The Future of Canada’s Medical Assistance in Dying (MAID) for the Mentally Ill and Physically Disabled

by

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Abstract

Canada’s Medical Assistance in Dying (MAID) law continues to be a dividing issue. While it has been decided that only a few qualifying Canadians suffering from severe conditions may request assistance in dying, barriers currently in place may inevitably be lifted as legal challenges are brought against Bill C-14 for potential discrimination towards parties excluded from qualifying under the bill’s eligibility criteria. There is a potential of using the Charter as a force to expand assisted dying which may likely have negative implications on two of the most vulnerable groups in society, those living with a mental illness or physical disability. Studies on controversial practices emerging within the most liberal assisted dying regimes in Europe, Belgium and the Netherlands, may inform Canadian lawmakers on issues to avoid when possibly enacting a broader legalized practice in the near future.
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Introduction

“I am forced to suffer with this disease without a choice, a disease which inherently limits my opportunities for choice. I would like, if I am suffering intolerably, to be able to make a final choice about how much suffering to endure.”

- Julia Lamb.

Assisted dying is a delicate and difficult issue which touches the lives of many Canadians and their families. It is closely related to end-of-life care and heavily debated around the world. Following several other countries, including Belgium, Luxembourg, the Netherlands and several parts of the United States, Montana, New Mexico, Oregon, Vermont and Washington, the Supreme Court of Canada (SCC) decided to overturn its blanket ban on physician-assisted death. The decision to legalize assisted dying took twenty-five years after the notion of euthanasia was first brought to the Court’s attention in the early 1990s by Sue Rodriguez, a 42-year-old woman suffering from the debilitating, terminal illness, amyotrophic lateral sclerosis (ALS). In the end, Mrs. Rodriguez’s fight for a right to die was unsuccessful.

After two decades, changing precedents, and a large cultural shift towards physician assisted death, the law was finally altered by the landmark Carter v Canada decision. Like many jurisdictions before it, Canada faced the difficult decision of creating rules for assisted dying. With deeply held beliefs on both sides of the debate, the government was tasked with crafting a law that could provide competent Canadians the choice to end their own lives and to protect the most vulnerable members of our society.

After a lengthy deliberation, the liberal government’s bill was finally given royal assent in June 2016. The law recognizes that competent adult Canadians have the right to a humane and dignified death so long as they are suffering intolerably, either physically or mentally, from a grievous and irremediable medical condition, in a state of irreversible decline, and at a point

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2 Carter v Canada (Attorney General) (2015), SCC 5 [Carter].
where their natural death has become reasonably foreseeable. Yet, this freedom from unbearable suffering is only a legally recognized right for some, not all.

Since the introduction of the new legislation, the government has been under immense pressure to expand access. Their requirement that death must be ‘reasonably foreseeable’ was highly criticized for excluding applications who were eligible for assisted death under the criteria set out in the Carter decision. For this reason, many commentators argued the government’s legislation was a violation of the Canadian Charter of Rights and Freedoms (Charter), specifically section 15, the provision on equality rights which prohibits discrimination based on race, nationality or ethnic origin, religion, sex, age, mental or physical disability.

Many, including the government’s joint committee and members of Parliament, were concerned the federal government’s law on assisted dying was overly restrictive than what was initially intended by the courts. The SCC held lawmakers were to balance conflicting rights from both sides of the debate and that Parliament was responsible to enact a legislation on the issue so long as it “was consistent with the constitutional parameters.” In attempting to strike a balance between preserving a right to die while also protecting vulnerable groups, the law was stricter in some areas than it was in others. Some of these barriers to access have been greatly contested as unfair and unclear.

In the Carter judgement, it was well-understood that Justice Lynn Smith believed pain was an inevitable aspect of a disease, illness or disability. However, suffering she argued, should be optional for people in either physical or psychological pain. She recognized that each individual should have the freedom to choose based on their subjective measure of tolerance and value of life. Similarly, the SCC decided that individuals suffering from grievous and irremediable medical conditions have the right to make decisions about their body and medical care as a part of their autonomy. To leave individuals to suffer intolerably would ultimately impinge on their rights within the Charter. However, the court also stressed that designing safeguards are


4 Ibid, s 15.

5 Carter, supra note 3 at para 126.
necessary in order to ensure protection of vulnerable individuals who may wish to commit suicide in moments of weakness. 6

The Supreme Court’s decision did not explicitly exclude the mentally ill or physically disabled. Justice Smith held, after reviewing expert evidence on end-of-life practices from other jurisdictions, persons with psychological illness and physical disabilities should still have the option to request assisted death. She highlighted that such a prohibition puts strains on individuals who have to travel abroad, sometimes with their families who may have to assist them on their journey whilst a criminal liability looms over their heads. Not to mention, she stressed that a heavier burden lies on individuals with physical disabilities who are unable to take their own lives due to mobility restrictions. Based on the flexibility the court took on these issues (in comparison to Parliament), many have argued assisted death should be an option granted across all conditions for competent Canadians.

As the law currently stands, individuals living with a mental illness or physical disability who wish to seek medical assistance in dying may be eligible if they meet the criteria set out in the legislation. However, many argue that it is still unclear who is eligible under these requirements. The government’s prerequisite that an individual must be in an ‘irreversible state of decline in capabilities’ and ‘natural death must be reasonably foreseeable’ are vague restrictions. There is no clarity on whether the law can be interpreted in a way that allows people to access assisted death if they are solely suffering from a mental illness or a physical disability not currently in the end-stages of their life. These conditions, as several commentators have argued, are not in the original court decision and exclude a class of people who would have otherwise been eligible.

This first portion of this paper focuses specifically on whether the law is discriminatory towards Canadians who are suffering only from a mental illness or have a physical disability, and whether any exceptions are being made to current restrictions based on recent case law. The equality argument is a critical factor in the initial judgement which recognizes that vulnerable Canadians are entitled to make autonomous decisions to pursue assisted death. Yet, it was also stated that Parliament had the power to develop regulatory standards to protect the vulnerable. This paper will discuss whether this “stricter” criteria is consistent with the Carter decision and

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6 Carter, supra note 3 at para 76.
the Charter. This is a highly debated area, so the second portion of this paper will discuss debates on whether or not to expand eligibility to mental illness and physical disability. Lastly, the effects of open-ended access in permissive regimes will be examined, mostly focusing on Belgium and the Netherlands since assisted dying has been a long-standing practice in these countries and are the most liberal of all jurisdictions.

Restricting access does not mean that certain suffering is less important, it just suggests that society does not consider certain forms of suffering as a good enough reason for someone to die. Ultimately, if a section 15 discrimination argument is accepted by the court then expansion of the eligibility criteria may soon follow. The government is already under a lot of pressure to expand access so it may be inevitable that eligibility expands to individuals who may not be competent to make such an irreversible medical decision. If a more tolerant criterion is where the country is headed, then there should be discussion on what can be done in order to expand access to prevent discrimination based on medical condition but also prevent unnecessary death for those with treatable conditions. It would be logical then to discuss what controversies have arisen out of more liberal regimes to determine what types of procedural safeguards are necessary to avoid similar errors.
Chapter 1
Is Canada’s MAID Legislation Unfair?

1 Recognizing a Right to Die

The Supreme Court of Canada ruled in favour of allowing MAID in a unanimous decision that led to finding sections 241(b) and 14 of the Criminal Code\(^7\), which carried a hefty 14-year imprisonment term, as unconstitutional for unjustifiably infringing section 7 of the Charter, the provision protecting the right to life, liberty, and security of the person. However, the court did not eliminate criminal liability for assisted suicide, instead it exempted liability for assisted death for the appropriate medical professionals who adhere to requirements set out in legislation for “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 illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.”\(^8\)

This overturned the longstanding ruling in R v Rodriguez\(^9\), which was in favour of the prohibition against physician assisted dying. Rodriguez argued that the ban violated her section 7, 12 and 15 rights of the Charter but a 5:4 decision dismissed her appeal. In the Carter decision, this restriction was held to be overly restraining and could not be saved by a section 1 test of whether such a restriction to a Charter right could be reasonably justified. Justice Smith held the blanket ban infringed section 7 and 15. The section 15 argument however was not acknowledged in the SCC decision, which ultimately gave Parliament more flexibility to overlook that particular aspect of the Charter when making its law on medical assistance in dying.

Among the plaintiffs, Kathleen (Kay) Carter, suffered from degenerative spinal stenosis and was in the later stages of her disease. She was battling an extremely painful condition for which she ultimately travelled to Switzerland for before the end of her trial to commit suicide. The second plaintiff, Gloria Taylor, was surprisingly in a very similar situation to Rodriguez. Both

\(^7\) Criminal Code, RSC 1985, c C-46.
\(^8\) Carter, supra note 3 at para 331.
\(^9\) R v Rodriguez (1993), 3 SCR 519 [Rodriguez].
Rodriguez and Taylor had suffered from ALS, a condition which leads to the inability to walk, write, speak, swallow and breathe, and has a 2 to 5-year life expectancy.\(^\text{10}\) Both wanted to end their lives on their own terms before the illness progressed and ended it for them. For Rodriguez though, the legal recognition to be free from her suffering would only be realized 20 years later. This decision was clearly long overdue, especially since Rodriguez did eventually get assisted death by an unnamed physician, who to this day has never been identified, nor held criminally liable for assisting in her death.

Justice Smith was able to review the constitutionality of the prohibition on assisted suicide not only because the blanket ban was grossly disproportionate in protecting the vulnerable from committing suicide at a moment of weakness by excluding all individuals, but also because of the substantive changes to the law, particularly in relation to the section 1 analysis and social changes that have happened over the past 20 years.\(^\text{11}\) She held that suffering could either be physical or psychological. Her criteria from the trial decision stated that assisted dying is only lawful when provided “by a medical practitioner in the context of a physician-patient relationship, where the assistance is offered to a fully informed, non-ambivalent competent patient who: (a) is free from coercion and undue influence, not clinically depressed and who personally (not through a substitute 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); 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 physical or psychological suffering that is intolerable to that person and cannot be alleviated by any such medical treatment acceptable to that person”.\(^\text{12}\)

Upon reviewing various regimes, Justice Smith did discuss that there were possible risks associated with physician-assisted dying. The areas of high risks she identifies are: assessing


\(^{11}\) Carter v Canada (Attorney General) 2012 BCSC 886 at para 908.

\(^{12}\) Ibid at para 1393.
competence, including cognitive impairment and depression; assessing voluntariness; assessing informed consent; ambivalence; and harm to the elderly and people with disabilities. Yet, after examining these areas, she concludes: “jurisdictions that permit physician-assisted dying have created safeguards to ensure that only defined categories of patients are involved and reporting requirements are followed. Research findings show differing levels of competence with the safeguards and protocols in permissive jurisdictions and no evidence of inordinate impact on vulnerable populations.”

Although she specifically mentions depression as a primary risk factor in assisted suicide requests, she does not explicitly state that individuals with mental illness should not qualify for assisted dying. It is common for people with chronic conditions or terminal illness to become clinically depressed and there are still no error-free capacity assessments available. She highlights that suicide is not illegal in Canada, however, people who are physically disabled and cannot commit an act of suicide themselves are disproportionately burdened under a law that prevents them from accessing assisted death. Correspondingly, the Supreme Court judgement did not deny access to mentally ill or disabled individuals.

Justice Smith acknowledged that “there are risks inherent in permitting physician-assisted death and that the utmost care would be needed in designing and managing a system that would allow it”. However, in her conclusion she stated that “the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully designed system imposing stringent limits that are scrupulously monitored and enforced.” Ultimately, the structure of a law based on what the trial judge and the Supreme Court outline would not preclude mentally ill or physically disabled individuals from accessing assistance in dying.

The SCC gave Parliament and provincial legislatures several months to create “an appropriate remedy” to the criminal law. However, being such a difficult task, the timeline was extended by

14 Ibid at 283.
15 Ibid at para 854.
16 Ibid at para 883.
four months. This was done despite Quebec having already passed its end-of-life Bill 53, the Act Respecting End-of-life Care.\(^\text{17}\) During this time, the court granted requests for assisted dying in accordance to the criteria set out in the Supreme Court’s judgement for persons “who (1) clearly consent to the termination of life; and (2) have a grievous and irremediable medical condition (including illness, disease or disability) that causes suffering that is intolerable to the individual in the circumstances of his or her condition.”\(^\text{18}\) So Canadians could qualify for assisted death so long as they met this criteria. However, since no safeguards were set in place, the only protection during this time was the fact that individuals had to seek judicial relief.\(^\text{19}\)

2 An Issue of Compliance with the Courts Ruling

When Parliament finally introduced an act amending the Criminal Code, there were mixed reviews. Some leading associations, such as the Canadian Medical Association and Canadian Nurses Association, were supportive of Parliament’s approach.\(^\text{20}\) While others argued that the criteria set out differed from the one initially introduced in Carter. Bill C-14 did more than just create procedural safeguards, it was more restrictive than the court’s decision.\(^\text{21}\) It added two additional limitation clauses: (1) that an individual must be in an advanced state of irreversible decline\(^\text{22}\) and (2) their natural death must be reasonably foreseeable\(^\text{23}\). This created an uproar as many believed this meant only persons with terminal illness would qualify for MAID. However, the government soon clarified that this did not mean assisted dying was reserved only for those in a terminal state.

\(^{17}\) An Act Respecting End-of-Life Care, RSQ C 2014, c 2.

\(^{18}\) Carter, supra note 3 at para 127.

\(^{19}\) Library of Parliament, “Legislative Summary of Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)” in Legislative Summary, No 42-1-C14-E (21 April 2016) at para 1.3, online: <https://lop.parl.ca/Content/LOP/LegislativeSummaries/42/1/c14-e.pdf>.

\(^{20}\) Paul C Webster, “Canada debates medical assistance dying law” 387:10031 The Lancet 1893.

\(^{21}\) “Know Your Rights: Get the Facts: Bill C-14 And Assisted Dying Law In Canada”, Dying with Dignity Canada, online: <http://www.dyingwithdignity.ca/get_the_facts_assisted_dying_law_in_canada>.

\(^{22}\) Canada, Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), 1st Sess, 42nd Parl, 2016, s 241.2(2)(b).

\(^{23}\) Ibid at s 241.2(2)(d).
Yet, the British Columbia Civil Liberties Association (BCCLA), who initiated the Carter litigation, said that the legislation was inadequate because it “leaves out entire categories of suffering Canadians who should have a right to choose a safe and dignified assisted death” and means “people will be trapped in intolerable suffering”. Dying with Dignity Canada said the natural death must be reasonably foreseeable criteria wording was vague and makes the law unconstitutional. Along the same lines, Peter Hogg, Canada’s leading expert on Canadian constitutional law stated: “In my opinion, the Bill is not consistent with the constitutional parameters set out in the Carter reasons… those who satisfy the Carter criteria and do not have an end-of-life condition will bring a constitutional challenge to the new legislation.” The Supreme Court did not mandate Parliament to create legislation in relation to this issue, instead it stated that if ‘Parliament and provincial legislatures chose to respond, they should enact legislation consistent with the constitution set out in these reasons’. Jocelyn Downie, a Professor of Law and Medicine at Dalhousie University, argues that the law must be amended because the criteria is inconsistent with both Carter and the Charter. Downie says the SCC did not place an “incurable” restriction on illness, disease or disability, nor was there any mention of needing the patient to be in an “advanced state of irreversible decline in capability” or that “natural death be reasonably foreseeable”. She says this would have meant that Kay Carter would not have qualified under the new eligibility criteria. Carter’s condition, spinal stenosis, was a debilitating disease which caused her leg pain and affected her ability to walk, however it did not reduce her life expectancy. It only affected her enjoyment of life.

24 Webster, supra note 19.
25 Supra note 20.
26 Peter Hogg, “Presentation to Standing Senate Committee on Legal and Constitutional Affairs Bill C-14 (medical assistance in dying)” (2016) online: <https://sencanada.ca/content/sen/committee/421/LCJC/Briefs/LCJC_June_6_2016_SN_Hogg_e.pdf>.
27 Carter, supra note 3 at para 126.
29 Ibid.
Further, Downie says the “reasonably foreseeable” requirement is too vague because everyone’s death is to some extent foreseeable since we all eventually die sometime in the future. According to Downie, mental illness should be included in the criteria because the Supreme Court did not expressly exclude it.

Several cases following Carter, before the enactment of Bill C-14, declared that terminal illness was not a requirement. In the first of these, AB v Canada (Attorney General), assistance in death was administered to an 81-year-old in an advanced stage of aggressive lymphoma who met the Carter criteria. In this case, Justice Perell stated: “I extract five criteria from Carter-2015, namely: (1) the person is a competent adult person; (2) the person has a grievous and irremediable medical condition including an illness, disease or disability; (3) the person’s condition is causing him or her to endure intolerable suffering; (4) his or her suffering cannot be alleviated by any treatment available that he or she finds acceptable; and, (5) the person clearly consents to the termination of life.” From this interpretation there was no requirement in Carter that a medical condition needed be terminal or life threatening. Although the government has since then provided some assurance that terminal illness is not a requirement, it was still clearly very problematic for those at the time who believed Carter would not have been eligible under Parliament’s new law.

On the other hand of the Charter argument, Dianne Pothier, who was also a professor of law at Dalhousie University, said that Parliament, as a protector of Charter rights, is still responsible for designing safeguards even though the court did not indicate what was needed to be done in order to set an appropriate balance between meeting its constitutional obligations while also protecting vulnerable Canadians from abuse. Around the same time, Thomas McMorrow, assistant

30 Ibid.
32 AB v Canada (Attorney General), 2016 ONSC 1912.
33 Ibid at para 22.
professor of Legal Studies at the University of Ontario Institute of Technology, asked: “why would the Court be willing to twice extend Parliament’s deadline to tailor a new law, if Carter imposes a legislative straightjacket?” The answer was the Court did not. Parliament was free to legislate as it pleased, so long as the blanket ban was lifted.

According to Pothier, the SCC’s analysis in Carter concerned an absolute prohibition, rather than a future regime with safeguards, so Parliament was left to decide how to draft the law on its own and was not prohibited from declaring any further restrictions, including a terminal illness criteria. She also said Justice Smith did in fact mention a requirement of “advanced weakening capabilities”, however the SCC did not comment on this in its judgement and by not doing so it cannot be said that it made any claim in favour or against it. Correspondingly, since the SCC did not make any comment on the criteria of “natural death be reasonably foreseeable”, it did not make a declaration against it either. She argued that the “reasonably foreseeable” requirement provided necessary flexibility because in many situations, the timing of death is not entirely predictable. Finally, in relation to Peter Hogg’s comment mentioned earlier, Pothier said he was simply referring to the possibility of a challenge, not commenting on whether a stricter criteria could pass a section 1 analysis.


36 Pothier, supra note 33 at 6.

37 Dianne Pothier, “Submissions to the Standing Senate Committee on Legal and Constitutional Affairs Re consideration of Bill C-14” (2016) Dal LJ at 4 online: <https://static1.squarespace.com/static/56bb84cb01dbae77f988b71a/t/57320f0e40261d67c7169e73/1462898446596/Pothier+-+Senate+Committee+submissions+on+C-14.pdf>.

38 Ibid at 5.

39 Ibid at 6.

40 Ibid at 5.
The Government of Canada did attempt to provide some clarification to the reasonably foreseeable issue on the Health Canada website as it is stated that people applying for MAID “do not need to have a fatal or terminal condition to be eligible”.\footnote{“End-of-life care: Medical Assistance in Dying” (26 April 2017), \textit{Government of Canada}, online:<https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>\).

This clarification however, is not written into Bill C-14. Additionally, the government removed the term “incurable” on their guidelines, yet the term still appears in legislation. This could be problematic for those who are trying to follow the law. Rather than adding or deleting terms from the government website without notice, any clarification made should be publically announced and implemented into the law to prevent misunderstanding.

3 Challenges Against the Assisted-Dying Law

Health Canada’s website states “If you have a mental illness or a physical disability and wish to seek medical assistance in dying, you may be eligible. Eligibility is assessed on an individual basis, looking at all of the relevant circumstances. However, you must meet all the criteria to be eligible for medical assistance in dying, which means: your natural death must be reasonably foreseeable in a period of time that is not too distant; you must be mentally competent and capable of making decisions immediately before medical assistance in dying is provided, the physician or nurse practitioner must ask you to confirm your choice before administering the service.”\footnote{Ibid.}

This section on eligibility for mentally ill or physically disabled persons does not appear anywhere on the legislation, which may likely mean it was added later to support and improve of the law, a measure the government expressed it would take.\footnote{Canada, Bill C-14, \textit{An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)}, 1\textsuperscript{st} Sess, 42\textsuperscript{nd} Parl, 2016, Preamble.} It further states there are questions that have been left unaddressed in the law which require careful consideration, including requests where mental illness is the sole underlying medical condition.\footnote{\textit{Supra} note 40.} It seems from this statement then, only having a mental illness may not qualify an individual for assisted dying.
In a paper with Justine Dembo, a Medical Director at Reconnect Trauma Centre in California, Jocelyn Downie addresses several arguments made by Pothier (as discussed above) and tackles uncertainties linked with mental illness within the legislation. They argue that individuals whose sole underlying condition is a mental illness are not ineligible but that the government has been providing misleading information to the public on which conditions would qualify.\textsuperscript{45} According to Downie and Dembo, having a mental illness alone does not bar a person from requesting access to assisted dying because of a recent decision by the Alberta Court of Appeal, in Canada (Attorney General) v E.F.\textsuperscript{46}, concerning a 58-year-old woman suffering from severe conversion disorder, a neurological illness that causes psychological stress to convert to physical problems which can affect one’s ability to walk, swallow, see or hear.\textsuperscript{47} Ultimately in this case, the plaintiff did qualify for MAID solely through her mental illness.

However, in E.F., the court stressed the plaintiff was in desperate need of relief because she was in agony for years, as they explained: “She suffers from involuntary muscle spasms that radiate from her face through the sides and top of her head and into her shoulders, causing her severe and constant pain and migraines. Her eyelid muscles have spasm[ed] shut, rendering her effectively blind. Her digestive system is ineffective and she goes without eating for up to two days. She has significant trouble sleeping and, because of her digestive problems, she has lost significant weight and muscle mass. She is non-ambulatory and needs to be carried or use a wheelchair. Her quality of life is non-existent.”\textsuperscript{48} On numerous occasions it was emphasized that although her condition was psychiatric, she was not depressed, instead she was living in dire physical pain for several years. Thus, based on this decision, what can be gathered from the law at this time is that an individual whose sole underlying condition is a mental illness is eligible for MAID when there is a physical component to his or her suffering which must be lengthy over a period of several years and unable to be mitigated by other treatments.


\textsuperscript{46} Canada (Attorney General) v EF, 2016 ABCA 155 [E.F.].

\textsuperscript{47} Ibid.

\textsuperscript{48} Ibid at para 7.
Downie and Dembo went on to argue that a person who is suffering solely from a mental condition can meet the eligibility criteria if they: (1) have decision-making capacity; (2) their mental illness is incurable (meaning that they are in an advanced state of irreversible decline and no treatment options are acceptable to the patient); and (3) their natural death can be reasonably foreseeable. Each of these factors, they argue, can be fulfilled by a person whose sole underlying condition is a mental illness. First, since psychiatric patients can be found to have capacity to consent to risky treatment that could result in death, they can also be found to have capacity to consent to assisted dying. An example they use is an anorexia nervosa patient who can legally refuse life-sustaining treatment. Second, they argue mental illness can be incurable since there have been reports of psychiatric patients unresponsive to treatments such as medications, electroconvulsive therapy and other high quality treatments. Again, they reference E.F., since the Alberta Court declared the plaintiff’s psychological disorder in this case an irremediable condition based on her lengthy unresponsive treatment history. Furthermore, they argue that many treatment options available currently for mental illnesses may not either be available or acceptable to the patient. For instance, they claim that many medications intended to treat psychotic illnesses have negative side effects, some of which are physical reactions such as muscle spasms, immobility, dizziness, fainting and so forth. Finally, they argue that natural death of psychiatric patients may be reasonably foreseeable. The example they use is again an anorexia nervosa patient who is so malnourished that she is now experiencing “organ failure, cognitive decline and multiple fractures as a result of premature osteoporosis”.

While the authors do raise some valid points, they also make some concerning ones. For instance, they argue that psychiatric patients who are not going through a sudden loss of capabilities, like the hypothetical anorexia nervosa patient, we could look to conditions like Kay Carter’s as clarification for what the government meant by “natural death” since her non-

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49 Supra note 44 at 3.
50 Ibid.
51 Ibid at 4.
52 Ibid at 5.
53 Ibid.
terminal condition qualified as a reasonably foreseeable death based on the fact that she was an elderly woman and frail, therefore “an individual whose sole underlying condition is mental illness would meet the reasonably foreseeable criterion if she was old and frail”.54 Another distressing claim they make is that research has shown people with mental illnesses die earlier than the general population and therefore based on their short lifespan could qualify for assisted dying.55 Finally, according to the authors, a decline in capabilities is a reality for persons with mental illness because many individuals cease to take care of themselves, become isolated and in many cases the risks of becoming homeless for such patients is heightened because access to proper education or job opportunities diminishes as their condition worsens.56

On this point, other commentators have suggested that prejudice towards people with mental illness are still deeply ingrained in our society and the mental healthcare system can only truly address needs of these patients by finding them (1) a home (2) a job and (3) a friend.57 For this reason, maybe we have no place in discussing medical assistance in dying for these patients when a large portion of their suffering is entrenched in our society’s response to addressing their needs. Nevertheless, the questionable remarks made by Downie and Dembo have not gone overlooked. Lemmens et al note that in making their arguments on why the law should be interpreted with a broader application, “they ignore the rules of statutory interpretation, in particular because of their explicit rejection of Parliaments intent”.58

Although the government has attempted to provide some clarity on the issue of qualifying conditions, present litigation also demonstrates that ambiguity continues to exist. For instance, litigation is arising to challenge the terms in the current legislation that make eligibility requirements unclear. In June 2016, the BCCLA and Julia Lamb, a woman suffering from spinal

54 Ibid at 6.
55 Ibid.
56 Ibid at 5.
57 Michael Bay, “The Devil is in the Details: Thoughts on Medical Aid in Dying for Persons with Mental Illness” (2017) 10 Journal of Ethics in Mental Health at 2.
muscular atrophy, a neurodegenerative disease, filed to challenge Bill C-14 on its requirement that only those whose natural deaths are “reasonably foreseeable” are able to access assisted dying.  59 Lamb is worried that if her conditions worsens, which it could at any time, she would be trapped and lose the ability to breathe on her own, move her hands and speak.  60 She is afraid of losing all of her independence and being stuck in a state of mental and physical suffering that could last months, years or decades.  61 The possibility of having this future causes her immense distress, especially because she may be in a state where she is suffering both physically and mentally, but the new law will require her to stay alive because her death is not “reasonably foreseeable”. She says that she would like to “make a final choice about how much suffering to endure”.  62 Furthermore, in May 2017, the BCCLA added a new plaintiff to the case, Robyn Moro. Moro is a 68-year-old woman suffering from Parkinson’s disease and says that she does not want to endure progressive suffering and wishes the law would support her choice by allowing her to die peacefully with her family by her side.  63 According to the BCCLA, Morro’s “days are spent in severe pain... her body shakes constantly with tremors... she has chronic nausea and vomiting, muscle freezing, and exhaustion.”  64 BCCLA say the current law violates the Charter because it discriminates against fast moving conditions such as cancer to slow moving conditions which cause individuals to suffer over a long period of time before their death is “reasonably foreseeable”.  65


60 Ibid.

61 Ibid.

62 Ibid.

63 Supra note 1.

64 “ASSISTED DYING: BCCLA to add new plaintiff to legal challenge for right to die with dignity” (23 May 2017), British Columbia Civil Liberties Association, online: <https://bccla.org/news/2017/05/assisted-dying-bccla-add-new-plaintiff-legal-challenge-right-die-dignity/>.

Canada’s assisted dying law is clearly still facing challenges. These challenges have deepened as they have now reached court-level. The Lamb lawsuit is arguing on the same Charter grounds that were brought to the Court’s attention in Rodriguez and Carter, on both section 7 and 15. Parliament cannot continue to ignore the importance of medical assistance in dying on section 15 grounds. Like the Special Joint Committee on Physician-Assisted Dying has stated, the difficulty surrounding many of these issues, should not be used as justification to discriminate against such individuals by denying them access to MAID.\(^66\)

Chief Justice Lamer, the only judge in Rodriguez to consider the section 15 claim, argued that preventing the physically disabled from ending their lives was discriminatory and could not be justifiable under section 1.\(^67\) Justice Smith was in favour of preventing such a discrimination against persons who are unable to physically take their own lives. She listed examples of illnesses, such as ALS, Huntington’s disease, locked-in syndrome and severe inoperable spinal stenosis, where a restriction on assisted dying could prevent such individuals from choosing to die peacefully, and instead causing a them to die a painful death or to prematurely end their lives in a possibly violent manner before their conditions worsen.\(^68\)

Depending on the outcome Lamb, this lawsuit against the government of Canada may not be the end of this conflict as other people with disabilities may one day come forward to fight for a choice to die peacefully. On this point, Lemmens et al argue that while the governments vagueness on such issues opens the door to a constitutional challenge, “public interest litigation could be launched by the many health advocacy and disability rights organizations that are expressly concerned about the implications of an open-ended MAID regime. One should hope that human rights commissions and organizations would also be interested in investigating the


\(^{67}\) *Carter*, supra note 10 at para 1013.

\(^{68}\) Ibid at para 1041.
implications of an all-too-open MAID regime that exposes the most vulnerable of our society to the risk of premature death and would take up the challenge of litigation on their behalf.  

Ultimately, the SCC did state that “Parliament must be given the opportunity to craft an appropriate remedy… [because] complex regulatory regimes are better created by Parliament than by the courts”. However, Parliament is not required to apply Supreme Court judgments identically into the legislation.

Yet, commentators like the President of Right to Die Society of Canada, Ruth von Fuchs, argues that Parliamentarians who defend Bill C-14 say that the Courts make judgements but Parliament has the end say on what the law is. However, she argues, Justice Smith went through volumes of research and testimony before making her decision, it is doubtful that Ministers writing the bill were as well informed by such quantity and quality of information. Therefore, Parliament should enact law that does not conflict with the Charter, to do otherwise would undermine the value of those rights and it would be inevitable that other plaintiffs affected by such a law will come forward to challenge it.

As it has been discussed, an argument based on section 15 could claim that persons excluded from MAID have equal say in whether they choose this form of medical treatment versus another, however an opposing argument based on that same equal treatment right could be argued in favour of a stricter law that provides equal protection to the vulnerable. Such a dispute in the courtroom is not far from reality. However, as for whether the current law is Carter and Charter compliant, it may not necessarily be Charter compliant since the question of whether the law is proportionate based on a section 15 equality right is still largely undetermined.

Even though Charter rights are not absolute, it is insured that when they are infringed, it is done so in the least intrusive manner, as required by the section 1 proportionality test. Some restrictions should be made in order to protect vulnerable people, however as we know from

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69 Supra note 57 at 39.

70 Carter, supra note 3 at para 125.

71 Ruth von Fuchs, supra note 64 at 5.
Carter these should be proportional to the objective. The Charter has been used to make some enormous changes in the law in the past so it cannot be said with absolute certainty that a section 15 argument in favour of broader access to MAID will never come into existence. The potential lack of equality has not gone unnoticed by many, including medical legal academics, right to die associations and especially by those who feel that their right not to suffer unbearably has been unfairly taken away from them. As, Ruth von Fuchs argues, “some people have just been dealt with a very bad hand… they did not join the game voluntarily – indeed none of us did – they should not be punished for their misfortune. And continued life, rather than a death, is what constitutes punishment in their case… Diagnosis should not be grounds for discrimination”.  

72 Ibid.
Chapter 2
Debates on Assisted Dying for Vulnerable Groups

4 Mentally Ill Patients

Many debates on whether mentally ill or physically disabled persons should be eligible were considered in the Carter decision and in academic commentary. Mental illnesses are non-terminal, so there are possibilities of improvement, even for conditions that cause long-term suffering to old age. However, many argue that just because it is not terminal does not mean it is remediable and it is unreasonable to require individuals to continue living out years in unbearable pain while they wait for a possible solution, which may never come. A major concern for those against extending eligibility is about consent. Some believe that mentally ill patients are unable to provide valid consent because their condition impairs their decision-making ability. It is true that there are currently many problems with capacity assessments, yet in the Carter decision, it was held that obtaining capacity from a mentally ill patient highly depends on the nature of their circumstances and therefore should be decided on a case-by-case situation.

In line with that assertion, psychiatrist and Clinical Professor, Dr. Smith, argued in Carter that all cases should be determined based on the level of impact of impairment to make decisions and that physicians can use current tests to make such assessments.\textsuperscript{73} He goes on to say that “most people with depression will not be cognitively impaired… it is only when depression is severe that concerns will arise in connection with a patient’s competence”.\textsuperscript{74}

However, competence requires an individual to appreciate his or her situation and the consequences of that decision, which many commentators suggest is not possible with persons who are mentally ill, especially depressed patients because their feelings of hopelessness completely diminish prospects of improvement in their subjective mind. For this reason, commentators suggest that special attention should be paid to the individual’s ability to perceive the future possibilities of improvement.

\textsuperscript{73} Carter, supra note 10 at para 779.

\textsuperscript{74} Ibid at para 787.
Either possibilities are not always explicit, or some individuals may not be fully aware what the possibilities for improvement are or that they can eventually be achieved. Dr. Linda Ganzini, geriatric psychiatrist and Professor of psychiatry and medicine, says it is important to understand that people with depressive disorders can make choices that are inconsistent with their personality and values.\textsuperscript{75} In her opinion, it is best to give such patients a trial of depressive treatment rather than lethal injection, even if they have capacity.\textsuperscript{76}

One psychologist in the Netherlands, where practice has been legal for quite some time now, says that doctors still struggle with determining whether requests by such patients for assisted dying are in fact very well considered.\textsuperscript{77} It is troubling to hear this from a psychologist who is practicing in a regime where assisted death for persons with mental illness has been lawfully permitted well over a decade now.

When people are suicidal due to their depression, it may be difficult for them to pinpoint why they wish to end their lives. Just as hopelessness is a reason, often times a person’s self-worth and lack of positivity in their lives can also be major factors in their decision to end life. Consequently, when mental illnesses are added to eligibility for assisted death, it reinforces a lack of hope in improvement.\textsuperscript{78} Feelings of hopelessness complicate competence assessments. When an individual has such strong negative emotions, it is difficult to resist becoming overwhelmed by the stress which ultimately disturbs one’s ability to make a sound judgement.

However, this does not negate the real pain and suffering mentally ill patients endure. There have also been many accounts where scholars have written on physical effects of psychological illnesses as well. For instance, it has been asserted that depression can prevent a person from moving and getting up to start their day because it requires a lot more effort an energy for a

\begin{footnotesize}
\textsuperscript{75} Carter, supra note 10 at para 789.
\textsuperscript{76} Ibid.
\textsuperscript{77} Ibid at para 791.
\end{footnotesize}
person experiencing severe depression than it would any normal non-depressed individual.\textsuperscript{79} Though, these are the kinds of physical results of certain mental illnesses that may be worked on over time and overcome, either through medication or with the help of a therapist.

On the contrary, some scholars have argued that current treatment options available for mental illnesses may not be a solution for some depressed patients. Udo Schuklenk & Suzanne van de Vathorst’s paper discusses treatment resistant depression (TRD) as a severe and incurable condition. In their article, they state: “limiting access to assisted dying to people with incurable physical illnesses unjustly discriminates against competent people who struggle with psychiatric illnesses.”\textsuperscript{80} According to their findings, approximately 20-30\% of people with depression suffer from an untreatable variety.\textsuperscript{81} While others have argued this number is between 12-20\%.\textsuperscript{82} They claim that many of these patients have tried numerous kinds of treatments, such as antidepressants, psychotherapy, and possibly even electroconvulsive therapy, but these unsuccessful attempts have left them paralyzed in distress.\textsuperscript{83} Yet, differing reports have suggested that TRD patients can sometimes have a high recovery rate, one study revealed this number to be as high as 60.2\%.\textsuperscript{84} Success rates vary and it may not be the case that patients with this condition will never recover.\textsuperscript{85}

Bioethicist, Professor Franklin Miller, urges against extending physician assisted suicide to those with TRD. He asserts that such an extension would be incompatible with the professional

\textsuperscript{79} Udo Schuklenk & Suzanne van de Vathorst, “Treatment-resistant major depressive disorder and assisted dying” (2017) 41:8 Journal of Medical Ethics 577 at 579.

\textsuperscript{80} Ibid at 578.

\textsuperscript{81} Ibid.


\textsuperscript{83} Supra note 76 at 580.


\textsuperscript{85} Ibid.
integrity of physicians and the morality of medicine.\textsuperscript{86} He says physician assisted dying should be an absolute last resort, mostly for terminally ill patients who are close to death regardless of medical intervention, because it completely goes against the goals of medicine to promote patient health and wellbeing, including mental health.\textsuperscript{87} He acknowledges that many critics in favor of assisted dying have argued that if a patient on life-support can deny this treatment and not be judged based on their level of competence, even though they may well be depressed, then so should other individuals not using mechanical ventilation to survive. However, he notes that it is important to consider though how deeply offensive it would be to the dignity of the person who is refusing care to then force them to remain on life support without control over their body.\textsuperscript{88}

He argues that allowing individuals with conditions like ALS to request assisted dying is much different that allowing someone whose sole underlying condition is severe depression because the ALS patients condition is in fact known to be incurable, whereas there is still no true way of determining whether someone’s form of depression will never be curable.

Schuklenk and van de Vathorst wrote a response paper to address points made by Miller against their claims. On Miller’s point of ALS as an acceptable terminal illness for assisted death, they argue that the effects of ALS can in some cases last over a course of a few years, so in these cases assisted death may cause them to die prematurely.\textsuperscript{89} For instance, in Gloria Taylor’s situation, she was expected to be fully paralyzed within six months of her diagnosis in January 2010 but during the Carter trial in 2012 she was not.\textsuperscript{90} Furthermore, they argue, there is always the possibility that a cure for a terminal illness may be found, in which case it would be unfair to permit terminal illness as a qualifier for assisted death but then ask a depressed patient, who has

\begin{flushright}
\textsuperscript{86} Franklin G Miller, “Treatment-resistant depression and physician-assisted death” (2017) 41:11 Journal of Medical Ethics 885.
\textsuperscript{87} Ibid.
\textsuperscript{88} Ibid at 886.
\textsuperscript{89} Udo Schuklenk & Suzanne van de Vathorst, “Physician-assisted death does not violate professional integrity” (2015) 41:11 Journal of Medical Ethics at 877.
\textsuperscript{90} Carter, supra note 10 at para 820.
\end{flushright}
undergone years of unsuccessful therapy, to wait until some form of treatment eventually works. 91

Another academic who criticized Schuklenk and van de Vathorst’s paper is Professor Christopher Cowely, who does not believe that TRD qualifies as an untreatable condition like other non-treatable debilitating diseases (such as motor neuron disease). He argues that distinct from non-treatable diseases like cancer and motor neuron disease, depression affects the brain and distorts an individual’s judgement about the world and themselves, and not all depression is the same so we cannot predict the outcome of the disease based on previous cases, as you can with non-treatable diseases. 92

What makes TRD different from other conditions that fit Canada’s current assisted dying criteria is that there is no telling how long a person has left to live, nor is it easy to determine whether a patient with TRD truly has capacity to consent. Expanding assisted dying to such patients may have far-reaching implications and therefore it should not be as easily accessible for these patients as it is for those with a more probable end. If criteria expanded without additional safeguards then what may happen is, as some fear, psychological illnesses could be more willingly treated with assisted suicide, instead of using it as a last resort.

On this note, Blikshavn et al believe if mental health therapists become more willing to offer assisted dying as an option for patients, then as a result it could become a more socially acceptable and potentially favorable option. 93 Since the law specifies that patients do not have to undergo treatments they do not want to then patients may be more willing to reject any potentially effective treatments and instead request assistance dying to alleviate their depression, anxiety or other psychological conditions. 94 To prevent this from happening patients should be required to seek several alternative options, which may go against the ‘preferred treatment

91 Supra note 88 at 1.

92 Christopher Cowley, “Commentary on ‘Treatment-resistant major depressive disorder and assisted dying’” (2017) 41:8 Journal of Medical Ethics 585.

93 Supra note 77 at 155.

capable of meeting the patient’s needs’ direction, as it may essentially be compelling patients to try options that they would not otherwise have considered. However, this would truly emphasize that assisted dying is a last resort rather than an easier or just more preferable option.

In relation to this point, John Maher says if eligibility is expanded, it would be due to the fact that mental health treatment and services are underfunded and the Canadian government is unwilling to provide the finances to improve quality and access of these services.95 Certain therapies are dependent on a long-term trusting relationship between the patient and psychiatrist. As a psychiatrist, he argues it is his role of prevent suicide and help people find hope and meaning in their lives. Maher has seen too many “hopeless” cases improve, and asks “if not me, then who keeps trying?”96

Furthermore, a remaining concern in the context of allowing assisted dying for psychiatric conditions is whether capacity for such patients can be properly assessed. Charland et al believe that even though there has been a lot of clinical progress in this area, there is no reliable scientific way to conduct capacity assessments on psychiatric patients.97 The current test, they argue is “highly subjective and can often be highly variable, especially in difficult cases”.98 A popular decision making tool at this time is the MacArthur Treatment Competence Assessment Tool. The evaluation takes roughly 20-30 minutes per assessment, however it still in its early stages.99 A major issue with this form of assessment is, depending on the circumstances, an individual may be feeling strong emotions, such as hopelessness, anger, fear or sadness, that

96 Ibid at 4.
98 Ibid.
99 Ibid at 5.
distort their reasoning to make sound judgements. These emotions can play a large role in their final decision. Furthermore, aside from emotions, passions and values are also very important in one’s decision-making capacity. Passions, “essential to the human pursuit of the meaning of life”, include the human “willingness to be” which can push someone to either recover from a serious illness, or give up. While, values can often be tied to social and cultural values. For instance, anorexia nervosa, a social problem, often arises in industrialized cultures. Therefore, any reasoning test which does not include these concerns should not be used as a model for high risk decisions. Without a proper method of assessment, expanding eligibility to psychiatric patients will most likely expose many to abuse.

Similarly, Mona Gupta, Associate Professor of Psychiatry in Montreal, argues that there is much more that goes into a psychiatric patients suffering than others. For instance, their wish to die could be based on existential, social or financial influences, all of which are outside the scope of medicine. Requesting assisted death based on mixed feelings and experiences, she argues, is more of a distress call than it is an expression of a Charter right.

On the other hand, Dr. Govert den Hartogh says even though many mentally ill patients who attempt suicide are often grateful for being rescued, there are a small number of them who are living in misery who should be allowed to request an assisted death, yet this is still a very minimal number and so extra precautions should be taken in allowing these individuals to make such a request when reasons to doubt their stableness and decision making capabilities exist. There may not be doubt in every case, but there will likely be in a majority of them. If requests

100 Ibid.
101 Ibid.
102 Ibid.
104 Ibid at 2.
are to be taken then, they should be with extreme caution because there will only be a very small amount of exceptional cases where individuals have been suffering intolerably for years without relief from currently available treatments. Keeping in mind, that it will be very difficult to determine that a patient cannot be helped.

Michael Bay, Founding Chair of the Consent and Capacity Board of Ontario, suggests if we are to proceed with expanding eligibility then we should do so with “great care and trepidation”.\textsuperscript{106} Psychological pain and horror is real but we still have a long road ahead of us in finding a way to create capacity assessments which address the effects of depression, as the “model we currently use to determine individual decision-making is not reality-based”.\textsuperscript{107}

### 5 Physically Disabled Persons

As for the second group of vulnerable Canadians discussed in this paper, the Carter decision dedicated a separate section in the judgement to discuss the issues related to expanding access to this group, most of which included Catharine Frazee’s opinions. She strongly believed that current scholarly writing on the issue of access to assisted dying for persons with disabilities was not a true reflection of the reality of their existence because it overemphasized a link between dignity and being actively in control of one’s body, as she stated: “Loss of control of bodily fluids is repeatedly emphatically represented as a catastrophic assault of suffering and indignity, such as to render life no longer worth living. Loss of mobility and diminished capacity for independent self-care are consistently described as a stripping away of dignity. Despair and surrender are uncritically accepted as the only possible response to a hopeless predicament – a predicament invariably associated with social shame.”\textsuperscript{108}

In her submission to the Special Joint Committee on Physician Assisted Dying, Frazee points out that the UN Commission on Social Determinants of Health confirms that what makes people

\begin{itemize}
  \item 106 Supra note 56 at 3.
  \item 107 Ibid at 5.
  \item 108 Carter, supra note 10 at para 850
\end{itemize}
vulnerable is “biases, norms and values within society”. More often than not, discussion of disabilities in favour of assisted dying highlights the struggles of disabled persons and links these to worthlessness. For this reason, she argues, a regime that allows disabled persons to access assisted death must “go beyond individual choice to a broader contemplation of social impacts and potential harm to disadvantaged groups”. People living with lifelong physical disabilities tend to face daily unpleasant challenges, however the unpleasantness of these diminish over time and they can find meaning in their lives, whether it is through work, community, friendships or other pleasures, they do not live out their entire lives in a state of unending distress.

Likewise, the Council of Canadians with Disabilities and Canadian Association for Community Living stated that people with disabilities already have to deal with being stigmatized in society for their conditions. On top of this, if we allow them to access assisted dying, we are putting them at risk of internalizing that their disabled lives are not worth living, ultimately working against them rather than benefitting them or improving their situation of living with a disability.

Carol Gill, Professor in the Department of Disability at the University of Illinois at Chicago, believes that disabled individuals are socially coerced into this desire to commit suicide because the support for living is inadequate. Their distress leading to request death differs from other conditions because it is mainly related to societies outlook towards their incapacity. Gill says: “People with disabilities, like everyone else, decide to die when life seems untenable. However, disabilities do not render life untenable; rather it is society’s treatment of people with disabilities that demoralizes them and spoils their quality of life. Through discriminatory practices, neglect and social segregation and impoverishment, society exhausts the spirits of people with disabilities, leading them to request death.

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110 Ibid.

111 Ibid at 6.


disabilities and then, label[s] their depression “rational,” lobbies for mechanism to discard them.”\footnote{114}{Ibid at 179.} On this point of external pressure, other academics have argued that like the dependant elderly patients who request assisted death due to pressure from their families who do not wish to take care of them, disabled individuals may also feel like they are a burden on their loved ones due to the time and effort required for their daily care. For this reason, critics Marilyn Golden and Tyler Zoanni say assisted death for disabled individuals result out of a lack of choice, rather than an availability of choice.\footnote{115}{Marilyn Golden & Tyler Zoanni, “Killing us softly: the dangers of legalized assisted suicide” (2010) 3:1 Disability and Health Journal 16 at 20.}

Opposition on expanding criteria argue that if MAID was expanded to disabled persons, it would harm them as a class because it would label their lives not worth living. To this, Danny Scoccia’s counterargument is if prostitution was legalized, then all women would be objectified because it would harm all women through its “message, symbolism or social meaning”. Scoccia says that we should reject paternalistic objections to assisted death because we cannot deny all disabled individuals the right not to suffer just because disability rights advocates argue that their choice would neither be free nor in their best interest.\footnote{116}{Danny Scoccia, “Physician-Assisted Suicide, Disability and Paternalism” (2010) 36:3 Social Theory and Practice 479 at 481.} According to Scoccia, if we respect decisions made by a Jehovah’s witness who refuses a blood transfusion based on her religious belief that transfusions are sinful, then we are respecting her autonomy by allowing her to make a decision based on her beliefs and values, even if they may be mistake or misguided.\footnote{117}{Ibid at 482.} We allow one set of individuals to make what they believe is a dignified choice based on a religious belief but we force another group to live a life they believe is undignified.\footnote{118}{Ibid at 483.}

However, the problem that still remains is labeling disabled persons as “second-class” citizens. If MAID is expanded to people recently afflicted by a disabling condition such as paralysis, then even the smallest tasks that were once easy suddenly become difficult and seem impossible to
accomplish. These individuals would need a lot of time to adjust to their new condition. As their body has overcome a drastic change, so will their mind and social life. Newly disabled persons can feel frightened and frustrated, which may often delay their recovery. It takes time and effort, along with social support to gradually heal and reconcile with this new existence. If MAID was available to a person in a time of weakness, then it is more likely that they will opt for it rather than seek help from medical professionals or social services that provide assistance and prepare newly disabled persons on how to handle their traumatic experience.

An applicable case related to this issue is of 23-year old Daniel James, a rugby player in England who traveled to Switzerland to commit suicide after a training accident left him paralyzed from the chest down. He felt that his body had become a “prison” and was not prepared to live a “second-class existence”. Since assisted suicide is illegal in England, family or friends who assisted could have faced up to 14-years imprisonment. A year before traveling abroad to the centre for assisted dying in Zurich, James attempted to kill himself several times. Had he waited though, maybe he could have found new meaning to his life.

Nevertheless, in light of such arguments Justice Smith held that there was not enough evidence persons with disabilities would be at a higher risk. She said: “I accept that persons with disabilities face prejudice and stereotyping and that there is a risk of unconscious bias about quality of life of a person with a disability. However, …I am not persuaded that the risks to persons with disabilities are such that they cannot be avoided through practices of careful and well-informed capacity assessments by qualified physicians who are alert to those risks.” Some people are physically incapable of taking their own lives so they are forced to hopelessly live out the rest of their days until they die of natural causes. Justice Smith clearly recognized that this was an inescapable problem for certain individuals.


120 Ibid.

121 Ibid.

122 Carter, supra note 10 at para 853.
For instance, Jean Brault, a 60-year-old Quebec man who was desperate to end his life but did not meet regulations to qualify for assisted death, made the decision to starve himself. He did so for nearly 2 months before his condition deteriorated so much that he eventually qualified for assisted death in April 2016.\footnote{123} At age 19, a blood clot in his brain left him paralyzed but he lived the last 42 years of his life out despite his debilitating condition.\footnote{124} He had some movement and could speak, but lost his independence when he lost all ability to move and slowly began to lose the ability to talk, he decided he wanted to die.\footnote{125} He planned on going to Switzerland to seek medical assistance in dying but was unable to get all the required medical documents so he was hoping Canada’s new end-of-life law would be his way out, but unfortunately he had to take matters into his own hands.\footnote{126} His brother, Pierre Brault, felt both relief and despair, and said “I think people who have a bad quality of life… and they decide to die, I think they should be allowed… the law should be wider to accept these people.”\footnote{127}

Unlike able-bodied people, some disabled people are still not given that choice based on the Government’s eligibility requirements. The criteria set out by the Government does not seem to suggest that assisted death would be available to a person who has been born with a physical disability, such as cerebral palsy, a permanent movement disorder that affects muscle tone and motor skills. Nor would it be legally acceptable for the families of these individuals to assisted them in their suicide abroad. Under Canada’s new assisted dying legislation, if a close relative becomes paralyzed and still wishes to die after years of therapy, any family or friends who assist in their suicide abroad may face criminal liability in Canada.


\footnote{124} Ibid.

\footnote{125} Ibid.


\footnote{127} Ibid.
During the Carter trial, Lee Carter, Kay Carter’s daughter, and her husband, Hollis Johnson described the journey to Switzerland to use the DIGNITAS assisted suicide service as a stressful and difficult process because of the expenses and fact that they were both aware that they could potentially be exposing themselves to prosecution in Canada. This is still the case today. Assisting anyone who does not meet the current eligibility for MAID is legally prohibited. According to the Criminal Code, liability does not apply to those who assist in MAID in accordance with the exemption set out in section 241(2)\(^\text{128}\). It is inferred that liability for those who are not eligible under the governments criteria still remains.

\(^\text{128}\) *Criminal Code*, RSC 1985, c C-46, s 241(2).
Chapter 3
Other Jurisdictions and Recommendations

6 Lessons from the Netherlands and Belgium

Justice Smith’s ruling overturned the ban on assisted dying after reviewing several assisted dying laws around the world, specifically within the United States and Europe. In her conclusion on practices abroad, she stated that the effectiveness of safeguards varied, however the justifications for such expansions were ultimately very convincing. They were largely accepted by the Supreme Court in taking the final step to lift the legal ban. However, many critics argue that the trial judge made an error in concluding that safeguards would minimize the risks that have surfaced in other permissible jurisdictions. In particular, current practices carried out in the Netherlands and Belgium are at the forefront of most controversy. In both jurisdictions, a patient who is suffering intolerably with no hope of relief or improvement can be assisted in suicide. Comparative studies on Canada and the United States have revealed that assisted dying in Canada is already under a more liberal rule than current laws in the US. So for our consideration, this section will exclusively focus on liberal European countries.

In the Netherlands, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act came into force in 2002 and Article 2 (d) established that patients are eligible for euthanasia and assisted suicide long as there is no reasonable alternative. While both euthanasia and assisted suicide are still offences under the Dutch Penal Code, exemptions have been created for physicians who comply with requirements under the act. The acting physician complies with due criteria so long as (a) the patients request is voluntary and carefully considered; (b) the acting physician is satisfied that the suffering was unbearable, with no prospect of improvement; (c) the patients has been informed of potential prospects; (d) both physician and patient are satisfied that there are no reasonable alternatives; and (e) at least one other independent

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129 Konstantin Tretyakov and Glen Cohen, “Medical Assistance in Dying and “Suicide Tourism” to Canada: Bill C-14 from a Comparative Perspective” (2016) Journal of Ethics in Mental Health at 1, online: <http://www.jemh.ca/issues/open/documents/JEMH_Open-Volume_Benchmark_Medical_Assistance_in_Dying_And_Suicide_Tourism_July2016.pdf>.

130 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, available online: <https://www.eutanasia.ws/documentos/Leyes/Internacional/Holanda%20Ley%202002.pdf>.
physician has met the patient and provided his/her written opinion about requirements (a) – (d), and the termination of life or assisted suicide was carried out with appropriate medical care and attention. Additionally, there are several reporting requirements. A physician is obligated to report the death to a medical examiner and indicate he or she has acted within the scope of the criteria, in turn the examiner must determine the accuracy of the report and notify the regional review committee. The review committees are comprised of physicians, legal experts and ethicists, who must decide whether each reported instance is within the Dutch Act, subsequently the committee’s decisions are published online for transparency and public accountability.

The Dutch Supreme Court decided in Chabot\(^\text{133}\) that mental and physical suffering may justify physician assisted dying, however it warned that physicians must be cautious when determining the outcome of such cases.\(^\text{134}\) Later in 2003, the Supreme Court held in Brongersma\(^\text{135}\) that physicians must be very selective and limiting in providing access to PAD to persons suffering from both physical and mental disorders.\(^\text{136}\)

Many commentators in Carter contended that any problems in the Dutch regulatory framework were now resolved, however academics argued this was not the case. For instance, as Professor Keown warned, Dutch criteria such as voluntariness and unbearable suffering are too broad and open to subjective interpretation.\(^\text{137}\) In a study on how practice is regulated in the Netherlands, Kim et al, raised some serious concerns. The authors reviewed psychiatric case summaries, analyzed what physicians reported as reasons for patients being euthanized and shed light on concerns about how physicians apply the Dutch criteria. They found that a majority of patients requesting assistance in dying had depression. Specifically, in a review of 36 cases, 55% of

\(^{131}\) Carter, supra note 10 at para 465.

\(^{132}\) Ibid at para 466.


\(^{134}\) Carter, supra note 10 at para 469.


\(^{136}\) Carter, supra note 10 at 469.

\(^{137}\) Ibid at para 501.
patients were suffering from a depressive disorder.\textsuperscript{138} Other prominent disorders included post-traumatic stress disorder and anxiety.\textsuperscript{139} In other cases, patients suffered from social isolation or loneliness and prolonged grief due to passing of a spouse or close relative.\textsuperscript{140} Majority of the patients effected were women, with high rates of depression and personality disorders.\textsuperscript{141} The study also noted that most patients who did have extensive history of treatments, also refused some treatment because they were concerned of ‘adverse effects, risk of harm, and had doubts about efficiency’.\textsuperscript{142} They also found that there were several instances where patients, who were granted euthanasia or assisted suicide, at a later point refused (32\% to be exact), and that in 27 cases less than half performing physicians were psychiatrists (at 41\%), while majority were general practitioners.\textsuperscript{143} They also discovered there were disagreements amongst physicians in 24\% of cases, yet the assistance in dying for most proceeded anyway.\textsuperscript{144} In all 110 cases reported to the Dutch regional euthanasia review committee, responsible to ensure rules on euthanasia and assisted suicide are met with due criteria, only one case was found to have not met legal requirements.

In another paper, entitled “Should assisted dying for psychiatric disorders be legalized in Canada?”, Scott Kim and Trudo Lemmens warn that the government should pay closer attention to the evidence from Belgium and the Netherlands when deliberating whether psychiatric disorders should qualify for assisted dying in Canada. They argue that evidence suggests eligibility for psychiatric disorders goes beyond severe depression, it extends to people with schizophrenia, posttraumatic stress disorder, anorexia, autism, personality disorders and

\begin{itemize}
    \item \textsuperscript{139} Ibid at 365.
    \item \textsuperscript{140} Ibid.
    \item \textsuperscript{141} Ibid at 367.
    \item \textsuperscript{142} Ibid at 365.
    \item \textsuperscript{143} Ibid.
    \item \textsuperscript{144} Ibid.
\end{itemize}
prolonged grief. Furthermore, they advise against the recommendations made by the Parliamentary Special Joint Committee on Physician-Assisted Dying because it does not require patients to undertake treatments that are not acceptable to them, which could especially be harmful to those with psychiatric conditions, as evidence suggests these patients can achieve remission if given high quality treatment. What happens when this becomes the case, as they specify is the current situation in the Dutch experience, is that patients with psychiatric disorders who receive assisted dying do so without having tried all recommended treatments. One study, they point out, conducted on Belgium and the Netherlands suggests that currently, available treatment is not provided to a majority of mentally ill patients who qualify for assisted-dying in these jurisdictions.

Dr Boudewijn Chabot, the Dutch psychiatrist in the historic Dutch Supreme Court Ruling mentioned above, assisted in the death of a healthy 50-year-old social worker, who he described as a ‘down to earth person’ with no evidence of psychosis, no hysteria, no personality disorder nor depression, but instead a competent woman. After the death of her two sons, she was determined to die, with or without Dr. Chabot’s assistance. Along with other psychiatrists, Chabot grew to believe her wish to die was genuine and well considered. He once fought for the right to self-determination in assisted dying cases, but is now concerned with the direction the practice has headed. What worries him the most, is the rate euthanasia is performed on

146 Ibid.
147 Ibid at 2.
150 Ibid.
demented and psychiatric patients. He worries that with less funding for care of patients with brain diseases, the number of cases could drastically rise. In the last 10 years, he says, the number of physicians willing to perform euthanasia has increased and it has become apparent that the review committee no longer assesses whether the requirement of “unbearable suffering with no prospect of improvement” is satisfied since there is no point in arguing against a qualified physician. 152 According to Chabot, the euthanasia and assisted dying law became wildly uncontrolled when eligibility requirements first created for requests made by physically ill patients were then being applied to psychiatric cases without limitation, and the review committee began concealing cases of incapacitated people being killed. 153

During the same time the Netherlands legalized euthanasia and assisted suicide, Belgium also legalized it for incurable patients with severe suffering. Like the Netherlands, euthanasia and assisted suicide are criminally prohibited by the Dutch Criminal Code, however, the acting physician is exempt from criminal liability, according to section 2(1) of The Belgian Act on Euthanasia of May 28 2002 154, so long as the patient is of age and legally competent at the moment of making the request; the request is voluntary, well considered and repeated, free from external pressure; the patient is in a medically futile situation which is constant and unbearable physically or mentally, his/her suffering cannot be alleviated, and results from a serious incurable disorder caused by illness or accident. 155 The act further requires in any situation where a physician finds himself/herself unable to establish that the patient is expected to die in the near future, a second physician, either a psychologist or specialist in the disorder in question must be consulted. 156 In the context of euthanizing or assisting in suicide of a person with mental illness, the law requires a more detailed consultation with a third physician. 157

152 Ibid.
153 Ibid.
155 Ibid at s 3(1).
156 Ibid at s 3(3)(1).
157 Supra note 83 at 296.
There must also be a one month reflection period from the moment of the request to the actual act of euthanasia or assisted suicide.\textsuperscript{158} Additionally, the patients request must be in writing, by way of being drawn up, dated and signed by the patient.\textsuperscript{159} In any case the patient is unable to do so by himself/herself, the document is drawn up by someone designated by the patient who must not have any interest in the patient’s death.\textsuperscript{160} In several areas of the legislation, it states physicians must report their findings. These reports are then directed to the Federal Control and Evaluation Commission (FCEC), which is composed of sixteen members, eight of which are doctors, four professors of law or practicing lawyers, and the remaining four are members from the groups that have experience in dealing with incurably ill patients.\textsuperscript{161} If two thirds of members vote that a case was not in line with legislation, it will then be forwarded to the public prosecutor who will then decide whether there is cause to prosecute.

On average, there are at least 5 cases of euthanasia or assisted suicide reported per day, yet since 2002-2015 there has only been one case referral to the public prosecutor, with failure to prosecute.\textsuperscript{162} Lemmens believes that the flexible nature of the criteria has meant that the FCEC can easily find many controversial cases as acceptable under the law, beyond what was first envisioned by the legislatures who created it.\textsuperscript{163} One controversial case, which received international attention, was written about in the New Yorker by Rachel Aviv, entitled “The Death Treatment”,\textsuperscript{164} of a woman who struggled with depression after the death of her husband but later improved following the birth of her grandchildren and relationship with her new partner. She relapsed and during a time of isolation, while she felt estranged from her family, she requested to be euthanized. Two psychiatrists qualified her depression as incurable. An uproar

\textsuperscript{158} Supra note 153 at s 3(3)(2).
\textsuperscript{159} Ibid at s 3(4).
\textsuperscript{160} Ibid.
\textsuperscript{161} Ibid at s 6(2).
\textsuperscript{162} Supra note 83 at 285.
\textsuperscript{163} Supra note 83 at 286.
\textsuperscript{164} Rachel Aviv, “The Death Treatment: When should people with non-terminal illness be helped to die?” The New Yorker (22 June 2015), online: <http://www.newyorker.com/magazine/2015/06/22/the-death-treatment>.
arose after the publication of this article and a group of 65 healthcare professionals protested to change the law.\textsuperscript{165} This encouraged others to come forward and speak out about their own stories. Sisters of 38-year old Tine Nys, told her story. Nys struggled with depression in her teenage years and attempted suicide, however, her condition improved for more than 15 years but she then relapsed and requested euthanasia from a psychiatrist, two months later she was diagnosed with autism, a diagnosis she had never received earlier, but an easier condition for the psychiatrist to claim that her condition was irremediable and thus in line with the legislative requirements.\textsuperscript{166} Other controversial cases include two 48-year old deaf-mute brothers, and a transgendered person with a “troubled life trajectory”.\textsuperscript{167} These cases raise sufficient concerns about the flexibility of the Belgian law.

Furthermore, an alarming 2014 article in the British Medical Journal, which reviewed the first 100 patients to receive euthanasia and assisted death for psychological disorders (between October 2007 – December 2011) revealed that only one psychiatrist was found to be the only consulting psychiatrist for each of these first 100 cases.\textsuperscript{168} The qualifying conditions ranged from post-traumatic stress disorders, anxiety, Asperger syndrome, schizophrenia, substance use, obsessive compulsive disorder, prolonged grief and so forth.\textsuperscript{169} This could be an example of what is known as “doctor shopping”, when one physician is unwilling to perform the euthanasia or assisted suicide, patients can seek out other physicians known to be more lenient and accepting, or contract an organization which will refer them to physicians who may be more willing. For example, the Netherlands’ End-of-Life Clinic, Stichting Levensindekliniek, refers patients to physicians whose own have declined. According to Dr. Chabot, in 2016, with 40 physicians working at the End-of-Life Clinic, 498 euthanasia procedures were performed which equates to 12 procedures per doctor per month.\textsuperscript{170} He warns us that a culture has emerged

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\textsuperscript{165} Supra note 83 at 305.
\textsuperscript{166} Ibid at 306.
\textsuperscript{167} Ibid at 309.
\textsuperscript{168} Ibid at 300.
\textsuperscript{169} Ibid.
\textsuperscript{170} Supra note 150.
\end{flushleft}
amongst medical professionals where euthanasia is considered a “virtuous labour”.\footnote{Ibid.} The Belgian experience is quite similar. One study reported that close to 50% of cases had been approved by a single psychiatrist.\footnote{Supra note 83 at 296.} As mentioned earlier, even though there are second, and in some cases, third consultations necessary, these are not considered binding.\footnote{Ibid at 302.}

Critics of euthanasia and assisted dying assert that legalization of the practice will inevitably lead to a ‘slippery slope’ effect, leading to a chain of significant negative effects resulting in involuntary deaths. In the Carter decision, Justice Smith referred to two types: a practical slippery slope and a logical slippery slope. The first refers to ‘the concern that even the most carefully crafted laws will eventually be ignored’, while the latter refers to ‘an inevitable expansion in areas not initially contemplated’.\footnote{Ibid at 287.} Evidence from the Netherlands has revealed that out of every 5 people who are euthanized, 1 is without consent.\footnote{J Pereira, “Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls” (2011) 18:2 Current oncology e38 at e39.} In Belgium, that rate is 3 times higher.\footnote{Ibid at e43.} It is worrying that physicians are able to decide themselves when a patient’s life should be shortened without their clear consent. Some argue such information is distorted because patients may have at some point expressed their desire to die, while the counterargument to this is that written consent is essential to avoid abuse.\footnote{Ibid.} The United Nations has found that practices of involuntary death is a violation of the \textit{Universal Declaration of Human Rights} because of risk to safety and integrity.\footnote{Ibid.}

Commentators have drawn attention to the fact that cases arising out of Belgium are much wider than the first adopted legislative proposals and emphasize that it is worth observing that once
‘one form of active life-ending practice is supported, it can create momentum for other forms’.

Debates in this area of law should discuss the reality of an eventual change in social and legal approaches to end-of-life care in the future.

### 7 Recommendations for Regulating Wider Access

Based on evidence presented in this paper, greater caution is needed before allowing vulnerable populations the right to access MAID. Problems that have arisen within these two jurisdictions are clearly valuable in the Canadian context. They inform us what could become a reality if Canada operates with wider criteria without taking appropriate precautions. However, there may still be a way to address the needs and concerns of people who currently fall outside the eligibility criteria in Canada, while also preventing harm. Preserving life in a category of people to protect some still cannot be justified because preserving dignity may be of higher value than preserving life. So rather than quickly dismissing a request that it does not fit into specific requirements, there should be an attempt to meet any patient’s needs. Therefore, rather than merely fighting against expansion, there should be extensive discussion on how to better regulate the practice through improved safeguards and reviews.

Many academics, even those who hold strong views against extending access to vulnerable groups, have made several recommendations on what could be done in this area of legislation if change were to occur and how to avoid end-of-life practices that have led to unnecessary or involuntary deaths. If there is an expansion in the criteria, then no single safeguard will be able to prevent harm to vulnerable persons, but instead, a ‘complex architecture’ of assisted death will be required, of which the ‘blueprint must go beyond a simple solution’.

Raphael Cohen-Almagor, Professor at the University of Hull, England, has extensively studied end-of-life decision-making, including in Belgium and the Netherlands. He is in favor of

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179 Supra note 83 at 302.

180 Ibid at 290.


182 Supra note 110 at 7.
physician assisted dying but is critical of what is happening in these jurisdictions. He notes where major developments need to be made and suggests how to improve the laws on assisted dying to prevent potential abuse of vulnerable patients. His ratification of assisted dying is restricted to only competent adult patients (over the age of 18) who are mentally capable and able to express their needs, thus excluding demented patients from his recommendations. Some of his guidelines are as follows: (1) physicians should not suggest assisted dying to the patient, only patients should initiate discussion; (2) it should be restricted to competent adult patients with incurable and irreversible conditions, who voluntarily request over a period of time, without family and social pressure; (3) if there are means to ease the patients pain, the patients request should not be fulfilled, instead necessary treatment should be prescribed; (4) the patient must be informed of the chances of recovery or possible growth of their suffering as their condition progresses; (5) a second opinion, of a specialist, independent of the first doctor, verifying diagnosis and possibility of misdiagnosis, along with other medical options should be provided; (6) to avoid collusion between physicians, it is advised that an small independent committee determine the identity of the second physician; (7) before the act is performed, the patient should meet with a doctor and psychiatrist to verify that the request is genuine without coercion or undue influence by a third party; (8) the patient can rescind the request at any time and in any manner; (9) the act should be performed only by a doctor in the presence two physicians, a lawyer and possibly a member of public, to prevent cases going unreported; (10) the service must be free from any financial incentive; (11) there must be extensive documentation in the patient’s medical file of the entire process, including: diagnosis, prognosis, consulting physicians, attempted treatments, reasons for request, written or video recorded request, conversations, offer of rescindment, discussion with loved ones, and psychological report, which is all then passed on to a coroner for examination of completion; (12) pharmacists should be required to report all prescriptions of lethal medication, to ensure the reporting obligation is being fulfilled; (13) physicians should not be coerced into taking requests; (14) local medical associations should establish committees to investigate reports and ensure that no cases have gone unreported or have not complied with legal guidelines; (15) physicians who fail to comply with the law should
be sanctioned by being charged and/or revoke license to practice by a disciplinary tribunal, with the possibility of including fines and prison sentences.\textsuperscript{183}

For an independent review committee, Lemmens et al suggest that the Ontario Consent and Capacity Board should be given authority to have final say on diagnosis and treatment options for persons whose sole underlying condition is mental illness.\textsuperscript{184} To avoid the problems that have arisen out of the more permissive regimes, some have suggested a more feasible option would be to use the existing structure of the provincial/territorial review boards, made up of a judge, and members with relevant experience, where physicians present their assessments of the patients requesting assisted dying to the boards who then determine whether the patient should be referred for vulnerability counselling, intended to determine whether their needs can be met through alternative means and whether other options have been exhausted.\textsuperscript{185} Accordingly, this would avoid subjective decisions being made by physicians. Additionally, the board would also be responsible for developing appropriate expertise and conducting inquiries into the motivations for such request, identifying potential pressure from family members or elsewhere.\textsuperscript{186}

Furthermore, Lemmens et al also stress that if psychological suffering is in fact included in MAID in the future, then patients should be required to wait a sufficiently long time to fully consider the outcome of their request and available treatments.\textsuperscript{187} It is worth mentioning that that out of 48 cases where a request was approved for euthanasia or assisted dying in Belgium, 11 patients decided to either postpone or cancel.\textsuperscript{188} This demonstrates that the physicians were wrong in their initial finding that the patients suffering was unbearable. As mentioned earlier, patients are obligated under Belgian law to wait at least one month between the time of request and time it may be carried out. The Provincial Territorial Advisory Group on Physician Assisted

\textsuperscript{183} Supra note 180 at 115.
\textsuperscript{184} Supra note 57 at 70.
\textsuperscript{185} Supra note 80 at 317.
\textsuperscript{186} Ibid.
\textsuperscript{187} Ibid at 301.
\textsuperscript{188} Ibid.
Dying\textsuperscript{189} (PTAG) did not recommend that the Canadian government create such a reflection period, yet as seen through the Belgian experience such a delay has proven to prevent unnecessary death.\textsuperscript{190} Given the problems associated with competency assessments mentioned earlier, it should be a requirement that the more difficult it is to assess competency in a patient, the longer the obligatory wait period should be. If Canada wishes to avoid the current difficulties in the Netherlands and Belgium, the proposals submitted by PTAG should not be pursed.

Additionally, as it has already been stated, according to Carter, patients are not obligated to undergo any treatments if they do not wish to. Yet, it often takes several repeated and varied attempts at trying treatments and medications to see any improvements in psychological conditions. Lemmens et al have argued that by not requiring patients to undergo potential alternatives would be problematic in the context of a psychological condition because there is no clear way to understand why a patient would refuse treatment, nor establish that it is an informed choice of a mentally competent person.\textsuperscript{191}

On the contrary, Michael Bay argues that it is important that no medication a patient finds worse than the disease should be forced on them, even if it is noticeably effective. While he is unsure whether patients should try other proposed treatments during reflection periods, he says: “On the one hand, this would address the objection from some that assisted dying should not be available to this population because there is always other treatment that we should try. On the other hand, it violates the spirit of Carter and puts a burden on those living with mental illness that does not apply to others. I also know that it is laughable to argue that no one should ever be able to seek assisted dying on the basis of mental illness because there are endless treatment possibilities and the patient should be required to try every one of them”\textsuperscript{192}

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\textsuperscript{190} Supra note 80 at 302.

\textsuperscript{191} Supra note 57 at 70.

\textsuperscript{192} Supra note 56 at 4.
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It would indeed be unreasonable to expect a patient to try every single type of treatment available before being eligible to request MAID. For this, Ruth von Fuchs provides a possible solution. She suggests patients should only be accepted for MAID if they: (a) have undergone at least 5 years of treatment without adequate improvement, and/or (b) attempted at least 6 different types of drugs/therapies without adequate improvement, and/or (c) have received a standard course of treatment from at least 3 different medical professionals without adequate improvement.\textsuperscript{193} Noting, that adequate improvement would be a subjective decision of that the patient would make.

Another quite creative suggestion made by Ruth von Fuchs to ensure mentally ill patients are making decisions that reflect their own beliefs and values, and are not making a decision out of desperation, she proposes the possibility of giving patients the option to undergo continuous deep sedation, with technology to ensure they receive sufficient nutrition, for a week or however long is safe enough for their bodies to sustain. These patients would be filmed on their thoughts and feelings prior to and after their procedure. She suggests that some patients may either feel relieved or disappointed which might be valuable in saving patients from making an irreversible mistake.

Nevertheless, it is important to create laws that do not reduce vulnerable Canadians to a state of being completely unprotected. To do so would be an injustice. End-of-life laws and policies on this matter should be shaped in a manner that respect patient autonomy for those who are truly in need of relief from deep suffering to prevent undermining the initial purpose of this treatment, while at the same time provide others with robust protection and support. Before expanding eligibility, the government should ensure vulnerable people are protected. These policies should be informed by evidence emerging out of Europe and what top experts are cautioning against.

\textsuperscript{193} Supra note 64 at 1.
Final Remarks

If the Canadian court establishes that Bill C-14 discriminates against Canadians based on their diagnosis, contrary to section 15 of the Charter, then legislators may soon pass an extension of the law. However, the concerns highlighted above demonstrate that we may be stepping into a regulatory minefield. A request for assisted dying should not be fulfilled without caution because many external factors may be driving a person to make such a decision. In other jurisdictions, as we have read, laws and safeguards were put in place to prevent abuse, however in these same countries patients are now being killed without expressing explicit consent and medical professionals are increasingly failing to report such cases.

Tolerance of end-of-life practices in societies, as we have seen, may lead to a “slippery slope” following legalization. Assisted dying in Canada is already being reviewed for a wider range of patients. It may be inevitable that eligibility will extend beyond Parliaments initial intent. The situation of the law as it currently stands, is unclear. Uproar against Bill C-14 began before it received royal assent and only 10 days after it passed, BCCLA filed a lawsuit against the Canadian government on behalf of a woman who is living with a disability. Also since its approval, E.F., the 58-year-old Alberta woman mentioned earlier, was believed to have met all the Supreme Court’s criteria for assisted death on the basis of a mental illness. So it may not be long until the law is altered.

The current legislation does not appear to apply to people whose sole underlying condition for suffering is a mental illness, especially because this does not meet the government’s requirement for only accepting applicants once “natural death has become reasonably foreseeable”. Already, requests are going beyond the requirements set by the government as the “reasonably foreseeable” requirement has taken a back seat in courtroom deliberations. If the law were changed to accommodate the interests of vulnerable groups, then so should their interest to be protected from opting for MAID in a moment of weakness or by threat of external societal pressure.

Though a legitimate concern of expanding criteria on the basis of equality should be how far the protection from discrimination would go. Some day in the future, a claim could be brought against the government for requiring additional safeguards for patients who have mental illnesses
or physical disabilities. A failure to consider the unique circumstances of these conditions may possibly lead to an unsafe practice, one we currently see happening in Europe. For this reason, additional safeguards should be required to prevent abuse from some more open-ended criteria, as well as for other vulnerable groups who have not been mentioned in the scope of this paper.