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CORPORATE
— ESTATE ALERT

FEBRUARY 2015

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The *Carter* Decision — What's Next?

Our Estate Alert of February 6, 2015 discussed the Supreme Court of Canada ["SCC"]'s decision of *Carter v. Canada (Attorney General)*[1] that was released that day. Now that we have had some time to consider the decision, we are asking "what's next?"

Several questions arise following this decision:

Criteria for physician-assisted death

What will be the criteria for the exercise of physician-assisted death? The trial judge offered one set of criteria in her judgment:

> "a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult person who: (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person."[2]

The SCC did not provide further insight on the eligibility requirements, nor did they offer any practical guidance as to what would constitute a "carefully designed and monitored system of safeguards."[3] Noticeably absent is the need for the illness, disease or disability to be terminal to the person for physician-assisted dying to be granted. Should the terminal status of a patient affect the decision of the physician? Are the current methods used by physicians to assess capacity adequate now that assisted dying is an alternative? What degree will a patient's level of suffering have to reach before it is considered intolerable? Who will decide the process for the granting and administration of the practice? Will there be a mechanism in place to review and regulate physicians? Most importantly, what happens if something goes wrong?

Life Insurance

The effect of this decision on life insurance remains to be seen. Life insurance policies typically contain a "suicide clause" that voids all death benefits if the insured commits suicide within two years of taking out a policy. However, a spokesperson for an insurance industry association stated that the industry does not anticipate a significant impact due to

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1 2015 SCC 5.

2 *Carter v. Canada (Attorney General)*, 2012 BCSC 886 at para 1393.

3 *Carter*, supra note 1 at para 117.

the fact that most insured patients would have purchased their life insurance policy more than two years prior to seeking physician-assisted death. Provided that the government implements proper safeguards, the number of patients to whom physician-assisted suicide is granted should be limited, thus this decision should not introduce financial burden for insurance companies.

Powers of Attorney

The SCC accepted the trial judge's conclusion that the request for physician-assisted death be personally made by a fully-informed, non-ambivalent competent adult, not through a substituted decision-maker. This clarification helps avoid the policy concerns that would have been sure to follow, particularly in cases where a substitute decision-maker may be as young as 16 years old. In the event the government expands the powers of substitute decision-makers to include the ability to elect physician-assisted death for their wards, estate practitioners may need to amend the clauses in their Powers of Attorney for Personal Care accordingly.

Outside of Canada

As a basis of comparison, in North America, Oregon, Washington and Vermont in the United States permit physician-assisted suicide. In all three states, physician-assisted dying is permitted but only by means of a prescription for lethal medication to be self-administered by the patient. Euthanasia is not permitted and the patient must self-administer the medication. In order to qualify for the medication, the patient must meet the minimum age requirement of 18 years, be a resident of the state, be capable (as defined in their state legislation), and suffer from a terminal disease (also as defined in their state legislation), and the request must be voluntary.

In South America, assisted death is permitted in Colombia "so long as it is performed by a medical professional with the consent of a patient who is experiencing intense suffering as a consequence of a terminal illness."[4]

In Europe, the Netherlands, Belgium and Luxembourg permit the practice of one or both of physician-assisted suicide and euthanasia. In Luxembourg, both practices are permitted so long as several conditions are met. In Switzerland, euthanasia is not permitted but the laws governing the practice of assisted suicide are far less restrictive as a person needn't be a Swiss citizen or have a medical precondition and a physician needn't be involved. In Belgium, the term "euthanasia" is used as a compendious term including both euthanasia and physician-assisted death. In 2014, Belgium also became the first country in the world to remove any age limit on practice. In the Netherlands, euthanasia is legal for children over the age of 12 with parental consent.

Though physician-assisted dying is much more narrowly defined and will have more practice restrictions in Canada, it is useful to look at other jurisdictions to evaluate what the impact of decriminalizing physician-assisted suicide will be on Canadians. However, it remains to be seen how receptive the Canadian government will be to learning from its international counterparts.

4 *Carter*, supra note 2 at para 619.

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