Submissions to the Standing Senate Committee on Legal and Constitutional Affairs
Re consideration of Bill C-14
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Some Preliminary Observations

One mistake that is commonly made, even by Supreme Court of Canada judges, relates to the legality of suicide and attempted suicide. In commenting on *Rodriguez v. Canada (Attorney General)*, [1993] 3 S.C.R. 519, Justice La Forest said that the "prohibition against assisted suicide …was upheld despite the fact that suicide itself was, and is at present, not illegal in this country; *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at 263. To describe suicide as "at present, not illegal" suggests that it could become illegal, but such a notion is illogical. If suicide is successful, the person is dead, and we do not prosecute dead people. Suicide never has been, nor could ever be, illegal. What used to be illegal, but no longer is, is attempted suicide. The decriminalization of attempted suicide should not, however, be seen as embracing a legal right to die. Rather it represents compassionate recognition that if things are bad enough that someone is attempting suicide, they do not need the extra burden of a criminal prosecution. The decriminalization of attempted suicide has not diminished the significance of suicide prevention as important public policy. For example, the fact of disproportionately high suicide rates among Aboriginal youth or gay, lesbian, and transgender youth, does not lead anyone to celebrate that they are exercising their legal right to die. It is in that context that it must be appreciated that the basis for a constitutional right to physician-assisted death is a constrained right, not an unqualified right to autonomy over life and death. The involvement of third parties, and the sanction of the state, raise issues beyond individual autonomy.

Competing Constitutional Rights

The SCC recognized in *Carter v Canada (Attorney General)*, [2015] 1 SCR 331 that deference is owed to Parliament, especially in the circumstance where, as with physician-assisted death, the objective pursued by Parliament implicates constitutionally protected rights (para. 95). The protection of the vulnerable "from being induced to commit suicide at a time of weakness" (para. 74) is the protection of rights of those who, by definition, are not well placed to advance their own rights. Thus Parliament needs to design safeguards with care. As the Supreme Court of Canada said: "We agree with the trial judge that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards" (end of para. 117).

At the outset the Supreme Court of Canada identified the issues at stake in *Carter*: "This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a

grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable" (para. 2). Because the only issue before it was the constitutional validity of an absolute ban on assisted suicide, the Court did not elaborate on what Parliament would need to do to meet its constitutional obligations to protect the vulnerable from error and/or abuse, beyond saying that an absolute ban was not a proportionate balance between competing constitutional rights.

In responding to *Carter*, Parliament and legislatures need to be mindful of possible future constitutional challenges. If it is alleged that there is insufficient access to physician-assisted death, individual claimants seeking physician-assisted death can come forward. On the other hand, a challenge that physician-assisted death is too easily available is a more complex claim to bring. A claim that the constitutional rights of the vulnerable are being violated would not likely properly be brought by an individual. Individuals opposed to physician-assisted death for themselves would not need litigation to vindicate that position; under any system of physician-assisted death an individual can just say no. Where the challenge is on behalf of the vulnerable who are not in a position to just say no, it would need to be public interest litigation.[1] Nonetheless, the problem in identifying individual litigants does not make the constitutional rights of the vulnerable any less real.

Where s. 1 limitations have been upheld in the pursuit of non-constitutional objectives, legislatures are at liberty to later abandon pursuit of such non-constitutional interests. For example, in *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713 Sunday closing requirements were upheld, despite infringement of the freedom of religion of those observing a Saturday Sabbath, in the interests of a common pause day (employees having the same day off as family and friends). Since then the interests of retailers and shoppers in Sunday opening have prevailed, with the pursuit of a common pause day giving way. With no constitutional right to a common pause day, that change in legislative policy has been not been susceptible to challenge. In contrast, failing adequately to protect vulnerable persons in a physician-assisted death regime would be susceptible to constitutional challenge.

In *Carter*, the constitutional challenge was based on both s. 7 and s. 15 of the *Charter*. Having found a violation of s. 7, a deprivation of life, liberty, and security of the person not in accordance with the principles of fundamental justice, the SCC did not deal with the s. 15 equality claim (para. 93). A challenge based on the constitutional rights of the vulnerable could likewise be based on either s. 7 or s. 15. The arguments based on s. 15 are more compelling. Reliance on s. 15 is preferable because of the comparative nature of an equality claim, i.e. that the law is more burdensome on some compared to others. That is the essence of a claim on behalf of the vulnerable. The claim is discrimination on the basis of the enumerated grounds of

[1] A disability organization should have no difficulty meeting the test for public interest standing set out in *Canada (Attorney General) v. Downtown Eastside Sex Workers United Against Violence Society*, [2012] 2 S.C.R. 524:

> [37] In exercising the discretion to grant public interest standing, the court must consider three factors: (1) whether there is a serious justiciable issue raised; (2) whether the plaintiff has a real stake or a genuine interest in it; and (3) whether, in all the circumstances, the proposed suit is a reasonable and effective way to bring the issue before the courts:

age, mental or physical disability, as well as the analogous ground of vulnerability. Moreover an equality claim is more amenable to a systemic approach, incorporating the collective responsibility of society, beyond an individual autonomy analysis.

The context of competing constitutional claims means there are two kinds of questions in the aftermath of *Carter* concerning the safeguards in a regime of physician-assisted death. One type of question is what kinds of safeguards are permissible, consistent with *Carter*. The other type of question is what kinds of safeguards are required to protect the rights of the vulnerable. The SCC to some extent dealt with the former in *Carter*, but, given the nature of the claim before it, did not address the latter. Anything that would be required to protect the vulnerable must be permissible, consistent with *Carter*. Things not absolutely required to protect the vulnerable could still be permissible.

Given that *Carter* only analysed a claim by those seeking a constitutional right to physician-assisted death, I will not pursue the details of a counter constitutional claim on behalf of the vulnerable. However, the context of competing constitutional claims underscores the importance of safeguards to protect the vulnerable, even where only analysed as the objective underlying limits on the right to life, liberty and security of the person.

Assessing Safeguards

A proportionate balance between competing *Charter* claims clearly requires that physician-assisted death be available. Any safeguards cannot make access to physician-assisted death illusory (Dickson C.J. in *R. v. Morgentaler*, [1988] 1 S.C.R. 30). In assessing safeguards, both the principles of fundamental justice and the stipulations of s. 1 of the *Charter* need to be scrutinized carefully. It must be remembered that the Supreme Court of Canada's analysis was in the context of an absolute ban on assisted suicide, and it made no effort to detail what a constitutionally valid regime of safeguards could entail, leaving that determination to Parliament. That is typical. When the Court finds legislation to be unconstitutional, the analysis of the flaws of the legislation will give some hints as to how it can properly be drafted, but not provide detailed prescriptions. An exception was *Charkaoui v. Canada (Citizenship and Immigration)*, [2007] 1 S.C.R. 350, where the SCC gave quite detailed indications of how a security certificate regime could pass muster under s. 1 of the *Charter*. *Carter* does not offer such detailed prescriptions. Nonetheless, *Charkaoui* is an important reminder that s. 7 breaches can be justified under s. 1 "in extraordinary circumstances where concerns are grave and the challenges are complex" (para. 66). Physician-assisted death aptly fits that description.

Grievous and Irremediable Medical Condition in Bill C-14

Bill C-14, in the proposed s. 241.2(2), provides the following definition of grievous and irremediable medical condition:

> (2) A person has a grievous and irremediable medical condition if
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> (a) they have a serious and incurable illness, disease or disability;
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> (b) they are in an advanced state of irreversible decline in capability;

> (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
> (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Subsections (b) and (d) are very contentious, and there will undoubtedly be amendments proposed to delete them. I am writing to urge Parliament NOT to delete them because they are both consistent with *Carter* and compliant with the *Charter*, as being required to protect the vulnerable.

(a) Consistency with *Carter*

The Supreme Court of Canada's (SCC) remedy in *Carter* was a declaration of invalidity:

> Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that 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. (paras. 127 and 147)

The effect of this declaration of invalidity was suspended, initially until February 6, 2016, later extended until June 6, 2016, to give Parliament the opportunity to come up with replacement legislation. The language in proposed subsections 241.2(2)(b) and (d) of Bill C-14 is not explicitly mentioned in the suspended declaration of invalidity in *Carter*. Jocelyn Downie concludes: "Access through the Bill therefore falls below the bare minimum established by *Carter*."[2] It is an extraordinary claim that judicial silence ties Parliament's hands, a claim that does not withstand careful scrutiny.

Subsection (b) parallels the language incorporated by Justice Lynn Smith at trial in her declaration of invalidity, stipulating "advanced weakening capacities with no chance of improvement" (trial judgment in *Carter*, 2012 BCSC 886, para. 1393(a) and (b)). Although this language was not explicitly adopted by the SCC judges, they did not disavow it either. Indeed, the SCC judges did not even acknowledge that she said it. In not commenting at all, the SCC cannot be said to have pronounced on the issue. The SCC was at the very least leaving it open to Parliament to adopt such a limitation, which one presumes Justice Smith included to cover people such as Kay Carter.

Similarly, although the SCC *Carter* suspended declaration of invalidity does not include any language stipulating "natural death has become reasonably foreseeable" as in proposed s.

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[2] Jocelyn Downie, "Bouquets and brickbats for the proposed assisted dying legislation" April 20, 2016, *Policy Options*, http://policyoptions.irpp.org/magazines/april-2016/bouquets-and-brickbats-for-the-proposed-assisted-dying-legislation/.

241.2(2)(d), the Court made no pronouncement against such a limitation. In canvassing the international and Quebec experience with regimes of medical assistance in dying, which vary as to whether a patient must in any sense be dying to be eligible, the SCC did not weigh the pros and cons of such a limitation. The SCC's suspended declaration of invalidity is not a declaration at large – it is a declaration against an absolute ban on physician-assisted suicide. It is not a declaration against any future regime of assisted death with safeguards. The SCC specifically limited the scope of its declaration:

> The scope of the declaration is intended to respond to the factual circumstances of this case. We make no pronouncements on other situations where physician-assisted suicide may be sought. (para. 127)

The SCC prefaced its declaration of invalidity by noting "that the impugned laws infringe the rights of people like Ms. Taylor" (para. 126), a co-plaintiff in *Carter*, terminally ill with ALS. The Court did not specify which factual circumstances were relevant. It is clear that neither Gloria Taylor's gender nor race was relevant to her right to physician-assisted death, but one would be hard-pressed to say that the fact the she was dying was not a relevant circumstance.

In its January 15, 2016 decision extending the suspended declaration of invalidity until June 6, 2016, the SCC made a point to "not be taken as expressing any view as to the validity of the [Quebec] *ARELC* [*Act Respecting End-of-Life Care*]" (2016 SCC 4, para. 4) which includes the stipulation of "advanced state of irreversible decline in capability" and is limited to "end of life" situations. The SCC's lack of comment is unsurprising, given that the Quebec legislation was not squarely before it, but it does underscore that such limitations are an open question.

(b) Protection of the Vulnerable

The Report of the Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying*: *A Patient Centred Approach* (February 2016) recommended (in the majority report) against a limitation to terminally ill patients (p. 12). Although Bill C-14 does not reference terminal illness as such, it is in that ballpark. The majority of the Special Joint Committee is thus presumably at odds with the proposed subsections 241.2(2)(b) and (d). In support of the recommendation against a terminally ill eligibility criterion, the Special Joint Committee referred to the testimony of Peter Hogg: "Prof. Hogg argued that, while it was not impossible for Parliament to require that the condition be terminal, such a law would be more susceptible to constitutional challenge" (p. 12). It is important to note that Professor Hogg said this in the context of challenges by those seeking physician-assisted death, without considering a possible counter challenge on behalf of the constitutional rights of the vulnerable. Moreover, even limiting the focus to a challenge by those seeking physician-assisted death, Peter Hogg did not elaborate on whether a limitation to terminal illness could be in accordance with the principles of fundamental justice or pass muster under s. 1 of the *Charter*. The Special Joint Committee likewise did not address the principles of fundamental justice or s. 1, saying only: "Furthermore, limiting MAID [medical aid in dying] in this way would result in Canadians with grievous and irremediable conditions faced with enduring and intolerable suffering having to continue suffering against their will" (p. 12). What this conclusion by the Special Joint Committee does not acknowledge is where protection of the vulnerable fits into the analysis.

In suspending the declaration of invalidity initially for twelve months, and ultimately for sixteen months, the SCC recognized that "Complex regulatory regimes are better created by Parliament than by the courts" (*Carter* 2015, para. 125). In *Carter* 2015 the absolute ban on physician-assisted death was found to be a deprivation of life, liberty, and security of the person contrary to the principles of fundamental justice, in violation of s. 7 of the *Charter.* The specific principle of fundamental justice implicated was the requirement that provisions not be overbroad, in other words that a provision cannot be one that "bears no relation to the purpose" or has "no connection with the mischief contemplated by the legislation" (*Carter 2015*, para. 85). The SCC found that an absolute ban on physician-assisted death went way too far in pursuit of its objective of protecting the vulnerable. In contrast, the proposed subsections 241.2(2)(b) and (d) are important in designing safeguards against error and abuse. If there is no state of irreversible decline in capability and death by natural causes is not reasonably foreseeable, the consequences of potential error are substantially magnified compared to hastening death by a relatively short time. Without the limitations of subsections (b) and (d), physician-assisted death will foreclose over a long period the possibility of the person changing their mind. The odds of a transitory suicidal wish being determinative increase. The opportunities escalate for assessments being distorted by notions of a disabled life not being worth living. The chances rise that premature death will result from unmet needs, that individuals will choose death because they are unaware of, or denied access to, supports (whether medical or non-medical) that would have made life worth living. Thus vulnerability concerns are substantially magnified if physician-assisted death is not limited as in subsections (b) and (d), and thus would weigh more heavily in the balance. Anyone challenging the constitutional validity of subsections (b) and (d) would not be able to say that they bear "no relation" or "no connection" to the objective of protecting the vulnerable. Thus they would not be overbroad. Nor could these stipulations be considered to run afoul of the principle that measures not be grossly disproportionate to the objective Parliament is trying to achieve.

In the alternative, the government would have a defence under s. 1 of the *Charter,* allowing for reasonable limits on protected rights. Under s. 1, where the focus shifts away from the individual claimant, the difficulty in identifying the vulnerable was recognized in *Carter 2015* as an important consideration (para. 88). In addressing the fear that the vulnerable would be subjected to premature death, the SCC said "theoretical or speculative fear cannot justify an absolute prohibition" (para. 119). Moving from an absolute ban to the stipulation in the proposed 241.2(2) is the type of "less harmful means" that are "reasonably tailored to the objective" (para. 102) to satisfy s. 1. The greater concerns about vulnerability would also preclude the negative effects of restricting physician-assisted death from outweighing the beneficial effects of protecting the vulnerable. Thus the proposed s. 241.2(2) would be a proportionate balancing.

It is argued that "reasonably foreseeable" is too vague.[3] However, that term incorporates the flexibility necessary[4] to deal with the reality that predictions as to the timing of death are

[3] *Ibid.*

[4] As an exception to what would otherwise be a crime, doubt should be resolved in favour of those claiming the applicability of the provision.

notoriously unreliable. The basic question is whether medical assistance in dying should be limited to those who are in some sense dying from natural causes.

If subsections 241.2(2)(b) and (d) were deleted, physician-assisted dying would be so wide open that the chances increase substantially of people dying who would not choose death if they fully appreciated other options. It is one thing to say that the person is dying and wants state sanctioned help to choose the manner and exact timing of death. It is quite another to say that someone who is in no sense dying should get state sanctioned help to die early, given that the person probably has a long life ahead of them during which any current wish to die could change. Vulnerability is potentially a concern for any physician-assisted death (hence the need for other safeguards), but those concerns go way up for people who are not in any sense dying. Thus subsections (b) and (d) are necessary in furthering the important public policy of suicide prevention.

Carter puts the onus on Parliament to craft a regime that provides equitable access to physician-assisted death. At the same time, it places on Parliament a responsibility to incorporate sufficient safeguards to protect the constitutional rights of the vulnerable. With competing constitutional rights (those claiming a right to die versus those vulnerable to being subjected to premature death) it is not open to Parliament to pursue one to the exclusion of the other – that was ultimately the downfall of an absolute ban on physician-assisted death.

The Significance of June 6, 2016

What happens, effective June 7, 2016, if no legislation has been passed by the federal Parliament to amend the *Criminal Code* respecting medical assistance in dying? Currently, the absolute criminal prohibition on physician-assisted death in Canada is in force (outside Quebec[5]) subject to an order of a superior court judge authorizing physician-assisted death in any particular case. This judicial authorization is an exception to the suspension of the declaration of invalidity which (outside Quebec) lasts until June 6, 2016 (*Carter 2016*). After that date, if there is no amendment to the *Criminal Code*, the suspension, and the judicial authorization exception, come to an end, and the declaration of invalidity from *Carter 2015* becomes generally effective (repeated for ease of reference):

> Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that 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. (paras. 127 and 147)

The further stipulation in paragraph 127 that "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations

[5] Within Quebec, the declaration of invalidity is no longer suspended. Instead of a criminal prohibition against medical assistance in dying, Quebec's *Act Respecting End-of-Life Care* S.Q. 2014, c. 2 (in force 10 December 2015) applies.

where physician-assisted dying may be sought." gives some guidance to Parliament as to the parameters within which to respond, but is likely not precise enough to provide legal effect in the absence of Parliamentary action. Nor does the declaration incorporate the "carefully designed and monitored system of safeguards" (para. 117 of *Carter 2015*) anticipated from Parliament by the Supreme Court of Canada. As discussed above, there is contention as to how far Parliament can go in designing such safeguards in a *Charter* compliant manner consistent with *Carter*, but there is no doubt that some kinds of safeguards, not articulated in the declaration of invalidity, are permissible to protect the vulnerable.

Once the declaration of invalidity were fully effective in the absence of a Parliamentary response, judicial authorization would no longer be required to make physician-assisted death legal. A doctor falling within the terms of the declaration of invalidity would, without anything more, not be guilty of an offence under ss. 241(b) and 14 of the *Criminal Code*.[6] Although cautious, risk-averse doctors may be hesitant to act, determined doctors could proceed, confident of the absence of criminal liability.[7] If prosecuted, a doctor would only need to raise a reasonable doubt on the non-applicability of the criteria of "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."[8] Doctors participating in physician-assisted death would not need to comply with <u>any</u> of the limitations/safeguards about which there is no disagreement in:

> The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report* (November 30, 2015) (Provincial-Territorial Report)
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> The Report of the Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying*: *A Patient Centred Approach* (February 2016) (Special Joint Committee Report)

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[6] There could be other sections of the *Criminal Code* in issue, such as s. 245:

> **245** 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
>
> > **(a)** 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; or
> >
> > **(b)** to imprisonment for a term not exceeding two years, if he intends thereby to aggrieve or annoy that person.

However, if the declaration of invalidity from *Carter* were otherwise applicable, a constitutional defence to a charge under s. 245 seems inevitable.

[7] Within Quebec, compliance with provincial legislation would still be required. Otherwise, the prospect of professional discipline would also be a consideration.

[8] There is some uncertainty as to the exact scope of the *Carter* declaration of invalidity against the absolute ban on physician-assisted death in terms of conditions covered; although the declaration itself does not exclude psychiatric disorders, in para. 111 of the judgment the Court specifically indicates that psychiatric disorders "would not fall within the parameters suggested in these reasons." In addition, since the *Carter 2015* declaration and judgment do not deal with either mature minors or advance directives, any attempt to invoke such circumstances as giving rise to a constitutional defence would require a fresh *Charter* challenge.

Quebec's *Act Respecting End-of-Life Care*, S.Q. 2014, c. 2 (in force 10 December 2015) (Que. *ARELC*)

Bill C-14 (tabled in the House of Commons on April 14, 2016)

Although not everyone signed the Provincial-Territorial Report, and although there was a dissent in the Special Joint Committee Report, there were many basic things about which there was easy consensus.

Specifically, without getting into anything about which there is contention as to what constitutes a *Charter* compliant response to *Carter*, if Parliament does not act by June 6, 2016, there would be a legislative vacuum in the criminal law on key issues:

- One doctor's involvement would be enough, despite unanimous agreement that (at a minimum) a second medical practitioner needs to concur that all of the eligibility criteria are met.
  Provincial-Territorial Report, Recommendation 22
  Special Joint Committee Report, Recommendation 12
  Que. *ARELC*, s. 29(3)
  Bill C-14, proposed s. 241.2(3)(e) [9]

- There would be no requirement of a written request, or other formality of consent, despite unanimous agreement that there be careful attention to such details.
  Provincial-Territorial Report, Recommendation 11
  Special Joint Committee Report, Recommendation 9
  Que. *ARELC*, ss. 26, 27
  Bill C-14, proposed s. 241.2(3)(b),(4),(5)

- No reflection period at all would be required between request and implementation of medical assistance in dying, despite unanimous agreement that, subject to the need to be flexible to meet individual circumstances, there ought to be opportunity for reflection as is appropriate.
  Provincial-Territorial Report, Recommendation 26
  Special Joint Committee Report, Recommendation 14
  Que. *ARELC*, s. 29(1)(c)
  Bill C-14, proposed s. 241.2(3)(g)

- There would be no requirement to report to anybody about anything, despite unanimous agreement regarding the need to collect data to enable assessment and evaluation of the practice of medical assistance in dying.
  Provincial-Territorial Report, Recommendations 15, 16, 39
  Special Joint Committee Report, Recommendation 16
  Que. *ARELC*, ss. 32, 36, 37, 42-46

[99] Moreover, the Special Joint Committee Report, Recommendation 12, the Que. *ARELC*, s.29(3), and Bill C-14, proposed s. 241.2(3)(f) and (6) further stipulate that the second medical practitioner be independent of the first.

Bill C-14, proposed s. 241.31

- There would be no requirement that medical assistance in dying be available only to insured persons eligible for publicly funded health care services in Canada, despite unanimous agreement that medical assistance in dying in Canada should not be available as a matter of medical tourism.

  Provincial-Territorial Report, Recommendation 21
  Special Joint Committee Report, Recommendation 8
  Que. *ARELC*, s. 26(1)
  Bill C-14, proposed s. 241.2(1)(a)

In short, it is not a responsible option for the Parliament of Canada to fail to act by June 6, 2016.

Conclusion

On November 14, 2014 Peter Singer, the Ira W. DeCamp Professor of Bioethics at Princeton University, gave a public lecture on "Assisted Dying" at the Schulich School of Law at Dalhousie University in Halifax, Nova Scotia. It was the inaugural Sir Graham Day Lecture in Ethics, Morality and the Law, presented in collaboration with the CBC radio program *Ideas*. There were two aspects of Peter Singer's talk that I found particularly disturbing.

In answer to a question about the risks of error, Professor Singer responded that medical misdiagnosis in the context of physician-assisted dying was rare. My reaction, which I was unable to express publicly because the line-up of questioners was so long, was that his answer completely missed the point. The real concern about error respecting assisted dying is on the assumption that the medical diagnosis is accurate, but that the person would have come to regret the decision to die if that reconsideration had not been precluded by premature death.

Another comment during Professor Singer's talk also took me aback. He said that support of physician-assisted dying was a feminist position. His explanation was that it was rational for someone to choose death because of concerns over being a burden to caregivers, and daughters disproportionately bear the burden of caring for ailing parents. Again I was unable le to ask my question: why should there be a binary choice between death and a burden on daughters? Why is the solution to a disproportionate burden on daughters not a broader social responsibility beyond children to care for the elderly? Why is meeting the needs of an aging population a private, rather than a public, responsibility? It starkly makes the fundamental point that physician-assisted death is not just an issue of individual autonomy of those seeking a right to die. It also involves a broader collective responsibility.