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### The Legal Status of Deep and Continuous Palliative Sedation Without Artificial Nutrition and Hydration

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# THE LEGAL STATUS OF DEEP AND CONTINUOUS PALLIATIVE SEDATION WITHOUT ARTIFICIAL NUTRITION AND HYDRATION

*Jocelyn Downie & Richard Liu\**

Deep and continuous palliative sedation combined with the withholding or withdrawal of artificial nutrition and hydration (collectively termed “PS $\bar{S}$ ANH”) is an important aspect of high-quality end-of-life care. It is one means of alleviating suffering. Unfortunately, the legality of this practice has been under-researched and PS $\bar{S}$ ANH is not yet appropriately regulated in Canada. In this paper, we explore the legal status of PS $\bar{S}$ ANH where it (1) will not hasten death (Type 1 PS $\bar{S}$ ANH); (2) might, but is not certain to, hasten death (Type 2 PS $\bar{S}$ ANH); or (3) is certain to hasten death (Type 3 PS $\bar{S}$ ANH). It is clear that Type 1 is lawful. While it could be argued that Types 2 and 3 are also lawful, their legal status is ultimately unclear. We argue that the current lack of clarity and robust regulation with respect to Types 2 and 3 is a profound disservice to suffering individuals and health care pro-

La sédation palliative profonde et continue combinée à la suspension ou au retrait de la nutrition et de l’hydratation artificielles (collectivement appelée « PS $\bar{S}$ ANH ») est un aspect important des soins de fin de vie de haute qualité. C’est un moyen d’atténuer la souffrance. Malheureusement, la légalité de cette pratique n’a pas fait l’objet de recherches suffisantes et la PS $\bar{S}$ ANH n’est pas encore réglementée de façon appropriée au Canada. Dans cet article, nous explorons le statut légal de la PS $\bar{S}$ ANH où elle (1) n’accéléra pas la mort (PS $\bar{S}$ ANH de type 1) ; (2) pourrait, mais sans certitude, accélérer la mort (PS $\bar{S}$ ANH de type 2) ; ou (3) est certaine d’accélérer la mort (PS $\bar{S}$ ANH de type 3). Il est clair que le type 1 est légal. Bien que l’on puisse argumenter que les types 2 et 3 sont également légaux, leur statut juridique n’est ultimement pas clair. Nous soutenons que le manque de clarté et

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viders and should be remedied by the federal government through amendments to the *Criminal Code*. We then propose amendments that would bring clarity, coherence, and comprehensiveness to end-of-life law, policy, and practice and thus enable better care for the dying.

de réglementation rigoureuse concernant les types 2 et 3 nuisent profondément aux personnes souffrantes ainsi qu'aux fournisseurs de soins de santé et que le gouvernement fédéral devrait y remédier en apportant des modifications au *Code criminel*. Nous proposons ensuite des modifications qui apporteraient de la clarté, de la cohérence et de l'exhaustivité au droit, aux politiques et à la pratique en fin de vie et qui permettront ainsi de mieux prendre soin des mourants.

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## INTRODUCTION

A patient has end-stage lung cancer. He is suffering extreme pain and the profound discomfort of breathlessness. His death from the cancer is anticipated within 24–48 hours. He has an advance directive that refuses all treatment including artificial nutrition and hydration. He asks his physician for deep and continuous sedation as it is the only way to alleviate his suffering. His physician refuses for fear of criminal liability and the patient dies after 36 hours of agony. Was the physician’s fear of liability reasonable?

Another patient has multiple system organ failure and is likely to die within 10–14 days. Her profound agitation can only be alleviated by deep sedation. Without discussing it with the patient or her family, the physician initiates deep and continuous sedation and withholds artificial nutrition and hydration. She dies in 12 days. Was the physician’s conduct lawful?

Another patient has Huntington’s disease. Her death from the disease is inevitable but only after a long, slow decline, including a lengthy period of dementia. She has reached the point at which she feels her suffering outweighs the value of her life but her death from the disease is still a number of years away. She tells her physician that she would like to have deep and continuous sedation and she refuses artificial nutrition and hydration. Her physician complies with her wishes and she dies in 15 days. Was the physician’s conduct lawful?

Deep and continuous palliative sedation combined with the withholding or withdrawal of artificial nutrition and hydration (collectively termed “PS̄sANH”)<sup>1</sup> is an important aspect of high-quality end-of-life care. It is one (and sometimes the only) means of alleviating or ending suffering.<sup>2</sup> Unfortunately, the legality of this practice has been under-researched and PS̄sANH is not yet adequately regulated in Canada. It is therefore not at all surprising that physicians and patients might not know what their legal rights and responsibilities are with respect to PS̄sANH. It should not be surprising if it turns out that the scenarios described above are happening in Canada. But should they be happening?

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<sup>1</sup> “s̄” is the medical abbreviation for “without.”

<sup>2</sup> See Société québécoise des médecins de soins palliatifs & Collège des médecins du Québec, *Palliative Sedation at the End of Life: 08/2016 Practice Guidelines* (Montréal: Collège des médecins du Québec, 2016) at 8, online: <[www.cmq.org/publications-pdf/p-1-2016-08-29-en-sedation-palliative-fin-de-vie.pdf?t=1472671915312](http://www.cmq.org/publications-pdf/p-1-2016-08-29-en-sedation-palliative-fin-de-vie.pdf?t=1472671915312)>.

In this paper, we explore the legal status of PS $\bar{S}$ ANH where it (1) *will not* hasten death (Type 1 PS $\bar{S}$ ANH); (2) *might, but is not certain to*, hasten death (Type 2 PS $\bar{S}$ ANH); or (3) *is certain to* hasten death (Type 3 PS $\bar{S}$ ANH). The three scenarios described above map onto the three types of PS $\bar{S}$ ANH.

We explore provincial and territorial legislation, case law explicitly commenting on the issue, and the *Criminal Code* in order to determine whether – and, if so, under what circumstances – the three types of PS $\bar{S}$ ANH are legal under Canadian criminal law. We conclude that Type 1 is clearly lawful. While it could be argued that Types 2 and 3 are also lawful, we conclude that their legal status is ultimately unclear. We argue that the current lack of clear and robust regulation is a profound disservice to suffering individuals and health care providers and should be remedied by the federal government through amendments to the *Criminal Code*. We then propose amendments that would bring clarity, coherence, and comprehensiveness to end-of-life law, policy, and practice and thus enable better care for the dying.

## I. WHAT IS THE LEGAL STATUS OF PS $\bar{S}$ ANH?

An examination of provincial and territorial legislation, case law, and the *Criminal Code* is required in order to determine the legality of PS $\bar{S}$ ANH.

### A. *Provincial and territorial legislation*

The only relevant provincial or territorial legislation is from Québec.

Since *An Act respecting end-of-life care* (the Québec Act) came into force in Québec on 10 December 2015, patients in Québec have had a right to “palliative care” and, more specifically, to “continuous palliative sedation,” if their condition requires it and the parameters established by the Québec Act are met.<sup>3</sup> “Continuous palliative sedation” is defined in the Québec Act as

care that is offered *as part of palliative care* and consists in administering medications or substances to an end-of-life patient to relieve their suffering by rendering them unconscious without interruption until death ensues.<sup>4</sup>

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<sup>3</sup> CQLR c S-32.0001, ss 4, 24.

<sup>4</sup> *Ibid*, s 3(5) [emphasis added].

“Palliative care” is defined in the Québec *Act* as

the total and active care delivered by an interdisciplinary team to patients suffering from a disease with reserved prognosis, in order to relieve their suffering, *without delaying or hastening death*.<sup>5</sup>

The Québec *Act* does not specifically address the withholding or withdrawal of artificial nutrition and hydration. However, “continuous palliative sedation” is defined as part of “palliative care,” which in turn is defined (for the purposes of the Québec *Act*)<sup>6</sup> as care that does not hasten death. The absence of artificial nutrition and hydration in a Type 1 situation does not hasten death. It is therefore reasonable to conclude that the Québec *Act* permits deep and continuous sedation coupled with the withholding or withdrawal of artificial nutrition and hydration *where death is already imminent* (Type 1 PS $\bar{S}$ ANH). However, the Québec *Act* arguably cannot be taken to permit Types 2 and 3 PS $\bar{S}$ ANH because the legislation is permissive rather than prohibitive in nature and its definition of “palliative sedation” captures only Type 1 PS $\bar{S}$ ANH.

Recognizing the need for guidance on the practice of palliative sedation, the Collège des médecins du Québec released practice guidelines in August 2016.<sup>7</sup> Interestingly, these guidelines assume that Types 1 and 2 PS $\bar{S}$ ANH are legal under the Québec legislation. The guidelines explicitly

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<sup>5</sup> *Ibid*, s 3(4) [emphasis added].

<sup>6</sup> It should be noted that we do not, in this paper, take a position on the debate about the definition of “palliative care” – specifically, whether the hastening of death can be a feature of palliative care outside of the context of the Québec *Act*. The most commonly accepted definitions of palliative care share the view that palliative care does not hasten death (see e.g. the definition adopted in Canadian Hospice Palliative Care Association, “A Model to Guide Hospice Palliative Care” (Ottawa: CHPCA, 2013) at 6, online: <[www.chpca.net/media/319547/norms-of-practice-eng-web.pdf](http://www.chpca.net/media/319547/norms-of-practice-eng-web.pdf)>). However, especially following the decriminalization of medical assistance in dying (MAID), some argue that hastening death can be a part of, or is consistent with, palliative care (see e.g. Lieve Van den Block et al, “Euthanasia and Other End of Life Decisions and Care Provided in Final Three Months of Life: Nationwide Retrospective Study in Belgium” (2009) 339:7717 *BMJ* 390 at 390). The analysis in this paper does not turn on the resolution of this debate and so we do not address it further.

<sup>7</sup> See *supra* note 2.

state that they have taken into account the Québec *Act*<sup>8</sup> but then state that continuous sedation is permissible for those with a prognosis of survival of two weeks or less.<sup>9</sup> This implies that Types 1 and 2 PSSANH are legal. They do not explain how Type 2 is legal given the interaction of the definitions of “continuous palliative sedation” and “palliative care” set out above. The guidelines propose the following limits:

Continuous sedation should be reserved for patients with refractory symptoms and a prognosis of survival of two weeks or less. For patients whose prognosis is uncertain or estimated to be more than two weeks, sedation may be initiated and will be intermittent or continuous depending on how the patient’s condition evolves.<sup>10</sup>

The guidelines also recognize the uncertainty about the withholding or withdrawal of artificial hydration and nutrition in the context of continuous palliative sedation. They state that, “legally, natural nutrition and hydration are also considered to be treatments to which the patient can consent or refuse.”<sup>11</sup> No authority is cited for this statement. Nor does the statement provide any suggestion that there may be circumstances in which failure to respect a refusal may be legal (e.g., some cases of anorexia<sup>12</sup>). Nor do the guidelines give much guidance regarding nutrition and hydration, stating only that, “[i]n fact, continuous palliative sedation rarely involves withholding nutrition or hydration, for they are usually discontinued spontaneously by the patient.”<sup>13</sup> What is to be done in circumstances where that has not happened? And what is to be done about *artificial* nutrition and hydration?

Further uncertainty exists because of the relationship between the Québec *Act* and the federal *Criminal Code*. Under the province’s jurisdic-

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<sup>8</sup> *Ibid* at 6.

<sup>9</sup> *Ibid* at 13.

<sup>10</sup> *Ibid*.

<sup>11</sup> *Ibid* at 24.

<sup>12</sup> Failure to respect a refusal may be legal if, for example, a person meets the criteria for involuntary treatment set out in the provincial/territorial mental health legislation. See e.g. British Columbia’s *Mental Health Act*, RSBC 1996, c 288, s 31.

<sup>13</sup> *Ibid*.

tion over health,<sup>14</sup> the Québec *Act* may be able to restrict that which is not prohibited under the *Criminal Code*.<sup>15</sup> However, it cannot make legal that which the *Criminal Code* prohibits (assuming, for the sake of argument, that the federal government has jurisdiction to regulate PS̄ANH under its criminal law power).

Thus, even in Québec, which, unlike the other provinces and territories, has legislation and practice guidelines regarding PS̄ANH, uncertainty remains. Practitioners in Québec trying to understand the legal status of PS̄ANH would still need to turn to the *Criminal Code* (discussed in detail in Sub-Part C).

It is worth noting here that the first official report from the Québec Commission sur les soins de fin de vie indicates that between 10 December 2015 and 9 June 2016, there were 263 cases of palliative sedation in Québec.<sup>16</sup> It is unclear whether the palliative sedation that is being reported is in fact limited to Type 1 PS̄ANH and whether providers, and perhaps even the Commission, are aware of the implications of the narrow definition of “palliative sedation” found in the Québec *Act*.

### **B. Case law explicitly commenting on the issue**

The legality of PS̄ANH has not been explicitly tested in any case law. There are, however, some obiter dicta in the British Columbia Supreme

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<sup>14</sup> Provincial jurisdiction over health care is rooted in the *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, ss 92(7), 92(13), reprinted in RSC 1985, Appendix II, No 5. For a discussion of how section 92(13) of the *Constitution Act* relates to health care (specifically, professions relating to health care), see Commission on the Future of Health Care in Canada, “Constitutional Jurisdiction over Health and Health Care Services in Canada”, by Howard Leeson, Discussion Paper No 12 (August 2002) at 5, online: <[https://qspace.library.queensu.ca/bitstream/handle/1974/6884/discussion\\_paper\\_12\\_e.pdf?sequence=29](https://qspace.library.queensu.ca/bitstream/handle/1974/6884/discussion_paper_12_e.pdf?sequence=29)>. However, the Supreme Court of Canada has recognized that “health” is not assigned specifically to one head of power. See *Schneider v The Queen*, [1982] 2 SCR 112 at 142, 139 DLR (3d) 417.

<sup>15</sup> See e.g. Alberta’s *Human Tissue and Organ Donation Act*, 2006 c H-14.5, s 3(2), which prohibits the sale and purchase of tissues, organs, and bodies. There is no prohibition of such activities in the *Criminal Code*.

<sup>16</sup> *Rapport annuel d’activités: 10 décembre 2015 – 30 juin 2016* (Québec: Gouvernement du Québec, 2016) at 16.



Court case of *Carter v Canada (AG) (Carter BCSC)*<sup>17</sup> and the subsequent appeal to the Supreme Court of Canada (*Carter SCC*)<sup>18</sup> that seem to suggest that at least some PS̄ANH is lawful. However, neither decision directly tested the legality of PS̄ANH, nor distinguished between the types of PS̄ANH, so they did not contribute much to the task of clarifying the law on this issue.<sup>19</sup>

In *Carter BCSC*, Justice Smith defined “palliative sedation” in broad terms such that sedation “may be accompanied by the withdrawal of artificial hydration and nutrition.”<sup>20</sup> She also used the phrase “terminal sedation” interchangeably with the phrase “palliative sedation.”<sup>21</sup> Justice Smith noted:

So far as I am aware, palliative or terminal sedation has not been the subject of judicial consideration in Canada. It seems, however, to be a practice that may fall within the principles already described with regard to informed consent and potentially life-shortening symptom relief.<sup>22</sup>

Justice Smith’s statement that “palliative sedation” may fall within the principle of “potentially life-shortening symptom relief” is a reference to an earlier passage in her judgment in which she quotes Justice Sopinka writing for the majority in *Rodriguez v British Columbia (AG) (Rodriguez)*:

The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the

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<sup>17</sup> 2012 BCSC 886, 261 CRR (2d) 1 [*Carter BCSC*].

<sup>18</sup> 2015 SCC 5, [2015] 1 SCR 331 [*Carter SCC*].

<sup>19</sup> In *Carter v Canada (AG)*, the plaintiffs challenged the *Criminal Code* prohibitions on assisted suicide and voluntary euthanasia. They argued that these prohibitions violated sections 7 and 15 of the *Canadian Charter of Rights and Freedoms* and could not be saved under section 1 (see *Carter BCSC*, *supra* note 17 at para 22). Kay Carter was an 89-year-old woman with spinal stenosis whose family (the plaintiffs in the case) took her to Switzerland for assisted suicide when her suffering became intolerable (see *ibid* at paras 57–68). Gloria Taylor, another plaintiff, was a 64-year-old woman with amyotrophic lateral sclerosis (a fatal neurodegenerative condition) (see *ibid* at para 47).

<sup>20</sup> *Ibid* at para 42.

<sup>21</sup> *Ibid*.

<sup>22</sup> *Ibid* at para 226.

distinction drawn here is one based upon intention – in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death. ... In my view, distinctions based upon intent are important, and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear.<sup>23</sup>

Unfortunately, there are a number of problems with relying on Justice Sopinka's statement in *Rodriguez* as the basis for a claim that PS $\bar{S}$ ANH is legal. First, it is unclear whether Justice Sopinka would have included PS $\bar{S}$ ANH in his definition of "palliative care." As Justice Smith noted in *Carter BCSC*, "[t]he majority in *Rodriguez* did not refer to palliative sedation."<sup>24</sup> Justice Sopinka appeared to have only been contemplating the potentially life-shortening effects of opioids and other pain medications (but not sedatives) and not the life-shortening effects of the withholding or withdrawal of artificial nutrition and hydration.

Second, as evidenced by the excerpt above, Justice Sopinka relied upon the doctrine of double effect, although he did not refer to it by name. This doctrine states that if the intention<sup>25</sup> of the physician who administers the drugs to the patient is not to kill them but to help them (e.g., by alleviating pain), then the practice is still lawful even if it is foreseen to possibly (or certainly)<sup>26</sup> shorten the patient's life. This doctrine is very

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<sup>23</sup> [1993] 3 SCR 519 at 607, 82 BCLR (2d) 273 [*Rodriguez*], cited in *Carter BCSC*, *supra* note 17 at para 225.

<sup>24</sup> *Supra* note 17 at para 332.

<sup>25</sup> "Intention" is understood in the narrow sense here and encompasses only situations where the defendant's actual object or purpose is to cause a consequence and not where they merely foresee that a consequence will occur.

<sup>26</sup> The doctrine is said to apply even where death is foreseen as a certain consequence and not just a *possible* consequence. This is implied by Justice Sopinka's comments in *Rodriguez* as he applies the doctrine to "the administration of drugs designed for pain control in dosages which the physician *knows* will hasten death" (*supra* note 23 at 607 [emphasis added]). See also Dan Brock, "Physician-Assisted Suicide as a Last-Resort Option at the End of Life" in Timothy E Quill & Margaret P Battin, eds, *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice* (Baltimore: Johns Hopkins University Press, 2004) at 136 ("But if death comes unintentionally as the consequence of an otherwise well-intentioned intervention, even if foreseen with a high probability or even certainty, the physician's action can be morally acceptable").

popular, especially in the end-of-life context, among palliative care physicians and Catholics.<sup>27</sup> However, it has also been heavily criticized in ethics literature.<sup>28</sup> More importantly for the purposes of this paper, and as will be explained in Sub-Part 5, there is significant legal authority rejecting double effect in the context of the *Criminal Code*. Therefore, double effect does not form part of Canadian criminal law.

Third, Justice Smith agreed with the Attorney General of Canada's claim that "the criminal law does *not* appear to recognize a distinction between intentionally bringing about a prohibited consequence and doing something knowing that the prohibited consequence is virtually certain to result."<sup>29</sup> She goes on to distinguish the context of Justice Sopinka's statements from that of *Carter*:

However, I note that Sopinka J. was drawing a line between acceptable end-of-life practices and criminal acts in the context of a constitutional challenge. The Court did not have a criminal case before it. The specific constitutional and factual context of the *Rodriguez* case, in particular its focus on the implications of the requirement for informed consent to medical treatment and on the legality of existing end-of-life practices, may explain why the majority's comments about intention do not perfectly track criminal law doctrine regarding intention and causation in homicide cases.<sup>30</sup>

Of course, the issue being discussed in this paper is the potential for criminal liability for the provision of PS $\bar{S}$ ANH – not a constitutional challenge to a ban on PS $\bar{S}$ ANH.

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<sup>27</sup> See e.g. Joseph Boyle, "Who Is Entitled to Double Effect?" (1991) 16:5 J Med Philos 475; Daniel P Sulmasy & Edmund D Pellegrino, "The Rule of Double Effect: Clearing Up the Double Talk", Commentary, (1999) 159:6 Arch Intern Med 545.

<sup>28</sup> See e.g. Frances M Kamm, "The Doctrine of Double Effect: Reflections on Theoretical and Practical Issues" (1991) 16:5 J Med Philos 571; Timothy E Quill, Rebecca Dresser & Dan W Brock, "The Rule of Double Effect: A Critique of Its Role in End-of-Life Decision Making", Sounding Board, (1997) 337:24 New Eng J Med 1768.

<sup>29</sup> *Carter* BCSC, *supra* note 17 at paras 327 (Attorney General of Canada's statement), 328 (Smith J's affirmation) [emphasis in original].

<sup>30</sup> *Ibid* at para 328.

Despite these three problems with relying on Justice Sopinka's statement in *Rodriguez*, Justice Smith in *Carter BCSC* tentatively suggested that "[palliative sedation] may fall within the principles" guiding "potentially life-shortening symptom relief."<sup>31</sup> If it does, then at least some palliative sedation is lawful.

A further problem is that, even if we take Justice Smith's tentative comments as definitive, it is unclear whether she meant to suggest that all types of PS $\bar{S}$ ANH are lawful – either all of the time or some of the time – or only Types 1 and 2 are lawful (always or sometimes). Her comments on PS $\bar{S}$ ANH (albeit not using that acronym) potentially cover all three types of PS $\bar{S}$ ANH. Justice Smith did have before her the fact that "palliative sedation" combined with the withholding of artificial nutrition and hydration may be used to hasten death. She reported that the plaintiffs and the defendants both accepted the use of PS $\bar{S}$ ANH to hasten death as lawful.<sup>32</sup> She seemed to agree<sup>33</sup> with the defendants' submission that "the law permits death-hastening acts through ... declining nutrition and hydration while under palliative sedation"<sup>34</sup> (i.e., PS $\bar{S}$ ANH). Justice Smith herself suggested that palliative sedation without nutrition or hydration is one possible method that those who are suffering may use to hasten death.<sup>35</sup> Therefore, an argument could be made that Justice Smith's comments<sup>36</sup> are supportive of the legality of all types of PS $\bar{S}$ ANH (in at least some circumstances).

In *Carter SCC*, the Supreme Court of Canada simply stated that "[t]he law allows people in this situation [a grievous and irremediable condition] to request palliative sedation, [or] refuse artificial hydration and nutrition."<sup>37</sup> The Court did not provide any guidance on the boundaries of permissibility and did not distinguish between the different types of PS $\bar{S}$ ANH. It is possible that the Court did not contemplate a situation in which, for example,

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<sup>31</sup> *Ibid* at para 226.

<sup>32</sup> *Ibid* at paras 321 (Justice Smith's acknowledgment of plaintiff's position), 1075 (Justice Smith's acknowledgment of defendant's statement).

<sup>33</sup> See *ibid* at para 1076.

<sup>34</sup> *Ibid* at para 1075.

<sup>35</sup> *Ibid* at paras 1158–59.

<sup>36</sup> See *ibid* at para 226.

<sup>37</sup> *Supra* note 18 at para 66.

PS̄ANH is used to hasten death when the patient otherwise has years to live (a Type 3 situation). Thus, it is unclear whether the Court would accept all types of PS̄ANH as legal.

Overall, it is not possible to draw any meaningful conclusions about the legal status of PS̄ANH from the case law that explicitly mentions it. There are *obiter dicta* in the *Carter* decisions, especially in the trial decision, which suggest that at least some types of PS̄ANH are at least sometimes lawful. Still, neither Justice Smith nor the Supreme Court of Canada fully addressed, appreciated, or even had before them, the complex issue of the legality of all three types of PS̄ANH.

### C. *The Criminal Code*

The legal status of PS̄ANH is still insufficiently clear after an analysis of provincial and territorial legislation and case law that explicitly addresses it. Therefore, it is necessary to ask *de novo* whether, on an application of the elements of criminal law for various offences, the physician would be liable for the offence. There are several provisions of the *Criminal Code* that PS̄ANH might offend: (1) aiding suicide, (2) administering a noxious thing, (3) failure to provide the necessities of life, (4) criminal negligence causing death, and (5) culpable homicide in the form of manslaughter or murder.

#### 1. **Aiding suicide**

Does PS̄ANH constitute aiding suicide under the *Criminal Code*? Section 241(1) on counselling or aiding suicide reads:

Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

(a) counsels a person to die by suicide or abets a person in dying by suicide; or

(b) aids a person to die by suicide.<sup>38</sup>

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<sup>38</sup> *Criminal Code*, RSC 1985, c C-46.

The federal legislation on medical assistance in dying (the *MAID Act*)<sup>39</sup> effectively makes legal some actions that would otherwise constitute the offence of aiding suicide. However, the assisted suicide provision of the *MAID Act* covers only assistance with the *self-administration of a substance*.<sup>40</sup> The substance in PS $\bar{S}$ ANH (sedatives) is not self-administered<sup>41</sup> – even if it were self-administered at the outset, it could not continue to be so as it requires ongoing administration after the loss of capacity. Thus, the recent decriminalization of some forms of assisted suicide will not prevent PS $\bar{S}$ ANH from contravening the aiding suicide provision of the *Criminal Code*.

Two issues therefore need to be considered: (1) whether the patient's refusal of artificial nutrition and hydration constitutes suicide such that physicians' provision of PS $\bar{S}$ ANH is aiding suicide (because it includes withholding or withdrawing artificial hydration and nutrition); and (2) whether the patient's request for, and consent to, deep and continuous sedation in order to make self-starvation and dehydration possible (or simply to make it more comfortable) constitutes suicide such that providing deep and continuous sedation is aiding suicide.

The first issue is whether the patient's refusal of artificial nutrition and hydration on its own constitutes suicide. The answer to this question is clear for Type 1 PS $\bar{S}$ ANH as it, by definition, does not hasten death. The answer to this question is unclear for Types 2 and 3 PS $\bar{S}$ ANH.

Justice Bouck in the British Columbia Supreme Court case of *British Columbia (AG) v Astaforoff* (*Astaforoff* BCSC) held that dying via a self-imposed hunger strike was equivalent to suicide.<sup>42</sup> It must be noted, however, that this case took place in 1983 and in the context of a prison rather than a hospital.

Justice Dufour in the Québec Superior Court case of *Nancy B v Hôtel-Dieu de Québec* held that a physician who assists a patient by turning off

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<sup>39</sup> *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, SC 2016, c 3 [*MAID Act*].

<sup>40</sup> *Ibid*, s 3, amending *Criminal Code*, *supra* note 38, s 241.1(b).

<sup>41</sup> See UCLA Hospital System, "Administration of Palliative Sedation to the Dying Patient", Policy HS 1318, revised 30 September 2015 at 5, online: <[www.pcqn.org/wp-content/uploads/2017/04/UCLA-Palliative-Sedation-policy.pdf](http://www.pcqn.org/wp-content/uploads/2017/04/UCLA-Palliative-Sedation-policy.pdf)>.

<sup>42</sup> [1983] 6 WWR 322 at para 16, 6 CCC (3d) 498 [*Astaforoff* BCSC].

their respirator, thereupon resulting in their death, is not liable for counseling or aiding suicide.<sup>43</sup> Justice Dufour seemed to have reached this conclusion on the basis that the refusal of artificial respiration is not suicide in the first place. He quoted with approval a passage from the American decision of *Re Conroy*, which stated that “declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide.”<sup>44</sup> While he did not explicitly consider whether the refusal of artificial nutrition and hydration would constitute suicide, he did state, albeit in the context of considering a different point under the *Civil Code of Québec*, that placing someone on a respirator was “a technique of the same nature as that of feeding a patient. One cannot therefore make distinctions between artificial feeding and other essential life-sustaining techniques.”<sup>45</sup> The logic of this passage suggests that if he had turned his mind to it, Justice Dufour would have concluded that the refusal of artificial nutrition and hydration also does not constitute suicide.

However, in *Carter BCSC*, the Attorneys General for British Columbia and Canada took the position that individuals can “commit suicide by refusing sustenance.”<sup>46</sup> By way of example, Canada noted that “people with complete disability can still commit suicide by refusing treatment, hydration or nutrition,”<sup>47</sup> while British Columbia submitted that “the able bodied and the disabled can equally commit suicide by refusing to eat or drink or by refusing provision of artificial nutrition or hydration.”<sup>48</sup> Justice Smith did not take issue with this characterization of refusing oral or artificial hydration or nutrition as suicide and, on appeal, the Supreme Court of Canada did not take issue with her acceptance of the characterization.

It must be noted here that Justice Smith did not speak to circumstances in which a patient refuses oral or artificial nutrition and hydration in the final stages of a grievous and irremediable medical condition. Perhaps she would, if asked, have said that refusal of oral or artificial nutrition and hy-

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<sup>43</sup> (1992), 86 DLR (4th) 385 at 394, 69 CCC (3d) 450 [*Nancy B*].

<sup>44</sup> 486 A (2d) 1209 at 1224 (NJ Sup Ct 1985), cited in *Nancy B*, *supra* note 43 at 392.

<sup>45</sup> *Nancy B*, *supra* note 43 at 391.

<sup>46</sup> *Supra* note 17 at para 1069.

<sup>47</sup> *Ibid* at para 1049.

<sup>48</sup> *Ibid* at para 1067.

dration by the able-bodied or persons with disabilities is suicide, but refusal by a patient who is, for example, three weeks away from dying of cancer is not. While this conclusion might reflect the views of physicians and clinical practice, we do not have reliable data on those views, on the incidence of withholding or withdrawal of oral or artificial nutrition and hydration for varying prognoses, or on the practices of those completing medical certificates of death. Nor can we conclude what Justice Smith would have said.

If refusing oral or artificial nutrition and hydration is suicide, then the next question that must be answered is whether withholding or withdrawing oral or artificial nutrition and hydration is aiding suicide. This is precisely the question that was raised in *Bentley v Maplewood Seniors Care Society (Bentley)*.<sup>49</sup> Unfortunately, the British Columbia Supreme Court declined to answer the question on the grounds that, as a civil court, it had

no ability to grant a declaration that could bind prosecutorial discretion. This Court cannot declare that those providing care to Mrs. Bentley would be immune from criminal liability for withdrawing nourishment and liquids by prompting with a spoon or glass. Nor can this Court declare that those providing care to Mrs. Bentley would be criminally liable for doing so.<sup>50</sup>

If the refusal of artificial nutrition and hydration is suicide, it is hard to escape the conclusion that a physician who withholds or withdraws a patient's artificial nutrition and hydration would commit the offence of aiding suicide. While "aiding" is not defined within section 241(1), we can turn to section 21(1)(b) and its associated jurisprudence for interpretive assistance. Under section 21(1)(b), a person "is a party to an offence" when he "does or omits to do anything for the purpose of aiding any person to commit it."<sup>51</sup> Withholding artificial nutrition and hydration constitutes "omitting to do something." Withdrawing constitutes "doing something." Therefore, the *actus reus* of the offence is met. "For the purpose of" has been understood to involve intention and knowledge:

For the intent component, it was settled in *R v Hibbert* that "purpose" in s. 21(1)(b) should be understood as essentially

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<sup>49</sup> 2014 BCSC 165, [2014] 7 WWR 808.

<sup>50</sup> *Ibid* at para 152.

<sup>51</sup> *Criminal Code*, *supra* note 38.



synonymous with “intention”. The Crown must provide that the accused intended to assist the principal in the commission of the offence. The Court emphasized that “purpose” should not be interpreted as incorporating the notion of “desire” into the fault requirement for party liability. It is therefore not required that the accused desired that the offence be successfully committed.<sup>52</sup>

...

The perpetrator’s intention to kill the victim must be known to the aider or abettor; it need not be shared ... It is sufficient that he or she, armed with *knowledge* of the perpetrator’s intention to commit the crime, acts with the intention of assisting the perpetrator in its commission.<sup>53</sup>

Moreover, wilful blindness to the patient’s intention can constitute the required knowledge.<sup>54</sup> Given this, it seems that withholding or withdrawing artificial nutrition and hydration constitutes aiding suicide (if refusal of artificial nutrition and hydration is suicide).

However, it is widely assumed that withholding or withdrawing artificial nutrition and hydration is perfectly legal. Indeed, this is the position held by the Attorneys General of Canada and British Columbia, the trial judge, and the Supreme Court of Canada in *Carter*.<sup>55</sup>

It is not surprising that this practice is widely assumed to be perfectly legal, given our legal system’s profound commitment to bodily integrity. The Supreme Court of Canada has clearly endorsed the view that the common law concept of bodily integrity requires that health care providers not touch patients without their consent.<sup>56</sup> Starting or continuing treatment that involves touching the patient (as artificial nutrition and hydration does), if

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<sup>52</sup> *R v Briscoe*, 2010 SCC 13 at para 16, [2010] 1 SCR 411 [*Briscoe*], citing *R v Hibbert*, [1995] 2 SCR 973 at para 35, 99 CCC (3d) 193.

<sup>53</sup> *Briscoe*, *supra* note 52 at para 18 [emphasis in original].

<sup>54</sup> See *ibid* at para 21.

<sup>55</sup> See *Carter BCSC*, *supra* note 17 at paras 1067, 1049, 231; *Carter SCC*, *supra* note 18 at para 66.

<sup>56</sup> See e.g. *Ciarlariello v Schacter*, [1993] 2 SCR 119 at 132, 100 DLR (4th) 609 [*Ciarlariello*].

done against a patient's wishes, is considered tortious battery<sup>57</sup> or criminal assault under section 265 of the *Criminal Code*.<sup>58</sup>

It is here that incoherence arises. Two lines of reasoning can be followed that lead to incompatible results.

First:

- Refusing nutrition and hydration is suicide.
- Aiding suicide is illegal.
- Withholding/withdrawing artificial nutrition and hydration is aiding.
- Therefore withholding/withdrawing artificial nutrition and hydration is aiding suicide.
- Therefore withholding/withdrawing artificial nutrition and hydration is illegal.

Second:

- Touching someone without their consent is illegal.
- Starting or continuing artificial nutrition and hydration is touching.
- Therefore, starting or continuing artificial nutrition and hydration without consent is illegal.

There are several ways to resolve this incoherence:

- Declare that refusing artificial nutrition and hydration is not suicide.
- Declare that withholding or withdrawing artificial nutrition and hydration is not aiding.
- Declare that starting or continuing artificial nutrition and hydration without consent is not battery or assault.
- Declare that refusing artificial nutrition and hydration is suicide and that withholding or withdrawing artificial nutrition and hydration is aiding suicide, but withholding or withdrawing artificial nutrition and hydration is nonetheless lawful.

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<sup>57</sup> See *ibid.*

<sup>58</sup> *Supra* note 38.

Without one of these steps being taken by a court or legislature, a physician must choose between (1) withholding or withdrawing artificial nutrition and hydration in accordance with a patient's wishes and thereby perhaps aiding suicide or (2) providing the artificial nutrition and hydration (which requires touching the patient) against a patient's wishes and thereby committing the tort of battery or criminal assault under section 265 of the *Criminal Code*. It is not clear what the courts would do if confronted with this issue.

Up to this point, we have asked whether the refusal of artificial nutrition and hydration constitutes suicide such that withholding or withdrawing artificial nutrition and hydration is aiding suicide. Now, we take up the second question: does the request for and consent to deep and continuous sedation in order to make self-starvation and dehydration possible (or simply to make it more comfortable) constitute suicide such that the provision of deep and continuous sedation in response to that request is aiding suicide?

Can it be said that the provision of sedation – as opposed to the withholding or withdrawal of artificial nutrition and hydration, as discussed above – provides the means of committing suicide? In some cases, it may well be that the only way a patient could successfully starve or dehydrate themselves to death is by being deeply and continuously sedated. We can imagine that such a patient, quite understandably, would otherwise lack the willpower to commit suicide in this way. Let us call these the “insufficient will” cases. These cases are more likely to be Type 3 PS $\bar{S}$ ANH than Type 2, as Type 3 would require more willpower than Type 2 by virtue of it likely taking longer to die by starvation and/or dehydration. In these cases, sedation is a means that allows the patient to starve or dehydrate themselves to death. If refusing artificial nutrition and hydration is suicide, then the provision of sedation would, in these “insufficient will” cases, be aiding suicide.

But can it be said that the provision of sedation is “aiding” suicide, even where it is not the means of committing suicide as in the “insufficient will” cases (i.e., the patient would have starved or dehydrated themselves to death even without sedation)? That is, does it constitute aiding suicide by making the self-starvation and dehydration more comfortable? We argue that it would not be the means of committing suicide if, even without the sedation, the patient would have refused oral nutrition and hydration and then refused artificial nutrition and hydration once oral nutrition and hydration became impossible. In such a case, the sedation is simply for comfort and is not a means of suicide – the patient dies no sooner than they otherwise would have from simply ceasing to eat and drink and refusing artificial nutrition and hydration. If “making more comfortable” is understood to con-

stitute “aiding,” then providing sedation could be aiding suicide. If not, then providing sedation would not be aiding suicide. It seems less likely that a court would find a physician liable for “aiding” suicide in the “making more comfortable” cases than “insufficient will” cases. However, in both of these situations (“insufficient will” and “making more comfortable”), we ultimately return to the lack of certainty around whether or not refusing artificial nutrition and hydration in Types 2 and 3 PS $\bar{S}$ ANH is suicide.

In summary, the provision of Type 1 PS $\bar{S}$ ANH is not aiding suicide because it does not hasten death. The provision of Types 2 and 3 PS $\bar{S}$ ANH might be aiding suicide, especially where the patient is able to follow through on the refusal of all nutrition and hydration only if they are sedated (this being more likely in a Type 3 than Type 2 situation).

## 2. Administering a noxious thing

Does PS $\bar{S}$ ANH constitute administering a noxious thing under the *Criminal Code*? Section 245(1)(a) on administering a noxious thing reads:

Every one who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years, if he intends thereby to endanger the life of or to cause bodily harm to that person.<sup>59</sup>

This question can be answered quite readily because a sedative, properly administered, is not a “poison or any other destructive or noxious thing.” Properly administered, a sedative is not harmful. Therefore all three types of PS $\bar{S}$ ANH, properly administered, should not be considered administering a noxious thing.

## 3. Failure to provide the necessities of life

Does PS $\bar{S}$ ANH constitute failure to provide the necessities of life under the *Criminal Code*? Section 215 on the duty on persons to provide the necessities of life reads, in part:

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<sup>59</sup> *Criminal Code*, *supra* note 38.

## (1) Every one is under a legal duty

...

(c) to provide necessities of life to a person under his charge if that person

(i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and

(ii) is unable to provide himself with necessities of life.

(2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if

...

(b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.<sup>60</sup>

It might appear that a physician commits the offence of failing to provide the necessities of life when they withhold or withdraw artificial nutrition and hydration from a patient as part of PS $\bar{s}$ ANH. For this to be the case, the physician would have to be under a legal duty to administer artificial nutrition and hydration and there would have to be no legal excuse for failing to provide artificial nutrition and hydration.

There is no duty to provide artificial nutrition and hydration in a Type 1 PS $\bar{s}$ ANH situation as, by definition, artificial nutrition and hydration cannot extend life and thus cannot be a “necessary of life.” That still leaves uncertainty around Types 2 and 3 PS $\bar{s}$ ANH.

Where there is no consent to Types 2 and 3 PS $\bar{s}$ ANH (i.e., there is no refusal of artificial nutrition and hydration), the physician has a duty to provide artificial nutrition and hydration and has no legal excuse for failing to provide it.<sup>61</sup> But what about when the patient or substitute decision maker has refused artificial nutrition and hydration?

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<sup>60</sup> *Ibid.*

<sup>61</sup> We are presuming that, barring some exceptions that do not apply here, physicians do not have the legal authority to unilaterally withhold or withdraw

In *Astaforoff* BCSC, Justice Bouck made it clear that correctional authorities did not have a legal duty under what is now section 215 of the *Criminal Code* to forcibly feed a prisoner who was on a hunger strike, even though she was likely to die without the force-feeding.<sup>62</sup> It could be argued that this situation is analogous to that of a physician who is alleged to be under a legal duty to administer artificial nutrition and hydration to a patient who clearly objects to the practice and that, in both situations, there is no legal duty to do so. Unfortunately, *Astaforoff* is the only case to address this issue. The court in *Bentley* was asked whether there is a legal duty to provide oral nutrition and hydration under the *Criminal Code*, but it declined to answer on the grounds that, as a civil court, it could not issue an enforceable declaration that would bind the exercise of prosecutorial discretion.<sup>63</sup> There is thus little guidance available from the case law directly.

We can argue from the case law indirectly, starting from the well-established common law right for competent adults to refuse “medical treatment” or to demand that “medical treatment” be discontinued, even if such treatment is life-sustaining.<sup>64</sup> This right to refuse treatment has been extended beyond contemporaneous refusals made by competent individuals to refusals made through valid advance directives or by legally authorized substitute decision makers.<sup>65</sup> The provision of artificial nutrition and hydration appears to fall within the term “medical treatment,” as forcibly feeding

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potentially life-sustaining treatment. This conclusion has been defended elsewhere and we rely on that defence (see e.g. Jocelyn Downie, Lindy Willmott & Ben White, “Cutting the Gordian Knot of Futility: A Case for Law Reform on Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment” (2014) 26:1 NZULR 24).

<sup>62</sup> *Supra* note 42 at para 14. This decision was affirmed on appeal, where it was held that

there is no such statutory duty, at least on the basis of the statutes and regulations to which we were referred. I do not think that any of those statutes or regulations can be construed so as to import a duty to feed a prisoner by force without the prisoner’s consent (*British Columbia (AG) v Astaforoff* (1983), [1984] 4 WWR 385 at para 16, 54 BCLR 309 [*Astaforoff* BCCA]).

<sup>63</sup> *Supra* note 49 at para 152.

<sup>64</sup> See *Carter SCC*, *supra* note 18 at para 67; *Rodriguez*, *supra* note 23 at 588, 598, 606, Sopinka J.

<sup>65</sup> See e.g. *Malette v Shulman* (1990), 72 OR (2d) 417, 67 DLR (4th) 321 (CA); *Fleming v Reid*, 4 OR (3d) 74, 82 DLR (4th) 298 (CA); *Health Care Consent*

a prisoner via a nasogastric tube was considered to be “medical treatment” in *Astaforoff* on appeal.<sup>66</sup> In fact, administering artificial nutrition and hydration to a patient against their wishes would likely constitute the tort of battery<sup>67</sup> and criminal assault under section 265 of the *Criminal Code*.

Given this, it would arguably be wrong to conclude that a physician has a legal duty to provide artificial nutrition and hydration when they would be liable for battery and assault for doing so. A court might accept this argument and conclude that there is no duty to provide artificial nutrition and hydration where the patient or substitute decision maker has refused it.

Similarly, a court might conclude that when a competent patient refuses artificial nutrition and hydration – either contemporaneously or through a valid advance directive – then the patient has withdrawn themselves from the physician’s charge and there is, again, no duty.

In the alternative, a court might conclude that there is a duty but that a refusal constitutes a lawful excuse for not meeting that duty. One source of a “lawful excuse” could be that administering artificial nutrition and hydration in the circumstances of a valid refusal would constitute tortious battery and criminal assault. A second source could be provincial or territorial consent legislation across Canada that allows patients or substitute decision makers to refuse consent to treatment, even if life-sustaining.<sup>68</sup>

Unfortunately, on the grounds that a civil court cannot issue an enforceable declaration that would bind the exercise of prosecutorial discretion, the court in *Bentley* also declined to rule on whether consent provides a lawful excuse, in spite of the fact that section 14 of the *Criminal Code* establishes that “[n]o person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent.”<sup>69</sup>

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*Act*, 1996, SO 1996, c 2, Schedule A, s 20 [Ontario *HCCA*]; *Care Consent Act*, SY 2003, c 21, s 4.

<sup>66</sup> *Astaforoff* BCCA, *supra* note 62 at para 14.

<sup>67</sup> See e.g. *Rodriguez*, *supra* note 23 at 606; *Ciarlariello*, *supra* note 56 at 132.

<sup>68</sup> See e.g. Ontario *HCCA*, *supra* note 65; *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, s 17; *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c 17.2.

<sup>69</sup> *Supra* note 38.

In summary, there is clearly no breach of section 215 for Type 1 PS $\bar{S}$ ANH because artificial nutrition and hydration cannot be considered “necessaries of life” where their withholding or withdrawal does not hasten death. There is likely a breach of section 215 for Types 2 and 3 PS $\bar{S}$ ANH where it is done either against the wishes or without the knowledge of the patient or patient’s substitute decision maker. There would be no breach of section 215 for Types 2 and 3 PS $\bar{S}$ ANH where valid refusal has been given and if a court finds that either (1) there is no duty to provide the necessaries of life if providing them would result in liability for battery or assault, (2) there is no duty to provide the necessaries of life if refusal constitutes withdrawal from a physician’s charge, (3) a refusal of artificial nutrition and hydration constitutes a lawful excuse because providing it without consent is otherwise tortious or criminal, or (4) there is a lawful excuse because of provincial or territorial consent legislation. Again, however, it is uncertain how a court would respond on this issue.

#### 4. Criminal negligence causing death

Does PS $\bar{S}$ ANH constitute criminal negligence causing death under the *Criminal Code*? Criminal negligence is defined by section 219:

- (1) Every one is criminally negligent who
  - (a) in doing anything, or
  - (b) in omitting to do anything that it is his duty to do,shows wanton or reckless disregard for the lives or safety of other persons.
- (2) For the purposes of this section, duty means a duty imposed by law.<sup>70</sup>

Section 220 of the *Criminal Code* further provides that it is an offence to cause death to another person by criminal negligence.<sup>71</sup>

Immediately, we can conclude that Type 1 PS $\bar{S}$ ANH is not criminal negligence causing death as, by definition, it does not cause the patient’s death.

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<sup>70</sup> *Ibid.*

<sup>71</sup> *Ibid.*



However, we must apply the criminal negligence analysis to Types 2 and 3 PS̄ANH and then, if there could be criminal negligence, assess whether Types 2 or 3 PS̄ANH would be said to cause death.

The *actus reus* of criminal negligence requires an act or an omission where there is a duty to act. The provision of sedation and withdrawal of artificial nutrition and hydration might constitute doing something. Withholding artificial nutrition and hydration might constitute omitting to do something. As argued in Sub-Part 3, apart from Type 1 PS̄ANH situations, there is a duty to provide artificial nutrition and hydration where the patient or substitute decision maker has not refused artificial nutrition and hydration or withdrawn themselves from the physician's charge. There might still be a duty to provide artificial nutrition and hydration where it has been refused or where the patient has withdrawn themselves from the physician's charge, in which case a court might nevertheless determine that there is no failure to provide the necessities of life because there is a lawful excuse.

The *mens rea* of criminal negligence requires a "marked and substantial departure from the norm of a reasonable person" in the same circumstances as the accused.<sup>72</sup> It seems certain that Types 2 and 3 PS̄ANH *without consent* satisfy the *mens rea* requirement of criminal negligence as there is a "marked and substantial departure from the norm of a reasonable person" in the same circumstances as the physician. Consent is very clearly required by law for medical treatment. However, it is less certain whether Types 2 and 3 PS̄ANH *with consent* constitute a "marked and substantial departure from the norm of a reasonable person" in the same circumstances as the physician. Presumably, medical guidelines and position statements regarding palliative sedation, although not legally binding in and of themselves, would be relevant when considering whether the *mens rea* of criminal negligence is fulfilled.<sup>73</sup> Unfortunately, there is little guidance to be drawn from existing guidelines. There are very few guidelines in Canada that address palliative sedation,<sup>74</sup>

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<sup>72</sup> *R v F (J)*, 2008 SCC 60 at para 11, [2008] 3 SCR 215.

<sup>73</sup> It was held in a trial involving a house fire that "it is appropriate to examine the applicable safety standards when considering whether the Crown has met its burden" regarding the *mens rea* (*R v Singh*, 2014 ONSC 6960 at para 9, 118 WCB (2d) 419).

<sup>74</sup> See e.g. Mervyn M Dean et al, "Framework for Continuous Palliative Sedation Therapy in Canada" (2012) 15:8 J Palliat Med 870; Fraser Health Authority, "Refractory Symptoms and Palliative Sedation Therapy Guideline" (2011),

and even fewer that address PS $\bar{S}$ ANH.<sup>75</sup> The guidelines demonstrate a willingness to accept continuous palliative sedation when it is administered within the last two weeks of life.<sup>76</sup> They are less willing to accept it if artificial nutrition and hydration are withheld (as by definition in all Types of PS $\bar{S}$ ANH)<sup>77</sup> or if the anticipated life expectancy is more than two weeks (as by definition in Type 3 PS $\bar{S}$ ANH).<sup>78</sup> This uneasiness seems particularly acute when the anticipated life expectancy is greater than two weeks and artificial nutrition and hydration are withheld (i.e., Type 3 PS $\bar{S}$ ANH).<sup>79</sup> Unfortunately, there is also little guidance to be drawn from existing practice. We do not have reliable data on the incidence of the three types of PS $\bar{S}$ ANH<sup>80</sup> or on public opinion regarding the three types of PS $\bar{S}$ ANH.

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online: <[www.fraserhealth.ca/media/RefractorySymptomsandPalliativeSedationTherapyRevised\\_Sept%2009.pdf](http://www.fraserhealth.ca/media/RefractorySymptomsandPalliativeSedationTherapyRevised_Sept%2009.pdf)>; Société québécoise des médecins de soins palliatifs & Collège des médecins, *supra* note 2.

- <sup>75</sup> Indeed, Dean et al explicitly decline to make recommendations with respect to the withholding or withdrawal of artificial nutrition and hydration (*supra* note 74 at 872). The Fraser Health Authority Guideline simply notes that the health care team should “plan for ... whether to provide artificial hydration” (*supra* note 74 at 10). Out of the three guidelines we listed in note 73, only the Collège des médecins guidelines discuss discontinuation of artificial nutrition and hydration combined with palliative sedation (*supra* note 2 at 24).
- <sup>76</sup> See Société québécoise des médecins de soins palliatifs & Collège des médecins, *supra* note 2 at 13; Fraser Health Guideline, *supra* note 74 at 1; Dean et al, *supra* note 74 at 871.
- <sup>77</sup> See, e.g. Société québécoise des médecins de soins palliatifs & Collège des médecins, *supra* note 2 at 24 (“Combined with the use of palliative sedation, [discontinuation of artificial nutrition and hydration] raises more questions of an ethical nature”).
- <sup>78</sup> See note 75.
- <sup>79</sup> See Dean et al, *supra* note 74 at 871 (although Dean et al do not make recommendations with respect to the withholding or withdrawal of artificial nutrition and hydration, they note that “the longer the anticipated time before death the greater the ethical challenges and the more controversial the procedure, especially regarding decisions around nutrition and hydration during sedation”).
- <sup>80</sup> As noted earlier, we do have some data on the number of cases of continuous palliative sedation in Québec from the Commission sur les soins de fin de vie, *supra* note 16, but nothing else (e.g., estimated prognosis at time of continuous palliative sedation and number of days after discontinuation of nutrition

Compelling arguments might be made that Types 2 and 3 PS $\bar{s}$ ANH with consent *should* fall within the norm by drawing an analogy between potentially life-shortening opioid use and Type 2 PS $\bar{s}$ ANH, and between MAID and Type 3 PS $\bar{s}$ ANH where the *MAID Act* eligibility criteria are met. However, whether a court would accept those arguments remains uncertain. Thus, it is uncertain whether Types 2 and 3 PS $\bar{s}$ ANH would satisfy the *actus reus* or the *mens rea* requirements of criminal negligence.

The final question that must be addressed with respect to criminal negligence causing death is whether a physician who administers PS $\bar{s}$ ANH causes the patient's death.

As noted earlier, Type 1 PS $\bar{s}$ ANH will not be seen to cause death since sedation does not hasten death<sup>81</sup> and therefore Type 1 PS $\bar{s}$ ANH will not constitute criminal negligence causing death. However, the analysis of whether Type 2 and especially Type 3 PS $\bar{s}$ ANH cause death is more complicated.

There are two aspects to causation: the factual aspect and the legal aspect. Factual causation is satisfied if PS $\bar{s}$ ANH is a “contributing cause, beyond *de minimis*,”<sup>82</sup> a “contributing cause that is not trivial or insignificant,”<sup>83</sup> or a “significant contributing cause.”<sup>84</sup>

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and hydration that death occurred – this data is gathered but has not yet been made available).

<sup>81</sup> See e.g. Marco Maltoni et al, “Palliative Sedation in End-of-Life Care and Survival: A Systematic Review” (2012) 30:12 J Clin Oncol 1378 at 1381; Nigel P Sykes, “Clinical Aspects of Palliative Sedation” in Sigrid Sterckx, Kasper Raus & Freddy Mortier, eds, *Continuous Sedation at the End of Life: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press, 2013) 86 at 96; B Barathi & Prabha S Chandra, “Palliative Sedation in Advanced Cancer Patients: Does It Shorten Survival Time? A Systematic Review” (2013) 19:1 Indian J Palliat Care 40; Elaine M Beller et al, “Palliative Pharmacological Sedation for Terminally Ill Adults”, online: [2015] 1 Cochrane Database Syst Rev CD010206 at 15 <cochranelibrary-wiley.com/doi/10.1002/14651858.CD010206.pub2/full>.

<sup>82</sup> *R v Nette*, 2001 SCC 78 at para 2, [2001] 3 SCR 488.

<sup>83</sup> *Ibid* at paras 2–4.

<sup>84</sup> *Ibid* at paras 71–73. Also note that the Supreme Court of Canada has said that “significant” and “not insignificant” mean the same thing (*ibid* at paras 4–5, 7, 10, 32, 69–71).

Factual causation could be met in some cases of Type 2 PS $\bar{S}$ ANH. Perhaps the patient would not have had the willpower and capacity to starve or dehydrate themselves to death without deep and continuous sedation. Perhaps the patient died from dehydration rather than from their underlying condition. It might be difficult to prove this causation: did the PS $\bar{S}$ ANH play any causal role in the death of a patient who died four days after the commencement of PS $\bar{S}$ ANH? However, the epistemological difficulties are consistent with the possibility that Type 2 PS $\bar{S}$ ANH could, in some cases, factually cause a patient's death (the fact that, by definition, it might, but is not certain to, hasten death means that uncertainty exists prospectively but not necessarily retrospectively).

Factual causation would clearly be met in at least some cases of Type 3 PS $\bar{S}$ ANH. With Type 3 PS $\bar{S}$ ANH, there is more epistemological certainty than with Type 2 PS $\bar{S}$ ANH: we know that the patient's underlying condition is not the factual cause of their death, so the analysis is more straightforward. The PS $\bar{S}$ ANH is not a factual cause if, without sedation, the patient would have successfully refused oral nutrition and hydration and refused artificial nutrition and hydration once oral nutrition and hydration became impossible. In such a case, sedation is simply for comfort, not for making death any more likely, and is not a factual cause of death. However, in other cases, being deeply and continuously sedated may be the only way the patient could successfully starve or dehydrate themselves to death. In still other cases, while not necessary, sedation may make it easier and more likely for the person to starve or dehydrate themselves to death and so might be considered a "not trivial or insignificant" cause. In such cases, sedation is a factual cause of death. It is also clearly the factual cause of death in cases where there is no consent to Type 3 PS $\bar{S}$ ANH.

However, the causation analysis does not end with factual causation; factual causation is necessary for liability but it is not sufficient. The test for legal causation is whether the accused person *should* be held responsible for the death.<sup>85</sup>

In the context of PS $\bar{S}$ ANH, it might be tempting to argue that the patient's consent is an intervening act sufficient to justify not finding legal causation.<sup>86</sup> However, this argument is not valid because the consent comes

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<sup>85</sup> *Ibid* at para 45.

<sup>86</sup> For an explanation of the law on intervening acts, see *R v Maybin*, 2012 SCC 24 at paras 23–29, [2012] 2 SCR 30.

before the physician's administration of sedation and before the withholding of artificial nutrition and hydration. The consent, therefore, cannot be said to have intervened between the physician's action(s) and the death.

It might be argued that where a patient refuses artificial nutrition and hydration the physician is legally prohibited from providing them. In these cases, it would seem unfair to blame the physician for the death. This is especially true where deep and continuous sedation, which precipitates the need for artificial nutrition and hydration, is necessary to ease the patient's suffering. It is unclear whether a court would accept this argument. A court is unlikely to accept the argument in circumstances where sedation is not necessary to ease the patient's suffering or where the patient did not consent to sedation and/or the withholding of artificial nutrition and hydration.

We conclude that Type 1 PS̄ANH would not be found to constitute criminal negligence causing death. Types 2 and 3 PS̄ANH might, in at least some circumstances, be found to constitute criminal negligence causing death, especially where there was no consent to PS̄ANH.

## 5. Culpable homicide (murder or manslaughter)

Does PS̄ANH constitute culpable homicide in the form of murder or manslaughter? The *Criminal Code* provides that culpable homicide can be caused, *inter alia*, by means of an unlawful act or by criminal negligence.<sup>87</sup> The *Criminal Code* further provides that culpable homicide can be committed in the form of murder, manslaughter, or infanticide.<sup>88</sup> Murder is defined by section 229, which reads in part:

Culpable homicide is murder

(a) where the person who causes the death of a human being

(i) means to cause his death, or

(ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not;

...

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<sup>87</sup> *Supra* note 38, s 222(5).

<sup>88</sup> *Ibid*, s 222(4).

(c) where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being.<sup>89</sup>

Manslaughter is defined as culpable homicide that is not murder or infanticide.<sup>90</sup>

Is PS $\bar{S}$ ANH unlawful act manslaughter, criminal negligence manslaughter, or murder? We have already concluded that Types 1, 2, and 3 PS $\bar{S}$ ANH should not be considered unlawful acts of administering a noxious thing but that Types 2 and 3 PS $\bar{S}$ ANH might be considered unlawful acts of failure to provide the necessities of life (where there was no consent) or criminal negligence.

The next question that must be answered to determine whether PS $\bar{S}$ ANH constitutes culpable homicide is whether the unlawful act or criminal negligence was objectively dangerous (i.e., had a reasonably foreseeable risk of bodily harm).<sup>91</sup> Clearly, Type 1 PS $\bar{S}$ ANH is not objectively dangerous, as it poses no threat to the health or well-being of the patient. Therefore, it cannot constitute culpable homicide. Types 2 and 3 PS $\bar{S}$ ANH are objectively dangerous, as the former might, but is not certain to, hasten death and the latter is certain to do so (assuming, as before, that the patient would not, even without the sedation, starve or dehydrate themselves to death).

Having already concluded in Sub-Part 4 that Types 2 or 3 PS $\bar{S}$ ANH might be found to cause the patient's death, the next question that must be addressed is whether the physician meant to cause the death.

According to the Supreme Court of Canada, the phrase "means to cause his death"<sup>92</sup> "clearly requires that the accused have actual subjective foresight of the likelihood of causing the death coupled with the intention to cause that death."<sup>93</sup>

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<sup>89</sup> *Ibid*, s 229.

<sup>90</sup> *Ibid*, s 234.

<sup>91</sup> See *R v Creighton*, [1993] 3 SCR 3 at 25, 105 DLR (4th) 632.

<sup>92</sup> *Criminal Code*, s 229(a)(i).

<sup>93</sup> *R v Vaillancourt*, [1987] 2 SCR 636 at 645, 47 DLR (4th) 399.

Justice Martin, writing for a unanimous Ontario Court of Appeal in *R v Buzzanga and Durocher* (*Buzzanga*), held that “as a general rule, a person who foresees that a consequence is certain or substantially certain to result from an act which he does in order to achieve some other purpose, intends that consequence.”<sup>94</sup>

Here, one might be tempted to introduce the doctrine of double effect and concede intention where the defendant has it as their object or purpose to cause that consequence, but to deny it when the defendant does not have the consequence as their object or purpose though they do foresee that the consequence will occur. Indeed, in *Buzzanga*, the court “assum[ed] without deciding that there may be cases in which intended consequences are confined to those which it is the actor’s conscious purpose to bring about.”<sup>95</sup> Unfortunately, Justice Martin gave no indication of when the meaning of intention would be confined to this narrow definition. In *Rodriguez*, Justice Sopinka appeared to have suggested that the double effect doctrine is part of Canadian law. However, the Supreme Court of Canada has, in a variety of cases, both before and after *Rodriguez*, rejected the doctrine of double effect (albeit not by name).<sup>96</sup> There are no cases in which Justice Martin’s hypothetical narrowing of intention has been realized. In other words, as noted earlier, while the doctrine of double effect may be popular with Catholics and palliative care providers, it will not provide a way out of finding *mens rea* in these circumstances.

In applying the *mens rea* provision to Type 3 PS $\bar{S}$ ANH, it seems that intention would be fulfilled because it is foreseeable that it is certain or substantially certain that the patient would die sooner than they would without PS $\bar{S}$ ANH from a lack of hydration (given that the patient must have indicated to the physician before sedation began that they did not wish to receive artificial nutrition and hydration). If the physician is thus found to have meant to cause death, then they might find themselves convicted of murder.

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<sup>94</sup> (1979), 101 DLR (3d) 488 at 503, 25 OR (2d) 705 (CA).

<sup>95</sup> *Ibid.*

<sup>96</sup> Pre-*Rodriguez* cases include *Lewis v The Queen*, [1979] 2 SCR 821 at 831, 98 DLR (3d) 111, and *R v Keegstra*, [1990] 3 SCR 697 at 774–75, [1991] 2 WWR 1. Post-*Rodriguez* cases include *R v Chartrand*, [1994] 2 SCR 864 at 890–91, 116 DLR (4th) 207.

If the physician is found not to have meant to cause death, further analysis is required.<sup>97</sup> First, did the physician mean to cause bodily harm to the patient that they know is likely to cause death? Even if the physician did not mean to cause death, section 229(a)(ii) remains a possible source of criminal liability if the physician “means to cause [the victim] bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not.”<sup>98</sup> The second half of the provision, requiring that the physician be “reckless whether death ensues or not” is redundant here and can be safely ignored.<sup>99</sup> With respect to the first half of the provision, the Court held in *R v Nygaard* that “the essential element is that of intending to cause bodily harm of such a grave and serious nature that the accused knew that it was likely to result in the death of the victim.”<sup>100</sup>

Applying this to an instance of Type 3 PS $\bar{S}$ ANH, one might argue that the physician intends to render the patient unconscious via sedation and that unconsciousness constitutes bodily harm of a grave and serious nature.<sup>101</sup> It seems unlikely that a trier of fact would consider unconsciousness arising from palliative sedation *simpliciter* to be bodily harm, given that it could be argued this sort of unconsciousness is not actually harmful (or indeed that it is beneficial). That said, perhaps a court would find that sedation causes dependence on artificial nutrition and hydration, which therefore constitutes sufficiently serious bodily harm. That dependence, coupled with the patient’s refusal of artificial nutrition and hydration, might be said to cause the patient’s death. If that is the conclusion drawn, then the physician could be convicted of murder. If it is concluded that the physician did not mean “to cause [the victim] bodily harm that he knows is likely to cause his death,” then they could be convicted of manslaughter.

As the final step in the culpable homicide analysis, we need to ask whether the physician, neither meaning to cause death nor bodily harm but knowing they are likely to cause the patient’s death, nonetheless violated section 229(c). This section provides that culpable homicide is murder

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<sup>97</sup> See *Criminal Code*, *supra* note 38, ss 229(a)(ii), (c).

<sup>98</sup> *Ibid*, s 229(a)(ii).

<sup>99</sup> See *R v Cooper*, [1993] 1 SCR 146 at 154–55, 103 Nfld & PEIR 209.

<sup>100</sup> [1989] 2 SCR 1074 at 1087–88, 70 Atla LR (2d) 1.

<sup>101</sup> “Bodily harm” and “serious bodily harm” are defined in *R v Moquin*, 2010 MBCA 22 at para 27, 251 Man R (2d) 160.



where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being.<sup>102</sup>

The part of the provision referring to “or ought to know” conflicts with sections 7 and 11(d) of the *Canadian Charter of Rights and Freedoms* and can be safely ignored as it is without effect.<sup>103</sup> In an instance of Type 3 PS̄ANH, we argue that the remainder of the provision would not be satisfied: the object of the physician is to alleviate suffering and respect autonomy, neither of which is an “unlawful object” amounting to a “serious crime” as required by *R v Vasil*.<sup>104</sup>

A quick comment on the role of the federal *MAID Act* is required here. The *Act* makes it tempting to argue that there is one possible exemption to culpable homicide for Types 2 and 3 PS̄ANH. Specifically, if Types 2 and 3 PS̄ANH are seen to cause death and to fall within the definition of MAID, and if the eligibility criteria and procedural safeguards for access to MAID set out by the legislation are met, then the practice would not be culpable homicide. If Types 2 and 3 PS̄ANH are seen to cause death and to fall within the definition of MAID, but the eligibility criteria or procedural safeguards are not met, they would not be saved by the legislation. However, a claim of an exemption through the *MAID Act* might fail because Types 2 and 3 PS̄ANH might not fall within the definition of MAID. The relevant definition from the legislation is: “the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death.”<sup>105</sup> The question then becomes: does the administration of the sedative (the substance that is administered) cause the patient’s death? As noted earlier, the answer to this question is not clear. Furthermore, one could point to the fact that Parliament clearly set out the circumstances in which assisted suicide and voluntary euthanasia are lawful, despite the multitude of

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<sup>102</sup> *Criminal Code*, *supra* note 38, s 229(c).

<sup>103</sup> See *R v Martineau*, [1990] 2 SCR 633 at 648, 6 WWR 97.

<sup>104</sup> [1981] 1 SCR 469 at 490, 121 DLR (3d) 451. Further, even if the physician’s object is to cause the patient’s death, that object cannot be the “unlawful object” for the purpose of this *mens rea* provision. That would require that the physician “desire to effect his object without causing death” so the “unlawful object” cannot be “to cause death.”

<sup>105</sup> *Supra* note 39, s 3, amending *Criminal Code*, *supra* note 38, s 241.1(a)

provisions in the *Criminal Code* about causing death. Given that Parliament did not clearly include exemptions for Types 2 and 3 PS $\bar{S}$ ANH, one could argue that they intended for the ordinary *Criminal Code* offences to apply.

In summary, we have argued that a physician who administers Types 2 or 3 PS $\bar{S}$ ANH could find themselves convicted of aiding suicide, failure to provide necessities of life (if PS $\bar{S}$ ANH is administered without consent), criminal negligence causing death, murder, or manslaughter, but could potentially find an exemption in some cases under the *MAID Act*. However, there is still much uncertainty as to if and when a court would make such findings.

## II. HOW SHOULD THE LAW SURROUNDING PS $\bar{S}$ ANH BE CLARIFIED, REGULATED, AND REFORMED?

Before moving on to discuss our recommendations for the clarification, regulation, and reform of the law surrounding PS $\bar{S}$ ANH, it is useful to take stock of the current legal status of the practice. A thorough review of provincial and territorial legislation, case law, and the *Criminal Code* (including the recent revisions made to permit MAID) reveals that Type 1 PS $\bar{S}$ ANH is clearly lawful and that, while it could be argued that Types 2 and 3 PS $\bar{S}$ ANH are also lawful, the legal status of Type 2 and Type 3 PS $\bar{S}$ ANH is ultimately unclear. A physician who administers Types 2 and 3 PS $\bar{S}$ ANH without a patient or substitute decision maker's consent is at real risk of criminal liability. A physician who administers Types 2 and 3 PS $\bar{S}$ ANH with a patient or substitute decision maker's consent is at lower, but not non-existent, risk of being found liable for aiding suicide, failure to provide necessities of life, criminal negligence causing death, murder, or manslaughter. This spectrum of liability risk can be expressed in terms of a modified (i.e., by adding orange) traffic light system:

Green light:

- Type 1 PS $\bar{S}$ ANH with patient or substitute decision maker's consent

Yellow light:

- Types 2 and 3 PS $\bar{S}$ ANH where it is certain the patient would starve or dehydrate themselves to death without sedation

Orange light:

- Types 2 and 3 PS $\bar{S}$ ANH where it is uncertain whether the patient would starve or dehydrate themselves to death without sedation

- Types 2 and 3 PS $\bar{s}$ ANH where it is certain the patient would not starve or dehydrate themselves to death without sedation

Red light:

- Any type of PS $\bar{s}$ ANH without the consent of the patient or substitute decision maker

In order to make recommendations for clarification, regulation, and reform, a necessary prior question is whether PS $\bar{s}$ ANH *should* be lawful. Given that the context of this paper is law and policy rather than ethics, we do not seek to perform an ethical analysis of PS $\bar{s}$ ANH here. Instead, when we state that PS $\bar{s}$ ANH *should* be lawful, we mean that PS $\bar{s}$ ANH *should* be lawful *in order to be consistent with the legal status of analogous practices*. Of course, we recognize that this approach is open to the criticism that the analogous practices should not be lawful in the first place. That being said, from a practical point of view, we do not believe that the analogous practices discussed below are at risk of being deemed unlawful in the foreseeable future.

We argue that Type 1 PS $\bar{s}$ ANH, which by definition does not shorten life, clearly *should* be lawful. Type 1 is analogous to all sorts of routine medical procedures that do not shorten life and are clearly lawful.

We argue that Type 2 PS $\bar{s}$ ANH *should* be lawful because it is analogous to the use of potentially life-shortening opioids and other pain medications, which are clearly lawful.<sup>106</sup>

We argue that Type 3 PS $\bar{s}$ ANH *should* be lawful when all of the eligibility criteria and procedural safeguards for access to MAID set out by the federal legislation are satisfied.<sup>107</sup> This is because we believe that Type 3 PS $\bar{s}$ ANH is analogous to voluntary euthanasia and assisted suicide.

With these conclusions as to whether PS $\bar{s}$ ANH *should* be lawful in mind, we make the following recommendations, which will hopefully clarify, regulate, and reform the law surrounding PS $\bar{s}$ ANH.

First, the federal government should amend the *Criminal Code* to make it clear that Types 1 and 2 PS $\bar{s}$ ANH are not contrary to the *Criminal Code*

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<sup>106</sup> See *Rodriguez*, *supra* note 23 at 607.

<sup>107</sup> The eligibility criteria are enumerated in *MAID Act*, *supra* note 39, s 3, amending *Criminal Code*, *supra* note 38, s 241.2.

and that, like any ordinary medical treatment, free and informed consent from the patient (or patient's substitute decision maker where the patient is not competent to make the decision) is necessary and sufficient for access. Thus, we suggest that the following should be added to the *Criminal Code*:

“Palliative sedation” means the administration of deep and continuous sedation whether or not accompanied by the withholding or withdrawal of artificial nutrition and hydration, where the physician's purpose is to alleviate suffering, and where the physician believes on reasonable grounds that it will not, or might but is not certain to, shorten the life of the person;<sup>108</sup>

No physician, other health care provider acting under the direction of a physician, or nurse practitioner is guilty of an offence under this Act where the physician, other health care provider acting under the direction of a physician, or nurse practitioner provides palliative sedation (whether or not accompanied by artificial nutrition and hydration) to a patient with valid consent from the patient if competent (or through a valid advance directive if incompetent) or the patient's statutory substitute decision maker (if incompetent and without a valid advance directive).

Second, the federal government should amend the MAID provisions in the *Criminal Code* to make it clear that Type 3 PS $\bar{S}$ ANH is not contrary to the *Criminal Code* if, and only if, the eligibility criteria and procedural safeguards for access to MAID are met. Thus, we suggest that the following should be added to the *Criminal Code*:

Exemption for medical assistance in dying

227(1) No medical practitioner or nurse practitioner commits culpable homicide, failure to provide the necessities of life, causing death by criminal negligence, or aiding suicide if they provide a person with medical assistance in dying in accordance with section 241.2.

241.1 Definitions

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<sup>108</sup> Note that this definition does not include Type 3 PS $\bar{S}$ ANH; Type 3 is dealt with separately.

“*medical assistance in dying*” means

...

(c) the administering by a medical practitioner or nurse practitioner of deep and continuous sedation accompanied by the withholding or withdrawal of artificial nutrition and hydration to a person, at their request, that the medical practitioner or nurse practitioner believes on reasonable grounds is certain to cause their death.

The use of federal legislation to amend the *Criminal Code* is the most appropriate method for clarifying, regulating, and reforming the law surrounding PS̄ANH.

While it is not impossible to interpret the current *Criminal Code* provisions and relevant case law so that they do not capture Types 2 and 3 PS̄ANH, it is difficult. Rather than requiring that health care providers try to do so in order to provide adequate symptom management to patients, it would be far preferable to explicitly acknowledge that the *Criminal Code* provisions do apply and to create a specific exception so that they will not apply where they should not. That runs far less risk of paralyzing confusion. This approach – broad offences with specific exceptions – has been taken by Parliament in many other instances.<sup>109</sup>

In addition, the legality of PS̄ANH is a criminal matter and, thus, is under the legislative jurisdiction of the federal government. Relying solely on provincial or territorial legislation or prosecutorial guidelines would be inappropriate as it would likely result in differing standards across various Canadian jurisdictions. Waiting for a clear test case would also be inappropriate, as it would leave the law unclear until then – it can take years after a case is heard in the lower courts for it to reach the Supreme Court (if it ever does), where there would be finality.<sup>110</sup> It also places the burden of law

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<sup>109</sup> See e.g. *Criminal Code*, *supra* note 38, ss 52(3)–(4), 60, 108(3), 163(3), 430(6)–(7).

<sup>110</sup> In the *Carter* case, almost four years passed from the time it was filed before the British Columbia Supreme Court in April 2011 to when the Supreme Court of Canada handed down its decision in February 2015. See British Columbia Civil Liberties Association, “Carter v. Canada Case Documents” (15 December 2012), online: <<https://bccla.org/2012/12/carter-et-al-v-attorney-general-of-canada/>>.

reform on those least able to bear it. The financial, emotional, and physical burden of the responsibility for the recommended law reform should rest on the shoulders of legislators – not vulnerable patients who are, by definition, suffering intolerably.

Once the federal government has acted, provinces and territories will need to ensure that their legislation is consistent with the *Criminal Code* (inasmuch as required by the constitutional division of powers). Professional organizations will need to ensure that their guidelines are consistent with the *Criminal Code* and any relevant provincial or territorial legislation.

Clarification, regulation, and reform of the law surrounding PS $\bar{S}$ ANH is desperately needed. Without it, suffering individuals are likely to be denied access to PS $\bar{S}$ ANH when they would be well-suited for it and would prefer to die this way. Without it, clinical practice will depend heavily on legally non-binding guidelines, which means that access to PS $\bar{S}$ ANH could differ widely across the country. Without it, health care providers will continue to operate in the shadow of potential criminal liability if they provide PS $\bar{S}$ ANH (especially Types 2 and 3) or practise defensive medicine in a way that is contrary to patients' interests. Finally, if a court agrees with the possible argument that all types of PS $\bar{S}$ ANH are "not unlawful," access to Type 3 PS $\bar{S}$ ANH might be available in a completely unregulated manner, which would be unacceptable for the obvious reason that Type 3 is certain to cause death.

## CONCLUSION

A thorough review of the law as it relates to PS $\bar{S}$ ANH reveals a disturbing lack of certainty with respect to Type 2 and Type 3 PS $\bar{S}$ ANH. While it is clear that Type 1 PS $\bar{S}$ ANH should not attract any criminal liability, since by definition it does not shorten life, it is not ultimately clear whether or when Types 2 or 3 would attract criminal liability.

It is indefensible to leave patients and health care providers in this situation. Patients need and want access to PS $\bar{S}$ ANH and they should not be denied it when analogous practices are clearly lawful. In addition, health care providers should not be required or expected to function under the shadow of criminal liability. Lawmakers have an obligation to clarify what they believe the law should be and to accurately reflect that position in the law.

