

# ***Medical Assistance in Dying and “Suicide Tourism” to Canada: Bill C-14 from a Comparative Perspective***

**Konstantin Tretyakov LLB PhD (Law),  
SJD (candidate), Harvard Law School,  
Boston, MA, USA**

**Glenn Cohen BA JD,  
Professor of Law, Harvard Law School  
Faculty Director, Petrie-Flom Center for Health Law Policy, Biotechnology & Bioethics,  
Boston, MA, USA**

## ABSTRACT

Bill C-14 was introduced by the government of Canada in the aftermath of the Supreme Court’s decision which legalized physician-assisted dying in Canada. This article compares the Bill with the decision of the Supreme Court (*Carter v. Canada (Attorney General)*) and tracks some of the important ways that the proposed Bill departs from the *Carter* decision. The Article also explores the ways in which the regime proposed under the Bill is both more and less restrictive than the U.S. states that have adopted regimes for assistance in dying. The article also analyzes the approach the Bill has taken to exclude non-citizen non-residents from using assistance in dying in Canada and whether this exclusion is in tension with the spirit of *Carter*. Finally, the article examines potential constitutional challenges should the Bill become law.

**Keywords:** medical assistance in dying; assisted suicide; right to die; comparative law

On April 14, 2016, the liberal government of Canada introduced Bill C-14 (Bill C-14: An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying) [Bill C-14], 2016), which amends the federal Criminal Code and several other federal statutes<sup>1</sup> to give effect to the legalization of medical assistance in dying in Canada. The Bill was introduced more than a year after the Supreme Court of Canada unanimously held in the case of *Carter v. Canada* that “the prohibition on physician-assisted dying infringes the right to life, liberty and security . . . , and that it does so in a manner that is overbroad and thus is not in accordance with the principles of fundamental justice” (*Carter v. Canada* [Carter], 2015, para. 56).

The Supreme Court accepted the definition of “physician-assisted dying” as “the situation where a physician provides or administers medication that intentionally brings about the patient’s death, at the request of the patient” (Carter, 2015, para. 56). The Supreme Court also concluded in *Carter* that the appropriate remedy to address the infringement of fundamental rights would be the declaration that the relevant sections of the Criminal Code were “void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease, or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition” (Carter, 2015, para. 127). Finally, the Court suspended its declaration of invalidity of the Criminal Code for twelve months, giving the legislature a year to amend the law (so the Bill was introduced more than a year after the decision in *Carter*) (Carter, 2015, para. 147); that period was later extended for four months (*Carter v. Canada*, 2016), which is set to expire on June 6, 2016.

In this essay, we compare Bill C-14 to the Supreme Court’s decision in *Carter*, compare it to the law in various U.S. jurisdictions that have legalized physician-assisted suicide, and finally consider its implications for so-called “medical tourism” for assistance in dying.

## **Following but Modifying Carter**

Bill C-14 largely, though not entirely, follows the contours set out by the Supreme Court’s decision in *Carter*. The definition of “medical assistance in dying” contained in Bill C-14 fairly closely matches the definition of “physician-assisted dying” accepted in *Carter*. In particular, the Bill decriminalizes “the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death” and “the

prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death” (Bill C-14, 2016, § 3).<sup>2</sup> One key difference, though, is that the Bill uses the broader term of “*medical assistance in dying*” apparently because the authors of the Bill suggest that not only physicians, but also nurse practitioners can participate in end-of-life decision-making. Some have found fault with that approach (Austen, 2016). In other jurisdictions and in the literature, the practices that C-14 decriminalizes are known, respectively, as voluntary active euthanasia and physician-assisted suicide.<sup>3</sup>

Also in line with the legislative contours suggested in *Carter*, the Bill restricts the eligibility to medical assistance in dying to competent individuals over the age of eighteen, physically or psychologically suffering from a grievous and irremediable medical condition who voluntarily requested such assistance and gave their informed consent to it (Bill C-14, 2016, § 3).<sup>4</sup> The Bill also contains an elaborate definition of a medical condition which makes an individual eligible for medical assistance in dying. In particular, eligible patients must either “have a serious and incurable illness, disease, or disability” or be in “an advanced state of irreversible decline in capability”; furthermore, either of those medical conditions must “cause[] them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.” Finally, the Bill specifies that the natural death of eligible patients must be foreseeable, “taking into account all of their medical circumstances,” but with a caveat that a specific prognosis as to the remaining time of their life is unnecessary (Bill C-14, 2016, § 3).

## Comparing Canada’s Regime with Various Regimes in the United States

The regime proposed for Canada in Bill C-14 resembles in some respects those in place in some U.S. states. Because the U.S. Supreme Court has rejected constitutional claims for a right to assisted suicide, and because the federal government has not sought to legislate in this area (except for the Assisted Suicide Funding Restriction Act (1997), which prohibited payments for assisted suicide from the federal government, including the prohibition to cover physician-assisted suicide through Medicare and Medicaid), there is a patchwork of approaches across most of the United States.

In the United States, voluntarily stopping eating and drinking (including refusing to be provided with nutrition and hydration by means of a nasogastric tube) is legal across the country after the United States Supreme Court decision in *Cruzan v. Missouri Department of Public Health* (1990), where a narrowly divided Supreme Court assumed for the sake of the argument “that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition” (*Cruzan v. Missouri Department of Public Health* [Cruzan], p. 279). The Court then upheld the clear and convincing evidence standard adopted by the state of Missouri to prove the will of an incompetent patient to terminate her life by withdrawing and withholding nutrition and hydration (Cruzan, 1990, pp. 286-287).

Seven years after *Cruzan*, in the case of *Washington v. Glucksberg* (1997), the unanimous Supreme Court underscored that its assumption in *Cruzan* originated from the common-law right to refuse medical treatment. In particular, the Court said, “Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation’s history and constitutional traditions” (*Washington v. Glucksberg* [Glucksberg], 1997, p. 725). This stands, we believe, for the United States Supreme Court’s view that a competent patient has a right to refuse not only nutrition and hydration, but also life-sustaining medical treatment. This right is also legally recognized in many states either by a statute or by the courts, subject to certain limitations.<sup>5</sup> By contrast, administering a lethal dose of medication by a medical practitioner with the intention to terminate the patient’s life is uniformly prohibited across the country.<sup>6</sup>

At the same time, in *Glucksberg*, the Supreme Court declined to recognize a constitutional right to physician-assisted suicide and deferred to the states to decide on whether to grant that right to their citizens or not (Glucksberg, 1997, p. 735). This has resulted in different approaches to regulating assisted suicide in the United States. While most of the United States prohibit physician-assisted suicide, several states permit it: some by virtue of a statute (California (California End of Life Option Act), Oregon (Oregon Death with Dignity Act), Vermont (Vermont Patient Choice at End of Life Act), and Washington (Washington Death with Dignity Act)), some by virtue of the decision of the highest state court (Montana (*Baxter v. State* [Baxter], 2009)),<sup>7</sup> and some states have no criminal liability for assisting in suicide (Hawaii (Morris v. Brandenburg, 2014)).

From this broad regulatory perspective, the suggested regime of medical assistance in dying in Canada is more liberal than the current regulations in those United States mentioned above, as it allows choosing the time, place, and manner of death for all patients satisfying the eligibility requirements, and not only for those whose lives depend on a life-sustaining medical technology or who are capable of self-administering a lethal dose of medication.<sup>8</sup>

The proposed Canadian regime also appears less restrictive than those adopted in the states permitting physician-assisted suicide in several other aspects. First, Bill C-14 speaks of “illness, disease, or disability” or “advanced state of irreversible decline in capacity” as the medical condition that makes an individual eligible for medical assistance in dying. By contrast, the statutes enacted by the states make only patients with terminal *disease* eligible for requesting physician-assisted suicide.<sup>9</sup>

While the distinction between disease and illness is not clear-cut and is subject to some debate in the literature (Cassell, 1976; Sadegh-Zadeh, 2000), we believe it to be significant in the end-of-life context. As some authors indicate, it is generally accepted that while “disease” requires a medically measurable bodily malfunction that can be confirmed or falsified empirically (Wikman, Marklund, Alexanderson, 2005), the notion of “illness” is more about the subjective attitude of a patient toward her condition (Wikman et al., 2005). Against that background, Bill C-14 legalizes medical assistance in dying where a patient subjectively feels acute suffering but is not diagnosed with a disease by a medical professional. In this respect, the Bill notably stipulates that a medical professional,

before providing a patient with medical assistance in dying, must “be of the opinion” that the patient meets all the eligibility criteria. This language is arguably broader than that adopted in Oregon, Washington, and Vermont, where the statutes identify patients eligible for physician-assisted suicide who “have been *determined* by [medical professionals] to be suffering from a terminal *disease*” (Oregon Death with Dignity Act, c. 127.805, § 2.01(1); Washington Death with Dignity Act, § 70.245.020(1); Vermont Patient Choice at End of Life Act, § 5283(a)(5)(A)). Therefore, it is possible (depending on how the court interprets the statute) that the effect of the statute could be that a patient who self-reports acute suffering with no medical diagnosis of a disease will be eligible for medical assistance in dying under Bill C-14, but will not be eligible for physician-assisted suicide in Oregon, Vermont, and Washington.

Second, the jurisdictions in the United States that legalized physician-assisted suicide did so for patients with “terminal” medical condition - that is, a condition, which, in reasonable medical judgment, produces death in six months after being diagnosed (Oregon Death with Dignity Act, c. 127.800, § 1.01 (12); Washington Death with Dignity Act, § 70.245.010(13); Vermont Patient Choice at End of Life Act, § 5281(10)).<sup>10</sup> By contrast, neither the Supreme Court in *Carter*, nor Bill C-14 mentions the terminal character of patient’s condition as a necessary prerequisite for eligibility to request medical assistance in dying; the Bill stipulates that the natural death of a patient must be “reasonably foreseeable,” but does not specify the time period during which the patient’s death is expected to occur. Therefore, a patient who, like one of the plaintiffs in *Carter* (2015, para. 17), suffers from spinal stenosis (the progressive compression of the spinal cord leading to progressively limited mobility and chronic pains), which is not a terminal disease, would appear to be eligible for medical assistance in dying under Bill C-14, but ineligible for physician-assisted suicide under the criteria set forth in Montana, Oregon, Vermont, and Washington. Another example of a patient suffering from a non-terminal illness eligible for medical assistance in dying in Canada but not for physician-assisted suicide in the United States could be a patient with clinical depression. At the same time, it appears that the Bill in its preamble explicitly attempts to exclude mental illnesses as a sole medical condition making a patient eligible for medical assistance in dying: “And whereas the Government of Canada has committed to develop *non-legislative measures* that would support the improvement of a full range of options for end-of-life care . . . and explore other situations . . . in which a person may seek access to medical assistance in dying, namely *situations . . . where mental illness is the sole underlying medical condition.*” (emphasis added) (Bill C-14, 2016, preamble).

There seems to be, however, one aspect of Bill C-14 (and *Carter*) where the Canadian regulatory regime of assisted suicide might be less permissive than that in some U.S. states. As we mentioned earlier, Bill C-14, following the guidelines outlined in *Carter*, makes eligible for requesting medical assistance in dying only those patients for whom the illness, disease, or disability causes intolerable, enduring “physical or psychological suffering . . . that cannot be relieved under conditions that they consider acceptable.” By contrast, the definition of the “terminal condition” adopted by Oregon, Washington, California, and Vermont does not contain suffering as one of its elements: all that matters is the reasonable medical prognosis for a patient (death in six months). At the same

time, the statutes speak of patients “suffering a terminal condition” (Bill C-14, 2016, preamble),<sup>11</sup> but this language seems to be less stringent than the positive, affirmative requirement of physical or psychological suffering set forth in the Bill. Therefore, in those of the United States where physician-assisted suicide is legal by a statute a patient who claims eligibility for assisted dying may not experience suffering as her pain is adequately controlled by comfort care. By contrast, in Canada physicians or nurse practitioners not only need to be “of the opinion . . . that [the patient’s] natural death has become reasonably foreseeable,” but also confirm that the patient’s medical condition is causing suffering and that the suffering cannot be relieved in way the patient deems acceptable.

Finally, there are several eligibility requirements that overlap between the regimes existing in the United States and Canada. Those are the age (adults only), competency, the absence of undue influence and duress, and informed consent. The two regimes also set forth similar, but not identical, approaches to residency requirements, to which we turn next.

## Travel for Assisted Suicide?

Travel for medical assistance in dying (a species of “medical tourism” though with quite different aims and intentions) is a legal phenomenon that has caused consternation for several countries. The Swiss canton of Zurich remains the most common destination for travel for assisted suicide because it permits non-residents to end their life lawfully with assistance therein. In their 2014 paper Gauthier et al. report that the six organizations that assist with suicide in Switzerland claim on their websites to collectively assist 600 suicides a year, including roughly 150-200 travelers, with Dignitas being the main organization facilitating travel for assisted suicide (Gauthier, Mausbach, Reisch, & Bartsch, 2014).

Some of the differences between the Canadian and U.S. assisted suicide regimes might present opportunities for travel to Canada for assisted suicide, but Bill C-14 attempts to create a bulwark against that. The Bill lists an eligibility requirement the Supreme Court did not include in its *Carter* decision: the individuals seeking medical assistance in dying must be “eligible—or, but for any applicable minimum period of residence or waiting period, would be eligible—for health services funded by a government in Canada” (Bill C-14, 2016, § 3). Typically this would exclude a “tourist, transient, or a visitor to the province;” the language of the Bill largely limits the right to medical assistance in dying only to the citizens or permanent residents of Canada and therefore enables individuals to qualify for medical assistance in dying in Canada on terms more onerous than in some of the U.S. states. In the United States, Oregon, Vermont, and Washington impose the residency requirement on the patients who want to execute physician-assisted suicide,<sup>12</sup> but they are easier to meet than those stipulated in Bill C-14. The statutes do not specify who the “resident” is. Official interpretations of the statutes provide for the physicians to make the determination of the state residency, considering such factors and the patient’s registration to vote in the state, possession of the state driver’s license, filing of the state tax return for the most recent tax year, or evidence that a patient owns or leases property in the state (Oregon Health Authority; Vermont Department of Health, 2015). Some of these requirements can be met in twenty-



four hours (for example, signing the lease). In Montana, the state Supreme Court imposed no residency requirement on terminally ill patients who want to execute physician-assisted suicide in that state (Baxter, 2009, p. 1222).

This requirement added to *Carter* by Bill C-14 is likely motivated by the Canadian government's desire not to become a haven for assisted suicide travel. This impulse is understandable, but in looking at the Swiss data may seem overly cautious. Even without a residency requirement in place, Zurich sees only roughly 150-200 travelers for assisted suicide a year. Canada would potentially see far fewer since many in Europe would likely continue to prefer to travel to Zurich rather than all the way to Canada.

The attempt to discourage travel to Canada for assisted suicide is notable for a second reason - it may fit poorly with the animating spirit behind the *Carter* decision. The driving force behind the Supreme Court's reasoning in *Carter* seems to be the argument about individual autonomy, which animated the concerns of the Justices about the restrictions on the individual right to die and about protecting the autonomous end-of-life decision-making of members of vulnerable populations (Carter, 2015, para. 64-68). Bill C-14 seems to be driven by the same concerns about autonomy: as the authors write in the preamble, "the Parliament of Canada recognizes the autonomy of persons [meeting the eligibility requirements] who wish to seek medical assistance in dying" (Bill C-14, 2016, preamble). From this perspective of individual autonomy, it is not clear why one should make the right for medical assistance in dying available only to the citizens and permanent residents of Canada; after all, many individuals who decide to travel to Canada to seek medical assistance in dying are capable of reasoned, informed judgment about how and when to end their lives.

Indeed, it is noteworthy that one of the parties to the *Carter* case was a couple who assisted their mother in traveling to Switzerland to seek assisted dying (Carter, 2015, para. 11), and one might put the question sharply as follows: if one reason why the Canadian Supreme Court decided *Carter* as it did was to avoid forcing *its* citizens to engage in travel abroad for assisted suicide, would it not be more in the spirit of that decision for Canada to open its own doors to citizens from other countries that now face the same predicament?

To be sure, we have thus far been careful to speak of the "spirit" of *Carter* and not what the Canadian Charter requires as to non-citizens. That latter issue poses a closer doctrinal question and requires a closer reading of *Carter*. The *Carter* Court first found under section 7 of the Canadian Charter of Rights and Freedoms that the blanket prohibition on physician-assisted dying deprived individuals "suffering from grievous and irremediable medical conditions" of the right to life, liberty, and security of the person (Carter, 2015, para. 70). Then the Court held that under section 7 of the Charter this deprivation was not in accordance with the principles of fundamental justice, as it was overbroad: a blanket prohibition on physician-assisted dying catches not only the cases of vulnerable people who must be protected (Carter, 2015, para. 84), but also "people with disabilities who have a considered, rational and persistent wish to end their own lives" (Carter, 2015, para. 86). Finally, the Court concluded that this overbroad deprivation of a fundamental right was not minimally impairing of the right

in question and therefore violated the proportionality principle under section 1 of the Charter (Carter, 2015, para. 121). Under that final prong of its analysis, the Court specifically noted that "[a] theoretical or speculative fear [about the vulnerable populations] cannot justify an absolute prohibition" (Carter, 2015, para. 119) and pointed out that in the situation where the laws of Canada already permit palliative sedation and withdrawal and withholding life-sustaining treatment it would be illogical to think that those seeking "more active assistance in dying" are more vulnerable than those who seek other legal ways to terminate their lives (Carter, 2015, para. 115).

How does this reasoning apply to Canadian non-citizens? The right to life, liberty, and security of the person guaranteed by the Charter applies not only to the Canadians or who reside in Canada,<sup>13</sup> so a foreign national on a tourist visa is constitutionally protected by section 7 of the Charter too. Therefore, if the government decides to limit that right, it must do so in a way that either does not violate the principles of fundamental justice (section 7), or at least is proportional to a "pressing and substantial object" of the law (section 1) (Carter, 2015, para. 55, 94). The fundamental justice analysis under section 7, in turn, requires the comparison of the statutory measure to the object of the law in terms of its arbitrariness, overbreadth, or gross disproportionality of consequences (Carter, 2015, para. 72, 73).

As the Supreme Court's analysis makes clear, the protection of the vulnerable cannot serve as a viable object of a blanket prohibition of medical assistance in dying to all foreigners, as not all of them are vulnerable, so a statute with that object will necessarily be overbroad. In this respect, the only reason mentioned in the Bill C-14 that might justify the eligibility limitation imposed on the foreign nationals is that "the Government of Canada has committed to uphold the principles set out in the Canada Health Act . . . with respect to medical assistance in dying" (Bill C-14, 2016, preamble). In other words, the Canadian government seems to set as one of the objectives of Bill C-14 that medical assistance in dying in Canada must be covered by publicly funded health insurance, and in that respect it seems that limiting that service to those who are insured under the Canada Health Act is not arbitrary, overbroad, or grossly disproportionate. It could be argued that Canadian non-citizens are not in treatment relation within the country and that it may be harder to obtain a reliable medical judgment about their medical condition. At the same time, the blanket prohibition for all non-citizens to seek medical assistance in dying in Canada seems too harsh a measure to address these potential medical uncertainties. Furthermore, in the situation where a foreigner traveling to Canada to obtain medical assistance in dying pays for that service from her own pocket (which is what happens in Switzerland), the objective provided by the government (upholding the viability of Canada's health care system) is not disturbed.

The government could nonetheless argue a third more blunt rationale: it does not want a stampede of "suicide tourists" in their country. As we discussed above, based on the example of Zurich - one of the few jurisdictions that does permit assistance in dying without a residency requirement - the numbers have not been great, suggesting such a concern may be exaggerated. At the same time, it is unclear whether the Canadian Supreme Court would go so far as to label the concern "speculative," as it did other rationales offered in *Carter*, such that it would not

survive the section 1 analysis (which arguably allows for more discretion to the government than under section 7) the Supreme Court applied in *Carter*. This remains an open question and may lead to a further challenge to Bill C-14 on behalf of non-citizen non-residents of Canada who seek assistance in dying in Canada, should the Bill become law.

## Conclusion

This essay has had three chief aims. First, to track some of the important ways that proposed Bill departs from the *Carter* decision. Second, to examine the ways in which the regime that C-14 would usher in is both more and less restrictive than the U.S. states that have adopted regimes for assistance in dying. Other authors have more extensively compared the C-14 regime to its equivalents in Europe (Lemmens, 2016). Finally, we have focused on the approach C-14 has taken to exclude non-citizen non-residents from using assistance in dying in Canada. We have pressed on whether this exclusion is in tension with the spirit of *Carter* as well as examined potential constitutional challenges should this approach become law.

## Endnotes

1. Pension Act, Correction and Conditional Release Act, and Canadian Forces Members and Veterans Re-establishment and Compensation Act.
2. Compare with *Carter*, paragraph 40 (2015): “[P]hysician-assisted dying” [refers to] the situation where a physician provides or administers medication that intentionally brings about the patient’s death, at the request of the patient.”
3. For example, the Supreme Court of the United States described physician-assisted suicide as the practice of prescribing lethal doses of regulated drugs to patients for later self-administration (*Gonzales v. Oregon*, 2006, p. 249), and medical professionals in the United States referred to the practice of administering the lethal dose of drugs at patient’s request as “voluntary active euthanasia” (Quill, Lo, & Brock, 1997).
4. Compare with the eligibility requirements set forth in *Carter*, paragraph 147 (2015).
5. See, for example, *In re Guardianship of Browning* (1990, p. 11): “We conclude that a competent person has the constitutional right to choose or refuse medical treatment, and that right extends to all relevant decisions concerning one’s health.” Compare with *In re Greenshields* (2014, p. 1289): “A competent adult has a constitutional and common law right to refuse even necessary medical treatment. The right to refuse medication may be limited by countervailing state interests such as caring for persons who are unable to care for themselves and ‘institutional security’” (internal citations omitted).
6. In her concurring opinion in *Glucksberg*, Justice O’Connor (who provided the right-leaning Members of the Court with the decisive fifth vote in the case of *Cruzan*) indicated that “[t]here is no dispute that dying patients in . . . can obtain palliative care, even when doing so would hasten their deaths” (*Glucksberg*, 1997, pp. 737-738). This demonstrates that while administering a lethal dose of a drug to a patient with intention to terminate patient’s life is prohibited in the United States, palliative care hastening death (where the patient’s death is not an intended, but a merely foreseeable result under the doctrine of double effect) is not. (This article is not a proper vehicle to address the issue of plausibility of the doctrine of double effect and the consistency of its use in the right to die jurisprudence of the Supreme Court of the United States.)
7. A court case that poses the question whether the state constitution grants the citizens of the state the right to physician-assisted suicide is currently pending before the Supreme Court of New Mexico (*Morris v. Brandenburg*, 2015).
8. Notably, the Supreme Court of Canada acknowledged in *Carter* that the law allows patients in grievous and irremediable medical condition “to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment” (*Carter*, 2015, para. 66).
9. See, for example, Oregon Death with Dignity Act c. 127.800, § 1.01(12) (providing definition for the term “terminal disease”). In the one state where physician-assisted suicide was permitted by judicial decision-making rather than the statute (Montana), the medical condition of a qualifying patient is “terminally ill patient[s]” (Baxter, 2009, p. 1222). At the same time, it bears noting that the Supreme Court of Montana probably used the terms “illness” and “disease” interchangeably in its decision, which came out from the controversy around the right to die of a patient with terminal cancer: “This appeal originated with Robert Baxter . . . who was terminally *ill* with lymphocytic leukemia with diffuse lymphadenopathy. . . . There was no cure for Mr. Baxter’s *disease* and no prospect of recovery” (emphasis added) (Baxter, 2009, p. 1214).
10. See also *Baxter* (2009, p. 1222): “We therefore hold that a *terminally ill* patient’s consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply” (emphasis added) (internal reference omitted). The Supreme Court of Montana, however, did not elaborate in its decision on what the term “terminal” means, presumably leaving that determination to medical professionals.
11. See Oregon Death with Dignity Act, c. 127.805, § 2.01; Vermont Patient Choice at End of Life Act, § 5283 (a) (5) (A)
12. See Oregon Death with Dignity Act c. 127.800, § 1.01(11). See also Washington Death with Dignity Act, § 70.245.010(11); Vermont Patient Choice at End of Life Act § 5281(8).

13. Singh v. Minister of Employment and Immigration (1985, para. 5): "I am prepared to accept that the term ["everyone" used in section 7 of the Charter] includes every human being who is physically present in Canada and by virtue of such presence amenable to Canadian law."

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**Address for Correspondence:** [ktretyakov@sjd.law.harvard.edu](mailto:ktretyakov@sjd.law.harvard.edu)

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