The Impact of An Act Respecting End-of-Life Care, RSQ c S-32.0001

One of the peculiarities of the Quebec Act that is likely to be amended in the wake of Carter is that it intentionally only legalizes euthanasia by lethal injection and not physician-assisted dying by lethal prescription. (Euthanasia refers to a lethal injection administered by a physician, and physician-assisted dying refers to a lethal prescription provided by a physician that is self-administered by the patient). As it stands, Quebec is the only jurisdiction in the world to do so. While several other jurisdictions permit both forms of medical aid in dying, some jurisdictions (including all U.S. jurisdictions) only permit lethal prescriptions, and prohibit lethal injections (i.e., U.S. capital punishment notwithstanding).

This peculiarity does not arise from clinical considerations, but rather from political ones. Since the Quebec Act pre-dates Carter, there was valid concern by the Quebec government that it would be challenged by either the federal government or private litigants based on arguments that (a) the paramountcy of the federal criminal law renders the Quebec Act constitutionally inoperable, or (b) the Quebec Act is in “nith and substance” criminal law, making it “ultra vires” the Quebec legislature, and therefore unconstitutional. There was some consensus in Quebec, however, that if physicians administered the lethal injection themselves, as opposed to merely prescribing a lethal dose for a patient to self-administer, Quebec would have a stronger argument that physicians are providing a logical continuity of end-of-life care throughout the dying process, and therefore the Quebec Act falls squarely within the health care law-making sphere, as a matter “of a merely local or private nature” reserved to the provinces under section 92(16) of The Constitution Act, 1867. Indeed, this argument has prevailed at the QCA.

While the distinction may become moot once Carter becomes effective law, absent further amendment to the Quebec Act to harmonize it with Carter, it does raise questions as to what the standard of care will be in Quebec for medical aid in dying, even if no criminal laws are broken. As the only medical aid in
dying legislation in force in Canada, however, the Quebec Act provides some insight into potential elements of legislation that may eventually be passed in Ontario. For example, the Quebec Act includes the following provisions:

- Consent must be in writing and the physician must verify the “persistence of suffering” and that the wish to die remains unchanged, by talking to the patient at “reasonably spaced individuals”. A second physician opinion is also required.
- Medical aid in dying must be administered by the physician personally (i.e., not by medical directive or delegation), and the physician must remain with the patient until death ensues.
- Within 10 days of death, the physician must inform the Quebec Council of Physicians, Dentists and Pharmacists, which will assess the quality of care provided.
- The physician must also send a report on the death to the newly created Quebec Commission on End-of-Life Care, which will review compliance with the Quebec Act. If two-thirds of the Commission find non-compliance with the Quebec Act, they will report their opinion to the Collège des médecins du Québec and the institution where service was provided, for them to take appropriate measures (i.e., including professional discipline).
- The patient must have capacity to consent, and the consent cannot be carried out via a Substitute-Decision Maker or Advance Medical Directive (Carter is silent on this point).
- “Medical-aid in dying” is defined as “end-of-life treatment for an incurable serious illness resulting in an advanced state of irreversible decline in capability and causing unbearable physical or psychological pain, which cannot be relieved in a manner the patient deems tolerable” (the Carter criteria is less proscriptive).
- Every “institution” must include a clinical program for medical aid in dying in its organization plan (e.g., a local community service centre, a hospital centre or a residential and long-term care centre etc.), so it applies to faith-based institutions (Carter is also silent on this point).
- Physicians may refuse to provide medical aid in dying (and health professionals may refuse to take part) on the basis of personal conviction, but they must notify the executive director of the institution or local authority (presumably so a referral can be made by the executive director) (Carter is also silent on this point).

Of these provisions, it remains very questionable whether Ontario will adopt the “every institution” model where even faith-based institutions would be expected to provide medical aid in dying. To the contrary, both the Advisory Group and the CMA have recommended alternative approaches, which respect conscientious objection at the institutional level. Additionally, it is unknown whether the federal Liberal government will amend the Criminal Code in response to recommendations from the Federal Panel or the Advisory Group, or whether they will enact separate legislation outlining criminal boundaries around medical aid in dying (i.e., similar to the federal Assisted Human Reproduction Act, which outlines criminal boundaries around fertility services in Canada).
Osler, Hoskin & Harcourt LLP's Health Industry Group has industry-leading expertise in assisting hospitals and other healthcare institutions develop policies and procedures that reflect best practices in complying with a complex and ever-evolving medico-legal landscape. Please contact us if your institution requires assistance navigating medical aid in dying in Canada.

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