physician-assisted death were in palliative hospice care.²² For Belgium, it was noted that legislation establishing a right to PC and further development of PC services was enacted concurrently with legislation authorizing physician-assisted dying.²³ The implication in both jurisdictions is that meaningful access to PC is an important safeguard of the lives, liberties and security of persons who require it, and more particularly of persons with publicly funded access to MAiD.

Despite this evidence, the Court in *Carter (BCSC)* did not engage in robust analysis of the importance of meaningful access to PC in the MAiD schemes of other jurisdictions. Analysis of the effectiveness of safeguards in MAiD regimes was silent as to the role of meaningful access to PC.²⁴ As well, the Court did not engage in comparison of the pros and cons of jurisdictions that have and have not enacted rights to PC/end of life treatment. The Supreme Court in *Carter v Canada* (2016), also made a point of not commenting on the validity of Quebec's legislation with its end-of-life stipulations and enshrinement of a right to PC.²⁵

PC ultimately was recognized as one safeguard in a regulatory regime which would enable the safe delivery of MAiD. Smith, J.'s "informed consent standard" for obtaining physician-assisted death (approved by the Supreme Court) included ensuring a patient was aware of "reasonable palliative care interventions."²⁶ There is an important distinction to draw here between access to medical information and access to medical services. Meaningful access to PC was not part of Smith, J.'s informed consent standard.

Interestingly, one condition imposed by Smith, J. for Ms. Taylor to obtain physician-assisted death was being "referred to a physician with palliative care expertise for a palliative care consultation" [emphasis added].²⁷ A consultation with a physician seems to be a more robust safeguard than simply providing a patient with PC options to explore. As discussed below, the legislative history of Bill C-14 shows Parliament abandoned this option.

¹⁹ *Carter (BCSC)*, *supra* note 4, at para. 189

²⁰ *Ibid*, at para. 416

²¹ *Ibid*, at paras. 4, 190.

²² *Ibid*, at para. 416.

²³ *Ibid*, at paras. 507, 585

²⁴ *Ibid*, at paras. 646-686.

²⁵ *Carter v Canada*, 2016 SCC 4, at para. 4; *An Act Respecting End-of-Life Care*, S.Q. 2014 c. 2, s. 1-6 and 24-32.

²⁶ *Carter (BCSC)*, *supra* note 4, at para. 831.

²⁷ *Ibid*, at para. 1414. The plaintiffs also proposed the requirement of undergoing a palliative care consultation as a pre-requisite to physician-assisted death (see paras 876 and 1413).

The inclusion of PC in the MAiD provisions of the *Criminal Code* are discussed in detail below in the section, Establishing a Right to Palliative Care through the MAiD provisions in the Criminal Code.

Establishing a Right to Palliative Care through the *Canada Health Act*

Canada's shortcomings in the provision of PC through the *Canada Health Act* can be challenged under two different sections of the *Canadian Charter of Rights and Freedoms*.²⁸

The *Canada Health Act*

The *Canada Health Act* is the Federal Government's means of promoting consistent delivery of health services in Canada.²⁹ It outlines the conditions and criteria regarding the provision of health care services that provinces need to satisfy in order to receive federal cash contributions, but it doesn't set out basic rights to health care.³⁰ Section 3 of the *CHA* declares "that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The *CHA* is adopted by reference into the health insurance legislation of all provinces and territories, which is the mechanism through which they authorize themselves to fulfill their obligations under it thereby entitling them to federal health funds.

Section 2 of the *CHA* distinguishes between 'insured health service' and 'extended health care services', with the former category eligible for federal funding. PC is not explicitly included within 'insured health services', nor specifically mentioned in the *CHA*. However, it largely falls under the extended health care services definition which includes "nursing home intermediate care service, adult residential care service, home care service and ambulatory health care service" (section 2 of the *CHA*). This is distinct from "insured services" which only covers hospital and physician services (section 2 of the *CHA*). Hospital and physician services are defined as "medically required/necessary" services provided in hospitals, or by physicians respectively. Physicians are further defined to be those that are legally entitled to practice medicine. Given the range of care providers often involved in PC, many would not fall into the category of physician services.

Yet, some PC services may be 'insured services.' Indeed, when the *CHA* was passed in 1984, PC was mainly provided in hospitals and fell under the ambit of 'hospital services.'³¹ Now that PC is often delivered in non-hospital settings, much of these services fall outside the ambit of the *CHA*. However, delivery still occurs in hospitals by physicians and nurses and can be medically necessary. Ontario, for instance, does fund medically necessary PC services in hospitals.³²

²⁸ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK), 1982*, c 11 [Charter].

²⁹ *Canada Health Act*, RSC, 1985, c. C-6 [CHA].

³⁰ *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, at para. 17 [Chaoulli].

³¹ Auditor General of Canada, *2002 September Status Report of the Auditor General of Canada* (2002) online at: http://www.oag-bvg.gc.ca/internet/English/parl_oag_200209_03_e_12388.html

³² See online at: http://www.health.gov.on.ca/en/public/programs/palliative/palliative_questionsandanswers.aspx

The *CHA* places the onus on provinces to determine if and how it will fund PC, as it does MAiD services. Because much of PC falls under the provincial purview of health care services, the country does not have a consistent approach to delivery and availability of services or funding at a local level. The country does, however, have a consistent approach to funding MAiD services. They are universally available at public expense in every province and territory.

Section 7 of the Charter

To establish a violation of section 7, a claimant must demonstrate that they have suffered an endangerment of their life, liberty or security of person, and that this deprivation was not in accordance with the principles of fundamental justice.

Life is interpreted by the Courts based on the usual and ordinary meaning of the term. In *Chaoulli*, the Court held that the restriction on attaining private health care insurance, combined with prolonged wait times at hospitals, was endangering the lives of Quebeckers. While that case involved an economic right, the right to private health insurance, the lack of the right endangered the complainants' life (at para 45).

The Supreme Court of Canada recognized in *New Brunswick (Minister of Health and Community Services) v G(J)* that the security of the person includes "both the physical and psychological integrity of the individual".³³ If stress reaches a sufficient level, it could be worthy of section 7 protection. The Court articulated that "state action must have a serious and profound effect on a person's psychological integrity . . . [it] must be greater than ordinary stress or anxiety."³⁴ In *Rodriguez v British Columbia (Attorney General)*, the Court stated that the security of the person is infringed if the state's actions impose suffering upon the individual.³⁵

As noted above, research suggests that a lack of access to PC can result in a quicker, more stressful death. The diagnosis of a life-limiting illness is inherently stressful, but the thought of having to face the illness without adequate access to pain and symptom management and social and psychological support further exacerbates this stress. Without this type of support, individuals are left with few options. Those who can privately fund PC may choose to do so. Others, who lack the means, may choose to wait for PC services to become available. Given wait times in accessing PC (that in some cases, like Ontario, an individual may wait until their death is virtually imminent), the delay alone creates an additional risk to health and increases the discriminatory necessity of end-of-life institutionalization³⁶ and further violates the security of the person.³⁷ Others may choose to commit suicide or resort to the physician assisted suicide option. Stress that rises to the level where an individual is compelled to consider ending their life certainly endangers both the life and security of the person. Thus, the current access to PC in Canada endangers both the life and security of Canadians.

This endangerment is only tolerable if it is in accordance with the principles of fundamental justice. The most applicable principle of fundamental justice in this case is arbitrariness. The Court in *Chaoulli* held that "[a] law is arbitrary where it 'bears no relation to, or is inconsistent

³³ *New Brunswick (Minister of Health and Community Services) v G(J)*, [1999] 3 SCR 46, at para. 58 [*G(J)*].

³⁴ *Ibid*, at 77-78.

³⁵ *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519, at p 589 [*Rodriguez*].

³⁶ *Olmstead v. L.C.*, 527 U.S. 581 (1999)

³⁷ *Chaoulli*, *supra* note 30, at para. 118.

with, the objective that lies behind [it].”³⁸ The Court stated that this requires consideration for the state interest and societal concern.³⁹

The *CHA* is the impugned law in the case of access to PC. A complainant would have to demonstrate that access to PC is inconsistent with the objectives stated within the legislation. As cited above, the *CHA*’s stated objective is to “protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (section 2). Rather than protecting and promoting the mental health and well-being of Canadian residents, the inadequate and inconsistent funding and access to PC is endangering the lives and security of persons. Regarding consideration for state interest and societal concern, as everyone will die and the vast majority of people will benefit from the provision of PC, the consideration would weigh in favour of societal concern regarding access to PC.

In *Chaoulli*, the Court found that the way the province had chosen to distribute resources was arbitrary, thus violating section 7. The same analysis and conclusion applies in the case of PC. While access to PC services occurs at a provincial level, the categorization of PC as an extended service rather than an insured service is not based on meaningful criteria. PC is deemed to be medically necessary by many medical professionals. Yet, in the *CHA*, it is not classified as such. There is no meaningful reason for this distinction and the inadequate resource distribution for such services.

Further support for the argument that the lack of access to PC violates section 7 of the Charter, can be found in the recent case of *Carter v Canada*.⁴⁰ The Supreme Court of Canada has held that Canadians should have access to physician assisted death. It would be arbitrary to support and publicly fund medical services that lead to death, without providing the same funding and access to services that aim to prolong life or at least manage pain and suffering. Adequate access to PC is even more imperative in the wake of the *Carter* decision.

Section 15 of the Charter

Section 15 protects the right to equality. The classification of PC as an “extended health care services” designation in the *CHA* relegates it to a second class standing. PC is listed as an extraneous type of care. This discriminates against disabled and aged individuals. Currently, the *CHA*’s classification of PC distinguishes between the medical needs of the elderly or people life-threatening disabilities, and the needs of the young and healthy.

Whereas young and healthy individuals can access more medically necessary insured medical services, those with life-threatening illnesses or disabilities or those who are at an advanced age, cannot access the type of care that they require. Once diagnosed, these individuals require support and medical services in the form of PC. The lack of access to this type of care perpetuates their already disadvantaged position in society.

Eldridge v British Columbia (Attorney General) established the principle that if the government is going to provide a service, it must do so without discriminating.⁴¹ In *Eldridge*, the Court held that

³⁸ *Chaoulli*, *supra* note 30, at paras. 130-31.

³⁹ *Ibid*, at paras. 130-131.

⁴⁰ *Carter v Canada*, 2015 SCC 5 [*Carter #1*].

⁴¹ *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 62, [*Eldridge*].

the failure to provide sign language interpreters was discriminatory. The current approach to funding medical services is under-inclusive. Only medically necessary services are funded, while those aimed at providing care, are not funded. This distinction disproportionately impacts the aged and those with disabilities. Current research is supporting a shift in thinking of PC as being medically necessary – and public policy is following suit.⁴² If it is understood as a medically necessary service, then the failure to provide for it would be a violation of section 15 rights.⁴³

An additional argument could be made that the Federal and Provincial Governments are not allocating resources for extended services in a non-discriminatory way. As noted above, the majority of PC services are used by cancer patients. Patients with other diagnosis have comparable need but face more barriers to accessing PC. By constructing the PC system in this manner, such as providing funding specifically for PC for individuals with cancer⁴⁴ and thus exacerbating differentials in access to care for other patients, the Government is failing to account for the needs of individuals with other life-threatening illnesses.

The Court's decision in *Nova Scotia (Worker's Compensation Board) v Martin* is particularly helpful for this argument. In that case, workers compensation legislation provided coverage for several disabilities; chronic pain was not one of them.⁴⁵ Therefore, where the government provides funding for some PC services, the limitations on who these services are provided to, could be argued as being discriminatory.

Establishing a Right to Palliative Care through the MAiD provisions in the *Criminal Code*

Canada's shortcomings in the provision of a regulatory scheme which promotes informed consent to prevent error and abuse in the form of premature death can be challenged under two different sections of the *Canadian Charter of Rights and Freedoms*.

Bill C-14 and Palliative Care

The Supreme Court of Canada in *Carter #1* ordered Parliament to create a regulatory scheme for MAiD but with the proviso that it includes a "carefully designed and monitored system of safeguards" to prevent error and abuse.⁴⁶ Bill C-14 ushered in a regulatory scheme that aims to promote informed consent and avoid premature death, by preventing error or abuse in the delivery of MAiD. Section 241.2(1)(e) of the *Criminal Code* requires individuals considering MAiD to be informed of PC options. However, the MAiD scheme does not impose requirements to provide meaningful access to PC, which can undermine informed consent and result in premature death.

⁴² Health Quality Ontario, *supra* note 16.

⁴³ See *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78 and *CUPE v Canada (Minister of Health)*, 2004 FC 1334.

⁴⁴ In 2016, the Federal Government specifically allotted funding over five years to Partnership Against Cancer for cancer treatment, including palliative care. See online at: <http://www.partnershipagainstcancer.ca/canadian-partnership-against-cancer-receives-endorsement/>. Note there nevertheless remains substantial criticism of the inadequacy of PC for cancer patients in many regions of the country.

⁴⁵ *Nova Scotia (Worker's Compensation Board) v Martin*, 2003 SCC 54, at para. 5, [*Martin*].

⁴⁶ *Carter #1*, *supra* note 40, at paras. 117, 125.

Passed on May 31, 2016, Bill C-14 established Canada's current MAiD scheme and built PC into the eligibility requirements for receiving MAiD.⁴⁷ In the process of passing Bill C-14, Parliament rejected a version of the Bill which saw a more robust role for PC. Parliament also declined, as both Belgium and Quebec did when legalising MAiD, to establish a right to PC.

Section 241.2(1) of the *Criminal Code* outlines the eligibility requirements for receiving MAiD. In terms of PC, it stipulates that: A person may receive medical assistance in dying only if they meet all of the following criteria:

...

(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.⁴⁸ [emphasis added]

An earlier version of Bill C-14 included a Senate amendment entailing a more robust role for PC:

(e) they give informed consent to receive medical assistance in dying after having had a palliative care consultation and having been informed of treatment, technology or support options available to relieve their suffering.⁴⁹ [emphasis added]

The operative wording in the amendment of “after having had a palliative care consultation” is stronger wording than the version that received Royal Assent. A palliative care consultation is a more robust procedural requirement than simply informing a patient of care options. Indeed, Smith, J.’s requirement in *Carter (BCSC)* that Ms. Taylor be “referred to a physician with palliative care expertise for a palliative care consultation” demonstrates it is not a light procedure.⁵⁰

Section 7 of the Charter

The Court in *Carter #1* held that the ‘life’ interest in s. 7 of the *Charter* is engaged “where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly.”⁵¹ Premature death can violate the life interest in s. 7. In *Carter #1*, the life interest was violated because the prohibition on MAiD “forced” some individual to take their lives prematurely where the availability physician-assisted dying would have enabled them to prolong their lives.⁵²

Similar to *Carter #1*, due to a lack of PC, some individuals are taking their own lives prematurely by resorting to MAiD (as noted above). Research shows that most individuals will not choose MAiD without first exhausting palliative treatments, which may sufficiently alleviate suffering.⁵³ Individuals lacking access to PC have no option to first exhaust these treatments. They are left to live with their intolerable suffering. Consequently, MAiD becomes the only realistic option to

⁴⁷ Bill C-14, online at: <http://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/third-reading>

⁴⁸ *Criminal Code*, *supra* note 2.

⁴⁹ See online at: https://sencanada.ca/en/content/sen/chamber/421/debates/046db_2016-06-09-e?language=e

⁵⁰ *Carter #1*, *supra* note 40, at para 1414

⁵¹ *Ibid*, at para. 62.

⁵² *Ibid*, at para. 57.

⁵³ Jansen-van der Weide MC, Onwuteaka-Philipsen BD, van der Wal G. “Requests for euthanasia and physician-assisted suicide and the availability and application of palliative options” (2006) 4:4 Palliat Support Care..

cease their intolerable suffering. In order to deal with their intolerable suffering, these individuals are “forced” into an option they otherwise would not have chosen, similar to the situation dealt with in *Carter #1* of people committing suicide prematurely.⁵⁴ Individuals who choose MAiD and whose pain otherwise could be adequately managed with palliative treatments thus die prematurely. The current MAiD scheme therefore violates the right to life insofar as it increases the risk of death for patients lacking palliative options and indirectly facilitates their death.

The risk of premature death is most pronounced in rural areas of Canada. The current lack of palliative care, coupled with the great availability of physician-assisted death means that for some individuals, it is easier to access services to cease their life than to make their life worth living. The probability of a person ending their intolerable suffering via PAD is increased where the most readily-available means of ceasing suffering is death. Given the value of the sanctity of life inherent in s. 7 of the *Charter*,⁵⁵ death should not be the more accessible solution to one’s suffering.

The liberty and security of the person interests are interrelated in this case. The Court in *Blencoe v British Columbia (Human Rights Commission)*, held that the ‘liberty’ interest is engaged where “where state compulsions or prohibitions affect important and fundamental life choices.”⁵⁶ The Court in *Carter #1* held that security of the person interest is engaged when a person is deprived of his or her control over their bodily integrity.⁵⁷ *Rodriguez*, provides further clarification that the interest entails control over one’s body free from “state-imposed psychological and emotional stress.”⁵⁸

Autonomy is an important element of Bill C-14’s MAiD scheme.⁵⁹ Both Smith, J.’s informed consent standard, articulated in *Carter (BCSC)*, and Bill C-14 presuppose some level of access to PC. Proper functioning of the scheme depends on meaningful patient autonomy and consent.

However, the current scheme deprives full individual autonomy in end-of-life care decision-making and limits one’s ability to make choices to make his or her life worth living and prolong it through proper pain management. Where there are no realistic palliative alternative treatments for an individual to be informed about and consider, patient autonomy is undermined. This negates the efficacy of s. 241(2)(e) of the *Criminal Code*, which finds force when there are options to explore.

An individual’s freedom to choose life-prolonging care is limited when facing a lack of palliative options. While an individual with no palliative options still exercises some control over his or her body, it is diminished control over their body because they lack the ability to make their lives worthwhile to live and prolong it. Their options of how to respond to intolerable suffering are restricted to coping with the suffering or ceasing it with premature death.

Infringements to physical and psychological integrity of the individual raise further security of the person issues. The arguments on physical and psychological integrity infringements from the

⁵⁴ *Carter #1*, *supra* note 40, at para. 57.

⁵⁵ *Ibid*, at para. 63.

⁵⁶ *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44, at para. 49.

⁵⁷ *Carter #1*, *supra* note 40, at para. 65.

⁵⁸ *Rodriguez*, *supra* note 35, at 587-588.

⁵⁹ Autonomy is stated in the opening line of the preamble, see online at: <http://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>

section above on ‘Establishing a Right to Palliative Care through the *Canada Health Act*’ are applicable here.

Justice Lamer wrote in *Rodriguez* that “while there may be no limitations on the treatments to which a patient may refuse or discontinue, there are always limits on the treatment which a patient may demand” [emphasis added].⁶⁰ Lamer, J. went on to give the example that PC cannot be demanded in all circumstances, such as where one’s death is not imminent. A response to our argument for autonomy could map along Lamer, J.’s point: patient autonomy does not entail the right to demand any treatment a patient perceives as beneficial. While this may be true in certain circumstances, the need to ensure autonomy while an individual explores MAiD is heightened. Consideration of palliative treatment forms one component of the MAiD assessment process. Given the extreme and irrevocable nature of physician-assisted death as a solution to suffering, individuals should be entitled to first meaningfully consider palliative treatments.

It may be argued that the MAiD provisions in the *Criminal Code* do not actually cause the intolerable suffering, but rather an individual’s suffering exists independent to the MAiD provisions. The Court in *Canada (Attorney General) v Bedford*, clarified that the “sufficient causal connection” standard prevails when analyzing whether there is a connection between state (in)action and an individual’s suffering to engage s. 7.⁶¹ Government conduct need not be the dominant cause. If there is a real link, “satisfied by a reasonable inference, drawn on a balance of probabilities”, the standard is met.⁶² The standard is satisfied in this case. Individuals are placed at increase risk of premature death when they lack treatment options for their intolerable suffering. Likewise, reduced autonomy is a by-product of the MAiD scheme, as the level of choice the MAiD scheme purports to provide in reality does not exist when palliative treatment options are unavailable.

The MAiD provisions in the *Criminal Code* is the impugned law in the case of access to PC. A complainant would have to demonstrate that access to PC is inconsistent with the objectives stated within the legislation. The applicable principle of fundamental justice is arbitrariness. Per the Court in *Chaoulli*, “a deprivation of a right will be arbitrary and will thus infringe s. 7 if it bears no relation to, or is inconsistent with, the state interest that lies behind the legislation.”⁶³

Bill C-14’s object can be described generally as protecting against premature death, by preventing error or abuse, with other more specific objectives to focus the analysis. This is an appropriate characterization and avoids an overly broad object.⁶⁴ The MAiD provisions in the *Criminal Code* are arbitrary insofar as they do not provide meaningful access to PC in order to prevent error and abuse. The MAiD scheme leads to the s. 7 *Charter* deprivation of premature death, which is inconsistent with its object of preventing abuse and error.

As with MAiD, Parliament would have the constitutional authority to legislate with respect to PC as a matter that touches upon health, but also falls within its criminal law jurisdiction.⁶⁵

⁶⁰ *Rodriguez*, *supra* note 35, at 560.

⁶¹ *Canada (Attorney General) v Bedford*, 2013 SCC 72, at para. 76.

⁶² *Ibid*, at para. 76.

⁶³ *Chaoulli*, *supra* note 30, at para. 232.

⁶⁴ *Carter #1*, *supra* note 40, at para. 77.

⁶⁵ *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 at para. 68.

Section 15 of the Charter

Access to healthcare is an equality issue. As recognized by the Court in *Eldridge*, persons with disabilities face unique barriers to accessing health care services. Persons with disabilities face greater barriers in access to PC than other people and thus are more adversely affected by the lack of PC when considering MAiD. Certain persons with disabilities will have less access to PC when considering MAiD than others, making them additionally vulnerable to error and abuse in the delivery of MAiD.

Inequities in access to PC violate s. 15 of the *Charter* in that they can perpetuate historical disadvantage faced by certain sub-groups of persons with disabilities.⁶⁶ The Court in *Quebec v A* described that “the root of s. 15 is our awareness that certain groups have been historically discriminated against, and that the perpetuation of such discrimination should be curtailed.”⁶⁷ Justice Abella directed that a contextual analysis be applied to substantive equality claims.⁶⁸

All persons requiring PC can have a disability in some form. However, there are inequalities between the sub-groups within this general group of persons requiring PC - different sub-groups have less access to PC than others. Previous jurisprudence has affirmed that discrimination can occur between persons with different types of disabilities.⁶⁹

Inequities in access to PC are seen between: A) persons with disabilities in urban and rural areas; B) persons with disabilities with pre-existing disabilities and those whose disability is synchronous with a terminal state of health; and C) Persons with disabilities depending on diagnosis. In all cases, the disparities in access to PC perpetuate historical disadvantage in access to health care services.

Persons who have a pre-existing disability that is not synchronous with a terminal state of health face unique barriers to PC. As recognized in *Eldridge*, persons with disabilities are subject to attitudes of stigma, pity and charity, resulting in a socially constructed conception that their lives are less valuable.⁷⁰ Scarce PC resources may be triaged and distributed based on discriminatory attitudes of who is more deserving of care. It is well documented that persons with disabilities receive a lower standard of health care than persons without disabilities.⁷¹ Bill C-14’s failure to provide meaningful access to PC perpetuates discriminatory distribution of PC resources for persons with disabilities who are considering MAiD.

Severe disparities in access occur between urban and rural areas. In rural areas, PC is often delivered by family physicians, instead of specialized PC teams.⁷² Yet, persons with disabilities in Canada are less likely to have a family physician than persons without disabilities.⁷³ This

⁶⁶ *Withler v Canada*, 2011 SCC 12, at paras. 32, 38.

⁶⁷ *Quebec v A*, SCC 2013 5, at para. 332.

⁶⁸ *Ibid*, at para. 418.

⁶⁹ *Martin*, *supra* note 45; *Plesner v British Columbia Hydro & Power Authority*, 2009 BCCA 188.

⁷⁰ *Eldridge*, *supra* note 41, at para. 56.

⁷¹ Canadian Disability Policy Alliance, *Submission to the Standing Senate Committee on Social Affairs, Science and Technology* (2011). Online at: http://69.89.31.83/~disabio5/wp-content/uploads/2012/10/CDPA_Senate_Submission_on_Healthcare_Renewal.pdf

⁷² Canadian Society of Palliative Care Physicians, *Highlight from the National Palliative Medicine Survey* (2015), at 9.

⁷³ McColl, M. A., Aiken, A., & Schaub, M. “Do People with Disabilities Have Difficulty Finding a Family Physician?” (2015) 12 *Int. J. Environ. Res. Public Health*.

results in unique barriers to accessing PC in rural areas from the common source: family physicians. Additionally, ramifications of inaccessibility include difficulty in receiving a physician's referral to specialized PC care.⁷⁴ In contrast, a non-disabled person living in a rural setting who becomes disabled through a terminal condition will have previously had better access to a family physician and thereby more likely to receive PC.

As discussed in *Chaoulli*, forcing someone to travel for healthcare can be unreasonable.⁷⁵ Requesting certain persons with disabilities to travel outside their region to access healthcare can be unrealistic because of their high dependence on other caregivers, such as family, for their sustenance. Having to dislodge oneself from a network of support and travel elsewhere for extended care is not a reasonable option, which limits care options to what is available in one's rural region.

Diagnosis impacts access to PC. As noted above, persons with cancer are more likely to receive PC than persons with other diagnosis. Forms of disability which have a less predictable trajectory, which make it more difficult to plan care in advance, render certain persons less likely to receive palliative treatment when considering MAiD. As well, persons with forms of disability which render a person in need of PC services for a long-duration will be disadvantaged (as already noted, in Ontario, for example, PC is often available in the last one or two months of life.)

Conclusion

Access to palliative care is important for all Canadians. This paper represents evolving thinking on strategies to establish a legal right to palliative care in Canada. We aim to stimulate discussion and lay the groundwork for future advocacy around this important form of care.

⁷⁴ *Ibid.*

⁷⁵ *Chaoulli*, *supra* note 30, at para 121.