CHRISTIAN LEGAL FELLOWSHIP

ALLIANCE DES CHRÉTIENS EN DROIT

Background paper of the

Christian Legal Fellowship (CLF)

in connection with CLF's brief to

The Special Joint Committee on Medical Assistance in Dying

regarding

A comprehensive review of the provisions of the *Criminal Code* relating to medical assistance in dying and their application, including but not limited to issues relating to mature minors, advance requests, mental illness, the state of palliative care in Canada and the protection of Canadians with disabilities.

[*An Act to amend the Criminal Code (medical assistance in dying)* (S.C. 2021, c. 2), s. 5(1)]

May 9, 2022

Introduction

How should we, as a society, support those who are struggling? What treatments should we prioritize for patients? What solutions should we offer to those in painful and difficult circumstances?

"Death" should not become a routine answer to these questions.[1] Yet that may be the effect of continuing to expand Canada's MAID regime, especially amidst growing concerns about socioeconomic barriers and inadequate access to healthcare and supports.[2]

By offering death as a "solution" for more conditions and forms of suffering,[3] and by expanding eligibility in more circumstances,[4] MAID is undergoing a radical transformation.[5] It is evolving from an exceptional procedure designed to *hasten* an already-foreseeable *death*, to a widely available option to *terminate* a person's *life* because they have lost their sense of hope and meaning.[6]

This expansion is proceeding in the name of compassion and dignity. But we must ask: where is the compassion and dignity in offering death for "isolation or loneliness"[7], or because a patient is afraid of being a "burden on family, friends or caregivers"[8], or for circumstances that can potentially

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[1] While the Supreme Court of Canada has noted that "the sanctity of life 'is no longer seen to require that all human life be preserved at all costs'", this does not mean that death should be *promoted* as an appropriate solution to all kinds of suffering, and certainly not as a *more* accessible solution than life-affirming treatment such as palliative care. As the Supreme Court affirmed in *Carter,* "[t]he sanctity of life is one of our most fundamental societal values", and s. 7 of the *Charter* is "rooted in a profound respect for the value of human life." See *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 63, referencing *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 at 595 (Sopinka J, for the majority).

[2] These concerns are discussed further throughout this paper.

[3] According to the data reviewed by the court in *Truchon*, psychological suffering (either alone or in combination with physical suffering) had contributed to 94% of MAID cases in Quebec. The main types of mental suffering reported included "psychological, social and existential suffering" such as "loss of meaning in life, […] dependence on others, [and] the perception of being a burden on one's loved ones": *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at para 210(e). Of the 7,384 patients who received MAID in Canada in 2020, the nature of their suffering was characterized as: "Loss of dignity" (53.9%); "Perceived burden on family, friends, or caregivers" (35.9%); "Isolation or loneliness" (18.6%), "Emotional distress/anxiety/fear/existential suffering" (5.6%), "No/poor/loss of quality of life" (3.1%): Health Canada, *Second Annual Report on Medical Assistance in Dying in Canada, 2020* (June 2021) online: https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2020/annual-report-2020-eng.pdf at 20 [*Second Annual MAID Report*]. More than one answer could be selected.

[4] I.e., mature minors, patients with a mental illness as a sole underlying condition, and incapacitated patients who made a prior request.

[5] As Professor Catherine Frazee observed, the expansion of MAID has reinvented it "so that it is no longer an alternative to a painful death, but for some, instead, an alternative to a painful life". Catherine Frazee, "Remarks for END OF LIFE, EQUALITY & DISABILITY: A NATIONAL FORUM ON MEDICAL ASSISTANCE IN DYING", Council of Canadians with Disabilities and the Canadian Association for Community Living (30 January 2020), online: https://vimeo.com/388515714.

[6] According to Statistics Canada, "[t]he number of Canadians receiving MAID has increased annually since its introduction": "In 2017, 2,838 medically assisted deaths were reported by Health Canada, compared with 4,478 deaths in 2018. In 2019, there were 5,425 medically assisted deaths in Canada, accounting for 1.9% of all deaths. In 2020, this increased to 7,383 deaths (2.4% of all deaths in Canada), representing a 36.0% increase in the number of MAID recipients from 2019 to 2020." See Statistics Canada, "Medical Assistance in Dying, 2019 and 2020" (10 January 2022), online: https://www150.statcan.gc.ca/n1/daily-quotidien/220110/dq220110d-eng.htm. Between mid-2016 to the end of 2020, there were 21,589 reported deaths by MAID. This does not include MAID deaths prior to mid-2016, when federal reporting legislation had not yet been enacted, and it does not include MAID deaths in 2021 or 2022. See *Second Annual MAID Report* at 5 and 13-14. The reasons for MAID requests are often related to "social and existential suffering", at least in part; see note 3.

[7] See note 3.

[8] *Ibid.*

be addressed through other means—including those that ought to be available but may be currently inaccessible—such as disability supports, palliative care, or adequate housing?[9]

Providing MAID as a "medical solution" in such circumstances presents patients with the "choice" between death on the one hand, or a life without support on the other. To borrow from the Supreme Court in *Carter v Canada (Attorney General)*: "The choice is cruel."[10] In fact, it is not a "choice" at all.

These are not hypothetical or "slippery slope" arguments. Media reports have highlighted disturbing accounts of Canadians who have reluctantly accepted MAID, including those who felt they had no other option to escape their suffering and socioeconomic distress.[11] For example, earlier this year, a woman with multiple chemical sensitivities accepted MAID after being unable to find affordable housing free of smoke and chemicals.[12] Despite repeated pleas for help and letters to government officials, no solutions were offered.[13]

Even in cases where supports may be available, a person's ability to pursue them may be overshadowed by the looming option of a "painless death" if it is promoted as part of the "continuum" of healthcare solutions for their psychosocial and existential suffering.[14] And these concerns are further exacerbated in light of troubling reports about non-compliance with existing safeguards.[15]

Since legalization in 2016, MAID has continually been expanded in response to arguments that restrictions are arbitrary and exclude individuals who desire it as an option.[16] But where does this end? *Any* limitation on MAID will arguably have an exclusionary effect, unless MAID is to be available, on demand, for everyone. Parliament must draw a line somewhere. The Supreme Court of Canada's decision in *Carter* relied on the notion that MAID would be "stringently *limited*" through a

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[9] See note 3 and notes 9-10.

[10] *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 1.

[11] See Jonas-Sébastien Beaudry, "What's missing from the conversation about assisted death", Policy Options (16 October 2019), online: https://policyoptions.irpp.org/magazines/october-2019/whats-missing-from-the-conversation-about-assisted-death/. See also Avis Favaro, "Woman with disabilities nears medically assisted death after futile bid for affordable housing", CTV News (30 April 2022), online: https://www.ctvnews.ca/health/woman-with-disabilities-nears-medically-assisted-death-after-futile-bid-for-affordable-housing-1.5882202 and Yuan Yi Zhu, "Why is Canada euthanising the poor?", UK Spectator (30 April 2022), online: https://www.spectator.co.uk/article/why-is-canada-euthanising-the-poor-.

[12] Avis Favaro, "Women with chemical sensitivities chose medically-assisted death after failed bid to get better housing", CTV News (13 April 2022), online: https://www.ctvnews.ca/health/woman-with-chemical-sensitivities-chose-medically-assisted-death-after-failed-bid-to-get-better-housing-1.5860579.

[13] *Ibid.*

[14] Such "social and existential suffering" is already a prominent factor in many MAID decisions in Canada; see note 3.

[15] Discussed in Part I below. See also Avis Favaro, "Police investigating medically-assisted death of B.C. woman", CTV News (26 April 2022), online: https://www.ctvnews.ca/health/police-investigating-medically-assisted-death-of-b-c-woman-1.5877288

[16] Expansions have included: situations where death is not "reasonably foreseeable", situations in which the patient loses capacity after making an initial request (final consent waiver), and potentially situations in which a mental illness is a sole underlying medical condition (Bill C-7's "sunset clause"). Legislative safeguards have been removed for some MAID cases, including the requirement that two people witness a MAID request and that patients complete a 10-day reflection period (per Bill C-7). Currently, consideration is being given to MAID for mature minors and MAID via advance directives.

"carefully monitored system of *exceptions*".[17] MAID is the *limited exception*, not the rule.[18] And in defining the parameters of this "stringently limited" exception, in a "complex regulatory regime", Parliament must consider and balance the rights of everyone—not only those seeking the option of MAID.[19]

The courts' decisions in *Carter* and *Truchon* proceeded on the basis that Parliament's only legislative purpose for limiting MAID was protecting vulnerable persons from being induced to end their lives in a moment of weakness.[20] That is *one* purpose, and a very important one, but Parliament's concerns extend further. The law must also take into account:

- The *Charter* rights of patients seeking solutions that prioritize life over death, who have the right to be free from societal or individual pressures, direct or indirect, to receive MAID;
- Canadians whose right to be recognized as "equally deserving of concern, respect and consideration"[21] may be susceptible to socially constructed conceptions regarding the value of their lives;
- The dignity and equality rights of persons with disabilities and mental illnesses if the law sends the message that their particular conditions effectively render life not worth living;
- Canada's international law obligations, including the United Nations *Convention of the Rights of Persons with Disabilities*;
- The adverse and disproportionate impact that expanding MAID will have on members of marginalized groups, particularly where access to meaningful healthcare aimed at alleviating suffering (e.g., palliative care, disability supports, mental health services, etc.) is lacking;
- Societal interests,[22] such as the need to "affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled", and the prevention of suicide generally, given its "lasting and harmful effects on individuals, families and communities";[23] and
- The harms associated with offering death as a medical solution to many forms of suffering, including psychosocial and existential suffering, and concerns "that human life should not be depreciated by allowing life to be taken" in such circumstances.[24]

These and other considerations affirm that Parliament has an interest in maintaining safeguards and limits not "*just* because MAiD could be administered in moments of weakness, but

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[17] *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 29, citing *Carter v Canada,* 2012 BCSC 886 at para 1243 (emphasis added).

[18] This is the legal status of MAID under Canadian law: a specific *exception* to culpable homicide and aiding suicide offences. See *Criminal Code*, RSC 1985, c C-46, ss 227(1),(4), and ss. 241(2)-(5.1).

[19] *Carter v Canada (Attorney General)*, 2015 SCC 5 at paras 98, 125. See also *Dagenais v Canadian Broadcasting Corp.*, [1994] 3 SCR 835 at 877: "A hierarchical approach to rights, which places some over others, must be avoided […] *Charter* principles require a balance to be achieved that fully respects the importance of both sets of rights."

[20] *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at para 556; *Carter v Canada (Attorney General)*, 2015 SCC 5 at paras 74-78.

[21] *R v Kapp*, 2008 SCC 41 at para 15, citing *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143 at 171 (per McIntyre J).

[22] *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 95.

[23] Bill C-14, *An Act to amend the Criminal Code and related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, SC 2016 c-3 (assented to 17 June 2016), preamble.

[24] *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 at 595 (Sopinka J, for the majority), as cited in *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 76.

because the law is structured to uphold a societal commitment [that] always affirms dignity in life".[25] Upholding the equal and inherent value of all people is not only about protecting patients from being pushed toward MAID because they may be vulnerable, but to "emphasize society's positive support for those who *choose to live* with an illness or disability [and affirm] that those lives are deeply valued and must never be viewed as lacking dignity or less worthy of support."[26] The law needs to "guard against disapprobation of one's choice to *live* with dignity – and to condemn any effort that might undercut social or medical support for that choice".[27]

These considerations were largely sidelined in *Carter* and *Truchon*, given how the courts framed the specific purpose of the challenged laws,[28] but they are directly at stake in the context of Parliament's legislative review. This background paper examines these considerations and concludes that the appropriate balancing of the human rights and competing interests at stake requires the government to (1) prioritize healthcare, supports, and safeguards for all Canadians; (2) respond to concerning reports about non-compliance and questionable cases of MAID to date; and (3) do so *before* expanding MAID any further.

I. The protection of Canadians with disabilities and the state of palliative care

Non-compliance with safeguards and the need for better oversight

CLF is deeply concerned about ongoing reports of cases on non-compliance with the current laws around MAID. For example, the First and Second Annual Reports on MAID in Canada indicate that, when determining whether the patient's request for MAID was voluntary and not due to external pressure, MAID practitioners *did not consult the patient directly* in at least 48 cases in 2019[29] and 59 cases in 2020.[30]

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[25] Derek Ross, "The fundamental risk of expanding Medical Assisted in Dying", Policy Options (19 February 2020), online: https://policyoptions.irpp.org/magazines/february-2020/the-fundamental-risk-of-expanding-medical-assistance-in-dying (emphasis in original).
[26] *Ibid* (emphasis in original).
[27] *Ibid* (emphasis in original).
[28] See John Sikkema, "The 'Basic Bedford Rule' and Substantive Review of Criminal Law Prohibitions Under Section 7 of the Charter" (2018), 85 SCLR (2d) 225, 49. See also Derek Ross, "What's the purpose of Canada's MAID law", Christian Legal Fellowship (10 October 2019) online: https://www.christianlegalfellowship.org/blog/2019/10/10/whats-the-purpose-of-canadas-maid-law.
[29] Health Canada, *First Annual Report on Medical Assistance in Dying in Canada, 2019* (July 2020) online: https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf at 33 [*First Annual MAID Report*]. For greater clarity, the *First Annual MAID Report* states in "Table 6.3: Determination of the Patient's Request as Voluntary, 2019" that 99.1% of the 5,389 MAID deaths represented in this table involved consultation with the patient. This means that 0.9% of the 5,389 MAID deaths did not involve a consultation with the patient. Taking the total number of MAID deaths represented in this table (5,389) and multiplying it by the percentage of cases where consultation with the patient did not occur (0.9%) indicates that the patient was not consulted in determining that the MAID request was voluntary in at least 48 cases (48.501 being the final result).
[30] *Second Annual MAID Report* at 28. For greater clarity, the *Second Annual MAID Report* states in "Table 6.2: Determination of the Patient's Request as Voluntary, 2020" that 99.2% of the 7,384 MAID deaths represented in this table involved consultation with the patient. This means that 0.8% of the 7,384 MAID deaths did not involve a consultation with the patient. Taking the total number of MAID deaths represented in this table (7,384) and multiplying it by the percentage of cases where consultation with the patient did not occur (0.8%) indicates that the patient was not consulted in determining that the MAID request was voluntary in at least 59 cases (59.072 being the final result).

There continue to be reports identifying non-compliance with other key safeguards designed to protect patients, including the following:

- In August 2018, the Office of the Chief Coroner of Ontario reported that, after reviewing 2,000 cases of MAID administration, "some case reviews have demonstrated compliance concerns with both the Criminal Code and regulatory body policy expectations, some of which have recurred over time."[31]
- Québec reports have indicated that multiple cases of MAID have involved non-compliance with Criminal Code provisions and/or provincial requirements:
    - From July 2017 to March 2018, there were 19 cases of MAID that did not comply with federal and/or provincial laws.[32]
    - From April 2018 to March 2019, another 13 cases of MAID did not comply with federal and/or provincial laws.[33]
    - From April 2019 to March 2020, at least 9 additional cases of MAID did not comply with federal and/or provincial laws.[34]
    - From April 2020 to March 2021, at least 6 additional cases of MAID did not comply with federal and/or provincial laws.[35]
    - Of the 1,374 cases that the Québec Commission on end-of-life care reviewed between 10 December 2015 and 31 March 2018, only 90% were verifiably conducted in accordance with the law, with at least 5% (62 cases) involving a non-compliance. Compliance with the law was impossible to verify in the other 5% (67 cases).[36]
- According to the federal government's *First Annual Maid Report* and *Second Annual MAID Report*:
    - In 2019, of those who died by MAID: 91 patients neither received nor had access to palliative care if they needed it; the accessibility of palliative care was unknown in 93

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[31] Dirk Huyer, "Medical assistance in dying memorandum", Office of the Chief Coroner (9 October 2018) online: https://www.ontario.ca/page/medical-assistance-dying-memorandum.

[32] Commission sur les soins de fin de vie, *Rapport annuel d'activités: 1er juillet 2017 – 31 mars 2018*, Gouvernement du Québec (2018), online : https://numerique.banq.qc.ca/patrimoine/details/52327/2718720?docref=eL5Kjy2HvNcjemLJk1VGJA at 15-16 [*2017-2018 Québec MAID Report*].

[33] Commission sur les soins de fin de vie, *Rapport annuel d'activités: Du 1er avril 2018 – 31 mars 2019*, Gouvernement du Québec (2019), online : https://numerique.banq.qc.ca/patrimoine/details/52327/2718720?docref=fUvA8tDZVpNag6uIMStNgw at 10-11.

[34] Commission sur les soins de fin de vie, *Rapport annuel d'activités: Du 1er avril 2019 au 31 mars 2020*, Gouvernement du Québec (September 2020), online: https://numerique.banq.qc.ca/patrimoine/details/52327/2718720 at 14-15.

[35] Commission sur les soins de fin de vie, *Rapport annuel d'activités: Du 1er avril 2020 – 31 mars 2021*, Gouvernement du Québec (2021) at 10-11.

[36] *2017-2018 Québec MAID Report* at 22-23. Specific forms of non-compliance included: "The doctor who administered the [assisted death] did not carry out the interviews with the person to ensure the clarity of his request or to ensure the persistence of his sufferings and the consistency of its desire to obtain [MAID]" [9 cases]; "The [assisted death] application was countersigned by a person who was not a health or social service professional" [5 cases]; "The person who obtained the [assisted death] did not have a serious and incurable [disease]" [5 cases]; "The person who obtained the [assisted death] was not at the end of his life" [2 cases]; "The doctor who administered the [assisted death] did not carry out the verifications provided for in section 29 of the Act" [2 cases]" (unofficial translation).

cases; 87 patients required disability support services but did not receive them, and the adequacy of the disability supports received by 1,996 patients was unknown.[37]

- Similarly, in 2020, of those who died by MAID: 126 patients neither received nor were able to access palliative care if they needed it, the accessibility of palliative care was unknown in 170 cases, and 123 patients required disability supports but did not receive them.[38]

When Canada's Office of the Correctional Investigator examined three known cases of MAID in federal corrections in 2019-2020, he found that "each raises fundamental questions around consent, choice, and dignity."[39] Two of the cases involved "a series of errors, omissions, inaccuracies, delays, and misapplications of law and policy."[40] This included one man who, after applying for full, day, and compassionate parole and being refused every time, ultimately seems to have "'chose[n]' MAiD not because that was his 'wish,' but rather because every other option had been denied, extinguished or not even contemplated."[41]

The Correctional Investigator's review also revealed that "there is no legal or administrative mechanism for ensuring accountability or transparency for MAiD in federal corrections."[42] He called for an independent investigation by an expert committee, as well as "an absolute moratorium on providing MAiD *inside* a federal penitentiary, regardless of circumstance."[43] CLF urges Parliament to adopt these recommendations, especially given the disproportionate impact of the harms identified by the Correctional Investigator on prison populations:

> "Hopelessness, despair, lack of choice and alternatives, conditions imposed by the fact and consequence of incarceration, are issues magnified in the correctional setting. As the Government considers extending MAiD beyond physical illness to intolerable psychic pain, there must be careful deliberation of the mental health profile of Canada's prison population. For prisoners, matters of free choice are mediated through the exercise of coercive administrative state powers. There is simply no equivalency between seeking MAiD in the community and providing MAiD behind prison walls."[44]

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[37] *First Annual MAID Report* at 24. The report indicates that 874 patients "did not receive palliative care services", although palliative "was accessible if needed" for 89.6% (783) of those patients. That leaves 91 patients who neither received nor were able to access palliative care, in addition to the 93 patients where it is unknown whether they received or had access to palliative care. In terms of the 1,996 individuals who received disability supports, the report specifically states that, "while the data provide insight into whether palliative care has been received, it does not speak to the adequacy of the services offered." See also Romayne Gallagher, "Lack of palliative care is a failure in too many MAiD requests", Policy Options (19 October 2020).

[38] *Second Annual MAID Report* at 21. The report indicates that 1,099 patients "did not receive palliative care services", although palliative "was accessible if needed" for 88.5% (973) of those patients. That leaves 126 patients who neither received nor were able to access palliative care, in addition to the 170 patients where it is unknown whether they received or had access to palliative care.

[39] Ivan Zinger, *2019-2020 Annual Report: Office of the Correctional Investigator*, The Correctional Investigator, Canada (26 June 2020), online: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20192020-eng.pdf at 2.

[40] *Ibid.*

[41] *Ibid* at 3.

[42] *Ibid.*

[43] *Ibid* at 4 (emphasis in original); see also 89, 108, and 110.

[44] *Ibid* at 3.

These new reports revealing that safeguards are not always being followed point to very serious concerns of a "slippery slope" that the courts in *Carter* said was lacking at the time.[45]

A premise of the *Carter* decision was that MAID would only be permitted through a "carefully-designed system imposing **stringent limits** that are **scrupulously monitored and enforced**".[46] The trial judge made it clear that "[t]he scrutiny regarding physician-assisted death decisions would **have to be at the very highest level**", and she cautioned that "the effectiveness of safeguards depends upon, among other factors […] the extent to which compliance with the safeguards is **monitored and enforced**."[47] Similarly, the court's analysis in *Truchon* rested, in part, on the conclusion that "the assessment process in this country is rigorous" and that the process "displays no obvious weakness".[48]

However, these reports of non-compliance call into question the extent to which individualized assessments of vulnerability, consent, and capacity can serve as the sole—or even primary—safeguard against the inherent risks and harms of a permissive MAID regime.[49] This is a question that must answered *before* access to MAID is expanded further.

The government must carefully review these reported cases of non-compliance and ensure that data on any non-compliance is used to inform future policy decisions. Failure to do so undermines the very premise on which MAID was said to be constitutionally justified.[50]

This data also raises further *Charter* concerns. If the government is offering MAID as a solution for medically manageable suffering, while simultaneously "failing to deliver health care in a reasonable manner", it could be interfering with the right to life and security of the person protected by s. 7 of the *Charter*.[51]

Canada's international obligations

The Supreme Court of Canada has stated that "[t]he balancing of competing *Charter* rights should also take into account Canada's international obligations with respect to international law treaty commitments".[52] It has also stated "that the *Charter* should generally be presumed to provide protection at least as great as that afforded by similar provisions in international human rights documents which Canada has ratified."[53]

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[45] *Carter v Canada,* 2012 BCSC 886 at para 1366: "An absolute prohibition might be called for if the evidence from permissive jurisdictions showed […] evidence of the reality of a practical slippery slope." See also *Carter v Canada (Attorney General)*, 2015 SCC 5 at paras 105, 107, 111-112.

[46] *Carter v Canada,* 2012 BCSC 886 at para 883, as cited in *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 105 (emphasis added).

[47] *Ibid* at paras 1239-1240 (emphasis added).

[48] *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at paras 624 and 466; see also para 464.

[49] Justice Lynn Smith acknowledged "the risks inherent in permitting physician-assisted death"; see *Carter v Canada,* 2012 BCSC 886 at para 883. The Supreme Court accepted this framing, quoting this passage directly; see *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 105.

[50] *Carter v Canada,* 2012 BCSC 886 at paras 883, 1365-1366; see also *Carter v Canada (Attorney General)*, 2015 SCC 5 at paras 105-107 and 117.

[51] See *Chaoulli v Quebec (Attorney General)*, [2005] 1 SCR 791 at para 124.

[52] *Saskatchewan (Human Rights Commission) v Whatcott*, 2013 SCC 11 at para 67.

[53] *Reference Re Public Service Employee Relations Act (Alta)*, [1987] 1 SCR 313 at para 59; see also *Health Services and Support – Facilities Subsector Bargaining Assn v British Columbia*, 2007 SCC 27 at para 70.

Canada has ratified the United Nations *Convention of the Rights of Persons with Disabilities* [*UNCRPD*]. Canada's obligations under the *UNCRPD* were explicitly noted by four justices of the Supreme Court of Canada in October 2021, who recognized that it "requires that states guarantee persons with disabilities equal and effective legal protection against discrimination on all grounds, to ensure full and equal enjoyment of all human rights and fundamental freedoms by children with disabilities and to take appropriate measures to protect persons with disabilities from exploitation, violence and abuse (arts. 5, 7 and 16)."[54]

That Canada's MAID regime undermines Canada's international legal obligations has been identified multiple times by UN experts. In 2019, the former United Nations Special Rapporteur on the rights of persons with disabilities called on the Government of Canada to investigate "worrisome information about persons with disabilities in institutions being pressured to seek medical assistance in dying" and urged Canada to ensure that viable alternatives are offered.[55] More than three years have passed since the Special Rapporteur first raised these concerns, and, to our knowledge, there has yet to be any government response.[56]

In February 2021, a joint letter was issued by the UN's Special Rapporteur on the rights of persons with disabilities, the UN's Independent Expert on the enjoyment of all human rights by older persons, and the UN's Special Rapporteur on extreme poverty and human rights. These UN experts expressed concern that expanding MAID in Canada outside of end-of-life circumstances would, among other issues:

(i) "be contrary to Canada's international obligations to respect, protect and fulfil the core right of equality and non-discrimination of persons with disabilities" (p. 4);

(ii) create and/or reinforce negative, ableist social assumptions, including that "it is better to be dead than to live with a disability" (p. 5);

(iii) have a discriminatory impact by "singling out the suffering associated with disability as being of a different quality and kind than any other suffering" and thereby potentially subjecting "persons with disabilities to discrimination on account of such disability" (p. 6); and

(iv) "result in a two-tiered system in which some would get suicide prevention and others suicide assistance, based on their disabilities status and specific vulnerabilities" (p. 7).[57]

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[54] *Ward v Quebec (Commission des droits de la personne et des droits de la jeunesse)*, 2021 SCC 43 at para 198 (Abella and Kasirer JJ, dissenting but not contradicted by the majority on this point).

[55] Catalina Devandas-Aguilar, "End of Mission Statement by the United Nations Special Rapporteur on the rights of persons with disabilities, Ms. Catalina Devandas-Aguilar, on her visit to Canada", UNHR Office of the High Commissioner (12 April 2019), online: https://www.ohchr.org/en/statements/2019/04/end-mission-statement-united-nations-special-rapporteur-rights-persons?LangID=E&NewsID=24481 [*Canada End of Mission Statement*].

[56] *Ibid.*

[57] Gerard Quinn, Claudia Mahler, and Olivier De Schutter, "Disability is not a reason to sanction medically assisted dying – UN experts" (25 January 2021), online: https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687 [*Joint Statement*]; Gerard Quinn, Claudia Mahler, and Olivier De Schutter, "Mandates of the Special Rapporteur on the rights of persons with disabilities; the Independent Expert on the enjoyment of all human rights by older persons; and the Special Rapporteur on extreme

This letter is only the most recent in a long line of UN communication expressing grave concern about Canada's implementation of MAID. To date, we know of no official response from the Government of Canada to these concerns or to the recommendations proposed in the UN reports, which are summarized below:

- In **May 2017**, the UN Committee on the Rights of Persons with Disabilities expressed concerns about Canada's "adoption of legislation that provides for medical assistance in dying, including on the grounds of disability" and issued a number of recommendations.[58]
- In **April 2019**, Catalina Devandas-Aguila, then UN Special Rapporteur on the rights of persons with disabilities, completed her visit to Canada and expressed that she was "extremely concerned about the implementation of the legislation on medical assistance in dying from a disability perspective."[59]
- In **December 2019**, UN Special Rapporteur Devandas-Aguilar reiterated these concerns in her final report and made numerous recommendations to the Government of Canada.[60]
- In **March 2020**, the UN Human Rights Council received a report from UN Special Rapporteur Devandas-Aguilar expressing concern about ableist stereotypes in debates that impact the rights of persons with disabilities, including those related to assisted dying; the report identified serious risks posed by "legalizing euthanasia and assisted suicide", especially when "normalized outside the end stage of terminal illness".[61]
- In **January 2021**, Gerard Quinn (the Special Rapporteur on the rights of persons with disabilities), Olivier De Schutter (the Special Rapporteur on extreme poverty and human rights), and Claudia Mahler (the Independent Expert on the enjoyment of all human rights by older persons) issued a joint statement expressing "alarm" about legislation that would expand access to assisted dying "based largely on having a disability or disabling condition", emphasizing that "[d]isability should never be a ground or justification to end someone's life directly or indirectly".[62]
- In **February 2021**, these three UN experts further observed that the concerns expressed in previous UN reports "appear heightened with respect to [Bill C-7] and especially because it appears irremediably entangled in ableist assumptions about persons with disabilities."[63]

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poverty and human rights", OL CAN 2/2021 (3 February 2021), online: https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=26002 [*Letter to Canada Re: Bill C-7*].

[58] Committee on the Rights of Persons with Disabilities, "Concluding observations on the initial report of Canada", CRPD/C/CAN/CO/1 (8 May 2017), online: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/CAN/CO/1&Lang=En.

[59] *Canada End of Mission Statement*.

[60] Catalina Devandas-Aguilar, "Visit to Canada: Report of the Special Rapporteur on the rights of persons with disabilities", Human Rights Council, 43rd Sess, A/HRC/43/41/Add.2 (19 December 2019), online: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/43/41/Add.2.

[61] Catalina Devandas-Aguilar, "Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities", Human Rights Council, 43rd Sess, A/HRC/43/41 (17 December 2019), online: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/346/54/PDF/G1934654.pdf?OpenElement.

[62] *Joint Statement*.

[63] *Letter to Canada Re: Bill C-7*.

In light of the clear warnings from United Nations experts, CLF urges this Committee to respond to these international concerns, to strengthen and uphold crucial safeguards, and to improve access to palliative care and disability supports. This must be prioritized and addressed *before* expanding MAID access even further.

II. MAID Where a Mental Disorder is the Sole Underlying Medical Condition (MAID MD-SUMC) [64]

Arguments for expanding MAID, including permitting MAID MD-SUMC, sometimes assert that it is arbitrary to allow MAID for some people in some circumstances, but not others. However, *substantive* equality requires more than identical treatment; as the Supreme Court of Canada has affirmed, "not every distinction is discriminatory."[65] The question under s. 15 of the *Charter* is not whether distinctions *exist,* but whether "the lines drawn are generally appropriate, having regard to the circumstances of the persons impacted and the objects of the [legislative] scheme."[66]

Thus, "the concept of equality does not necessarily mean identical treatment" and "the formal 'like treatment' model of discrimination may in fact produce inequality".[67] In *Withler v Canada*, the Supreme Court wrote: "The focus of the inquiry is on the **actual impact** of the impugned law, **taking full account of social, political, economic and historical factors concerning the group**."[68]

Limiting eligibility for MAID for certain conditions (e.g., those mental illnesses that are potentially remediable or that may affect capacity) or based on the maturity/competence of the patient (e.g., minors or incapacitated patients) are examples of distinctions that may not be "discriminatory", because (1) they are not necessarily based on s. 15's enumerated grounds,[69] and (2) even if they are, they take into account a number of relevant considerations regarding "the 'full context of the claimant group's situation', to the 'actual impact of the law on that situation'".[70]

For example, legal scholars Isabel Grant and Elizabeth Sheehy explain how expanding MAID can perpetuate *disadvantage* by "portray[ing] death as preferable to a disabled life", rather than responding to "underlying inequalities":

> "Profound social inequality is inconsistent with an autonomous choice of death for someone whose intolerable suffering is tied to that inequality. The irrevocable 'choice' of death, driven

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[64] This is the terminology adopted by the CCA's Expert Panel Working Group on MAID Where A Mental Disorder Is the Sole Underlying Medical Condition, and it is similarly used here. See The Expert Panel Working Group on MAID Where A Mental Disorder Is the Sole Underlying Medical Condition, "The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition", Council of Canadian Academies (2018) Ottawa (ON), ISBN: 978-1-926522-48-7 [*MAID MD-SUMC CCA Report*].

[65] *R v Kapp*, 2008 SCC 41 at para 28 (McLachlin CJ and Abella J, for the majority). At para 28, the majority also noted: "*Andrews* requires that discriminatory conduct entail more than *different* treatment. As McIntyre J. declared at p. 167, a law will not 'necessarily be bad because it makes distinctions'" (emphasis in original).

[66] *Withler v Canada*, 2011 SCC 12 at para 67. See also *R v CP*, 2021 SCC 19 at paras 145, 153, and 155 (per Wagner CJ).

[67] *R v Kapp*, 2008 SCC 41 at para 15.

[68] *Withler v Canada*, 2011 SCC 12 at para 39 (emphasis added); see also *Fraser v Canada (Attorney General)*, 2020 SCC 28 at para 42 (Abella J, for the majority) and *R v CP*, 2021 SCC 19 at paras 153 (per Wagner CJ) and 57 (per Abella J).

[69] See, for example, *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at paras 109-111.

[70] *Fraser v Canada (Attorney General)*, 2020 SCC 28 at para 42 (Abella J, for the majority, references omitted). See also *R v CP*, 2021 SCC 19 at paras 145 and 153 (per Wagner CJ).

> by the suffering of poverty, homelessness, perceiving oneself to be a burden, or a racist, sexist and ableist health-care system, should never be sanctioned by the state for those who are not at the end of life."[71]

Consideration must also be given to how expanding MAID may produce inequality in another way: by enlarging not the *benefit* of the law's equal protection of the inviolability of human life, but rather an *exception to* that benefit.[72] Constitutional lawyer André Schutten, writing in the *Supreme Court Law Review*, explains how expanding MAID can perpetuate disadvantage:

> "People are categorized according to their abilities and disabilities. Judgments of some regarding their worthlessness are projected onto others. The disadvantages are profound: people in this category lose the benefit of the *Criminal Code* assumption of non-consent; physicians and society assume that individuals in this category prefer death; and health care systems develop different standards of suicide response and care depending on disability and disease."[73]

The issues at stake in this matter are complex and nuanced. In examining them, Parliament must take full account of the social, political, economic, and historical factors concerning those who may be adversely impacted by any law establishing MAID as a medical solution for their circumstances.[74] In the context of MAID MD-SUMC, this requires, among other considerations, careful examination of (1) the specific nature and impact of mental illnesses, and (2) the extent to which permitting MAID MC-SUMC may disproportionately impact members of minority and marginalized groups. These points are discussed below.

Considering the nature and impact of mental illnesses

According to the CCA's Expert Panel Working Group on MAID Where A Mental Disorder Is the Sole Underlying Medical Condition (MAID MD-SUMC Working Group), "[m]ental disorders may impair a person's capacity to make decisions with respect to their health and their ability to give informed consent to MAID."[75] For example, "a person's capacity for making decisions can be impaired by the disorder's impact on their mood and emotions", such as in the context of depression, which "can impair one's ability to deliberate about the future or to maintain a minimal concern for self."[76] This contributes to "a unique challenge in assessing decision-making capacity for MAID MD-

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[71] Isabel Grant and Elizabeth Sheehy, "Focus on dignified lives, not facilitated deaths", LexisNexis: The Lawyers' Daily (24 March 2021), online: https://www.thelawyersdaily.ca/articles/25576/focus-on-dignified-lives-not-facilitated-deaths-isabel-grant-and-elizabeth-sheehy. See also Kerri Froc, "Extending MAiD access puts the vulnerable at risk", Telegraph Journal (7 May 2022), online: https://tj.news/telegraph-journal/101865291.

[72] Recall the legal status of MAID under Canadian law: a specific *exception* to culpable homicide and aiding suicide offences. See *Criminal Code*, RSC 1985, c C-46, ss 227(1),(4) and ss. 241(2)-(5.1).

[73] André M Schutten, "Lethal discrimination: a case against legalizing assisted suicide in Canada" (2015) 73 SCLR (2nd Series) at 176-177.

[74] *Withler v Canada*, 2011 SCC 12 at para 39; *Fraser v Canada (Attorney General)*, 2020 SCC 28 at para 42 (Abella J, for the majority); and *R v CP*, 2021 SCC 19 at paras 153 (per Wagner CJ) and 57 (per Abella J).

[75] *MAID MD-SUMC CCA Report* at 64.

[76] *Ibid* (references omitted), referencing G Meynen, "Depression, possibilities, and competence: A phenomenological perspective" (2011) *Theoretical Medicine and Bioethics, 32*, 181-193; J Halpern, "When concretized emotion-belief complexes derail decision-making capacity" (2012) *Bioethics, 26*(2), 108-116; GS Owen, F Freyenhagen, M Hotopf, and W Martin, "Temporal inabilities and decision-making capacity in depression" (2013) *Phenomenology and the Cognitive Sciences, 14*, 163-

SUMC in people with mental disorders: **their desire to die could be a symptom of their condition**".[77]

Mental illnesses can also impact a person's experience of suffering. The *MAID MD-SUMC CCA Report* identified this as "a special vulnerability of people with mental disorders in the context of MAID MD-SUMC: **there will be situations in which a patient's perception of their intolerable suffering could be addressed clinically despite their view that it is irremediable**."[78]

Furthermore, there is a lack of medical consensus on the irremediability of mental illnesses. According to the Expert Advisory Group on Medical Assistance in Dying:

> "The Canadian Psychiatric Association has stated that 'there is no established standard of care in Canada, or as far as CPA is aware of in the world, for defining the threshold when typical psychiatric conditions should be considered irremediable.' In its policy advice on MAiD, the Centre for Addiction and Mental Health (CAMH) has indicated it is impossible currently to identify irremediability in any individual case of mental illness: 'At any point in time it may appear that an individual is not responding to any interventions – that their illness is currently irremediable – but it is not possible to determine with any certainty the course of this individual's illness. There is simply not enough evidence available in the mental health field at this time for clinicians to ascertain whether a particular individual has an irremediable mental illness.'"[79]

Moreover, "the CCA expert panel […] could not find evidence from anywhere in the world that supports being able to identify irremediability in individual cases of mental illness."[80] The lack of medical consensus on the irremediability of mental illnesses was discussed at length in the *MAID MD-SUMC CCA Report*.[81] It was also recently reiterated by the *Report of the Select Committee on the Evolution of the Act respecting end of life care* in Quebec.[82] This, among other factors, led the Select Committee to recommend "that access to medical aid in dying **not** be extended to persons whose only medical condition is a mental disorder".[83]

182; and C Elliot, "Caring about risks: Are severely depressed patients competent to consent to research" (1997) *Archives of General Psychiatry, 54*(2), 113-116.

[77] *Ibid* at 68 (emphasis added), referencing PS Appelbaum, "Physician-assisted death for patients with mental disorders - Reasons for concern" (2016) *JAMA Psychiatry, 73*:4, 325-326. However, requiring that patients be competent in order to receive MAID may not sufficiently protect patients whose "ability to deliberate about the future […] or to maintain a minimal concern for self" has been impaired by their underlying condition (at 64).

[78] *Ibid* at 79 (emphasis added).

[79] Expert Advisory Group on Medical Assistance in Dying, *Canada at a Crossroads: Recommendations on Medical Assistance in Dying and Persons with a Mental Disorder—An Evidence-Based Critique of the Halifax Group IRPP Repor*t (13 February 2020) Toronto (ON): doi: 10.13140/RG.2.2.36236.87687 at 10 (references omitted) [*EAG Report*].

[80] *Ibid* at 12.

[81] *MAID MD-SUMC CCA Report* at 69-73, 154-155.

[82] Select Committee on the Evolution of the Act respecting end-of-life care, *Report of the Select Committee on the Evolution of the Act respecting end-of-life care*, Assemblée Nationale du Québec (December 2021), online: http://www.assnat.qc.ca/fr/travaux-parlementaires/commissions/cssfv-42-1/index.html#:~:text=En%20vertu%20d'une%20motion,de%20problèmes%20de%20santé%20mentale at 51: "there is no clear medical consensus on the incurability of mental disorders and the irreversible decline in capability that would be associated with them."

[83] *Ibid* at 57 (emphasis added).

The MAID MD-SUMC Working Group also identified that there is a "long history of stigma, discrimination, and paternalism against people with mental disorders in Canada and elsewhere".[84] The MAID MD-SUMC Working Group noted that "the history of mistreatment of many people with mental disorders in the delivery of healthcare […] demonstrates how such people could be vulnerable to further mistreatment in the context of MAID MD-SUMC."[85]

Canadian legal scholar Trudo Lemmens has explained how expanding MAID beyond the end-of-life context to include disability-related suffering "ignore[s] how ableist, ageist and 'diseasist' attitudes can lead to an internalized form of oppression that undermines the autonomy of people with disabilities in their decision making with respect to requests for termination of their life."[86] CLF shares these concerns, particularly in the context of patients receiving MAID MD-SUMC due to *societal* marginalization. As Archibald Kaiser, Isabel Grant, Trudo Lemmens, and Elizabeth Sheehy stated:

> "People do not die from mental illness. They are at risk of premature mortality due to poverty, poor health, human rights violations, and even homicide, including by police. They are marginalized by inequality and ableism, as they struggle with mental health conditions and society's neglect. […] Bill C-7 would give people with mental illness a legal impetus to see MAID as a solution to socially inflicted suffering."[87]

Canada must not expect individuals struggling with mental illnesses to tolerate societal stigma, mistreatment, and failure, and we especially must not point to such hardships as *evidence of eligibility* for MAID. Rather, we must combat stigma at a societal level and offer meaningful support to those with mental illnesses. Sanctioning MAID MD-SUMC in Canada's current state—where mental health supports are often lacking or inaccessible[88]—risks perpetuating disadvantage and harm for many

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[84] *MAID MD-SUMC CCA Report* at 34.
[85] *Ibid* at 47-48.
[86] Trudo Lemmens, "How the Mantra of Informed Consent in the Canadian Assisted Dying Debate Obscures Somatic Oppression", Health Law: Jotwell (8 September 2021), online: https://health.jotwell.com/how-the-mantra-of-informed-consent-in-the-canadian-assisted-dying-debate-obscures-somatic-oppression/, reviewing Jonas-Sébastien Beaudry, *Somatic Oppression and Relational Autonomy: Revisiting Medical Aid in Dying through a Feminist Lens*, 52 UBC L Rev 241 (2020).
[87] Archibald Kaiser, Isabel Grant, Trudo Lemmens, and Elizabeth Sheehy, "MAID bill is an affront to equality", Toronto Star (11 March 2021), online: https://www.thestar.com/opinion/contributors/2021/03/11/maid-bill-is-an-affront-to-equality.html. See also Kerri Froc, "Extending MAiD access puts the vulnerable at risk", Telegraph Journal (7 May 2022), online: https://tj.news/telegraph-journal/101865291.
[88] See Nicholas Moroz, Isabella Moroz, and Monika Slovinec D'Angelo, "Mental health services in Canada: Barriers and cost-effective solutions to increase access", (2 July 2020) *Healthcare Management Forum 33*:6, 282, online: https://journals.sagepub.com/doi/full/10.1177/0840470420933911 (references omitted). "There exists a well-documented need for MHA [Mental Health and Addiction] services in Canada. In 2018, an estimated 5.3 million Canadians reported they needed help for their mental health in the previous year. Of these 5.3 million people, 1.2 million reported that their needs were only partially met (22%) and 1.1 million (21%) reported that their needs were fully unmet. […] Furthermore, access to services is limited by long wait times for primary and/or psychiatric care, as well as community care that is often not integrated with healthcare services.

Documented barriers to accessing MHA services across Canada include not knowing where to go for help, long wait times, shortage of accessible mental health professionals, lack of mental health service integration and government oversight, culture and language barriers, concerns about stigma, inequities due to geography or demographics (eg, youth, rural communities, and Indigenous populations), and cost of services not covered by private insurance plans […] Finally, Canadians living in rural areas have a severe lack of access to mental health services."

individuals, not alleviating it. These risks may be heightened even further for members of marginalized groups who are disproportionately impacted by mental illnesses, as discussed in the next section.

The potentially disproportionate impact of MAID MD-SUMC

The MAID MD-SUMC Working Group noted that "different gender, ethnic, cultural, socio-economic, and demographic groups experience differences in the prevalence of and risk factors for mental disorders, suicidality, and access to mental healthcare and social supports" and identified unique concerns, barriers, and risks for the following sub-populations: Indigenous people; youth; women; immigrant, refugee, ethnocultural, and racialized populations; LGBTQ+ communities; seniors; Canadian Armed Forces members and veterans; and incarcerated individuals.[89]

For example, the MAID MD-SUMC Working Group observed that mood disorders, major neurocognitive disorders, somatic disorders, and eating disorders are all more prevalent in women than in men, and this is "strongly associated with women's greater exposure to poverty, discrimination, socio-economic disadvantage, and gender-based violence."[90] MAID MD-SUMC may therefore disproportionately impact women: "International experience suggests that permitting more MAID MD-SUMC in Canada may lead to a greater proportion of women than men requesting it", since the "[e]vidence from Belgium and the Netherlands indicates that women access psychiatric EAS [Euthanasia/Assisted Suicide] more than twice as often as men in those countries."[91]

Academics have also expressed concern about the discriminatory impact that MAID MD-SUMC may have on women: "Other jurisdictions show that with MAID for mental illness, women will disproportionately be its recipients, including women who have experienced sexual trauma and abuse, and others whose experience of trauma, racism and colonialism has led to intolerable suffering."[92]

The MAID MD-SUMC Working Group also identified that "Indigenous people overall experience mental health issues at a higher rather than the non-Indigenous population", while simultaneously having "limited access to formal mental health supports."[93] "Racism continues to create and reinforce disparities", and "poorer access to mental healthcare on the part of Indigenous people may lead to increased suffering that may result in them seeking MAID MD-SUMC."[94]

We also see increased risks associated with mental illness in other marginalized populations. For example, seniors "have a higher risk of social isolation because of the greater chance of compromised health status, living alone, death of family or friends, changing family structures, and

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[89] *Ibid* at 50-54.
[90] *Ibid* at 44-45.
[91] *Ibid* at 44-45 and 110.
[92] Archibald Kaiser, Isabel Grant, Trudo Lemmens, and Elizabeth Sheehy, "MAID bill is an affront to equality", Toronto Star (11 March 2021), online: https://www.thestar.com/opinion/contributors/2021/03/11/maid-bill-is-an-affront-to-equality.html.
[93] *MAID MD-SUMC CCA Report* at 49, referencing Statistics Canada, *Aboriginal Statistics at a Glance: 2nd Edition* (Ottawa: 2015).
[94] *Ibid* at 28 and 173, referencing S Loppie, C Reading, and S de Leeuw, Aboriginal Experiences with Racism and its Impacts, National Collaborating Centre for Aboriginal Health (Prince George, 2014) and B Allan and J Smylie, *First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada* (Wellesley Institute: Toronto 2015).

retirement".[95] Similarly, incarcerated individuals have rates of mental disorders "exceed[ing] that of the general population", and the suicide rate among federal inmates is "more than seven times the Canadian average".[96]

The data on mental illness within minority and marginalized populations is only briefly reviewed here. CLF urges this Committee to undertake a more comprehensive review of how MAID MD-SUMC risks disproportionately impacting members of each of these groups, surveyed in more detail by the MAID MD-SUMC Working Group.[97]

The (Un)Constitutionality of an Expanded MAID Regime

In *Carter*, the trial judge explicitly rejected the argument that MAID should include suffering caused by "psychosocial" factors.[98] Justice Smith wrote: "I do not accept that the term 'grievously and irremediably ill persons' should incorporate reference to 'psychosocial suffering'."[99] Justice Smith specifically limited the court's declaration to apply only to "a fully-informed, non-ambivalent competent adult person who […] **is not clinically depressed**".[100] In addition, the Supreme Court of Canada emphasized that "euthanasia for minors or **persons with psychiatric disorders**" did not fall "within the parameters suggested in these reasons".[101]

Extending MAID to offer death as a "solution" for mental illness—while ignoring the socioeconomic context, societal barriers, and lived realities faced by many individuals who may be impacted by such a regime—fails to ensure *substantive* equality.[102] CLF echoes the words of Archibald Kaiser, Isabel Grant, Trudo Lemmens, and Elizabeth Sheehy:

> "Arguing that denying assisted suicide to people with mental illness who are not dying is discriminatory ignores the overlay of stigma, discrimination and exclusion. In Canada, we condemn people with disabilities to live in poverty, to unemployment, homelessness, segregation and loneliness. If assisted dying is extended to people with mental illness, the message is clear: after relegating you to the margins, after our broken promises, Canada offers you death instead of a good life."[103]

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[95] *Ibid*.

[96] *Ibid* at 54.

[97] *Ibid* at 50-54.

[98] While Justice Smith did not offer a definition for "psychosocial" factors, she did refer to evidence "that suicide related to **mental illness, substance use, impulsivity and other psychosocial factors is different from end-of-life decision making by grievously and irremediably ill individuals**" (emphasis added). Justice Smith observed: "it is problematic to conflate decision-making by grievously and irremediably ill persons about the timing of their deaths, with decision-making about suicide by persons who are mentally ill, or whose thinking processes are affected by substance abuse, trauma or other such factors." See *Carter v Canada,* 2012 BCSC 886 at paras 813-814.

[99] *Ibid* at para 1390.

[100] *Ibid* at para 1393 (emphasis added).

[101] *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 111 (emphasis added).

[102] *Withler v Canada*, 2011 SCC 12 at para 39: "Substantive equality, unlike formal equality, rejects the mere presence or absence of difference as an answer to differential treatment. It insists on going behind the facade of similarities and differences."

[103] Archibald Kaiser, Isabel Grant, Trudo Lemmens, and Elizabeth Sheehy, "MAID bill is an affront to equality", Toronto Star (11 March 2021), online: https://www.thestar.com/opinion/contributors/2021/03/11/maid-bill-is-an-affront-to-equality.html.

The Government of Canada must not offer death to Canadians living with disabilities and mental illness, in the name of equality, when it has failed to offer adequate assistance in *living*, thereby failing to ensure *substantive* equality.

III. MAID and Mature Minors

CLF is deeply concerned about the possible expansion of MAID eligibility to include children. Although Canadian courts have accepted the common law mature minor doctrine—namely, that "when a minor is able to understand and appreciate the nature and consequences of a treatment decision, they can give legally valid consent to treatment"[104]—this is not an unqualified or absolute right. In the healthcare context, courts take into account "the nature, purpose and utility of the recommended medical treatment" and its "risks and benefits"[105], and have intervened to protect minors from making "life-threatening mistakes".[106]

In *AC v Manitoba (Director of Child and Family Services),* the leading case on the mature minor doctrine, Justice Abella observed that "the more serious the nature of the decision and the more severe its potential impact on the life or health of the child, the greater the degree of scrutiny will be required."[107] The ultimate question is what is in the best interests of the child, but the state may be justified in "retaining an overarching power to determine whether allowing the child to exercise his or her autonomy in a given situation actually accords with his or her best interests."[108]

In the *AC v Manitoba* case, the Court affirmed that minors should be given the opportunity to demonstrate that they possess the requisite maturity, independence, and capacity to *refuse* forced medical intervention; however, nothing in the decision contemplated the right of minors to have their lives *intentionally terminated*. In fact, the Court acknowledged that, in Canadian and international jurisprudence, courts "have generally not seen the 'mature minor' doctrine as dictating guaranteed outcomes, **particularly where the consequences for the young person are catastrophic**."[109]

The Supreme Court "has long recognized that children are a 'highly vulnerable' group".[110,111] Four Supreme Court justices recently observed that "children's 'physical, mental, and emotional immaturity' make them 'one of the most vulnerable groups in society'".[112] In *AB v Bragg Communications*

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[104] The Expert Panel Working Group on MAID for Mature Minors, "The State of Knowledge on Medical Assistance in Dying for Mature Minors", Council of Canadian Academies (2018) Ottawa (ON, ISBN: 978-1-926522-46-3 at 38 [*Mature Minors CCA Report*], referencing *Van Mol v Ashmore*, 1999 BCCA 6.

[105] *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 96 (Abella J, for the majority).

[106] *Ibid* at para 106 (McLachlin CJ and Rothstein J, concurring).

[107] *Ibid* at para 22 (Abella J, for the majority).

[108] *Ibid* at para 86; see also para 62 (Abella J, for the majority).

[109] *Ibid* at para 69 (Abella J, for the majority).

[110] *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 104 (Abella J, for the majority), citing *Canadian Foundation for Children, Youth and the Law v Canada (Attorney General)*, 2004 SCC 4 at para 56, as well as *R v DB*, 2008 SCC 25 at para 48.

[111] Justice Abella also recently noted that minors with disabilities may be uniquely vulnerable/subject to marginalization; see *Ward v Quebec (Commission des droits de la personne et des droits de la jeunesse)*, 2021 SCC 43 at paras 117, 147, 178, 194, and 218 (Abella and Kasirer JJ, dissenting but not contradicted by the majority on this point).

[112] *Ibid* at para 174 (Abella and Kasirer JJ, dissenting but not contradicted by the majority on this point), citing *R v Sharpe*, [2001] 1 SCR 45 at para 169 (per L'Heureux-Dubé, Gonthier, and Bastarache JJ). See also *Ward* at paras 117, 147, 178, and 194.

Inc, the Supreme Court unanimously stated: "Recognition of the *inherent* vulnerability of children has consistent and deep roots in Canadian law."[113]

On these grounds, the law has drawn distinctions based on age to protect youth. In the criminal law context, it has been recognized that young people may be treated differently from adults because they "have heightened vulnerability, less maturity and a reduced capacity for moral judgment".[114] These considerations must be taken into account by Parliament when crafting a law with broad implications for minors. While the court in *Truchon* noted that vulnerability should be assessed on an individual basis for adults,[115] Justice Beaudoin also emphasized that access to MAID for minors was "not at issue" in that case.[116] And, while some minors may possess adequate capacity to make certain healthcare decisions and may not be considered "vulnerable" to the same extent, vulnerability/maturity must not be the *only* consideration in the context of a child's decision to deliberately end his or her life.

For example, in *AC v Manitoba*, after surveying the relevant authorities, the majority observed that "none of these cases asserted that a 'mature minor' should be treated as an adult for *all* decisional treatment purposes".[117] Chief Justice McLachlin specifically noted that "it is dangerous to speculate on whether a judge would *ever* […] decline to order medical treatment for a child under the age of 16 *where the result would be probable death*."[118]

If this is the approach to healthcare decisions where the *possibility* of the minor's death is due to the *refusal* of treatment, where death happens naturally, how much more vigilance is required for *positive action* designed to *purposely* end the minor's life, such as MAID?[119]

Unlike any other mature minor decision considered by courts in the past, MAID involves the irrevocable and intentional act of prematurely terminating a child's life with *certainty*.[120] This renders MAID different in kind than any healthcare decision deemed within the capacity of a mature minor

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[113] *AB v Bragg Communications Inc*, 2012 SCC 46 at para 17 (Abella J, for the Court) (emphasis in original).
[114] *R v DB*, 2008 SCC 25 at para 41. See also para 106, where the dissenting justices, while disagreeing with the majority on the outcome of the case, agree "that young persons are entitled, based on their reduced maturity and judgement, to a presumption of diminished moral blameworthiness and that this presumption is a principle of fundamental justice."
[115] *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at paras 1-2 and 252-253.
[116] *Ibid* at para 16. See also para 466.
[117] *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 56 (Abella J, for the majority) (emphasis added).
[118] Ibid at para 133 (McLachlin CJ and Rothstein J, concurring) (emphasis added).
[119] *Mature Minors CCA Report* at 65: "Although several cases have dealt with healthcare decisions of a life-threatening nature, those mature minors wished to *refuse* a life-*sustaining* treatment. For MAID, the mature minor would be *requesting* a life-*ending* treatment" (emphasis in original).
[120] Bill C-14's preamble implicitly acknowledged the gravity of MAID, noting "the irrevocable nature of ending a life". See Bill C-14, *An Act to amend the Criminal Code and related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, SC 2016 c-3 (assented to 17 June 2016), preamble.

in jurisprudence to date,[121] even other end-of-life treatment options (e.g., palliative care).[122] This distinction is crucial.

Ultimately, the purpose underlying the mature minor doctrine is "'to create or support the conditions which are most conducive to the flourishing of the child"'.[123] The aim must be to "'provide for the healthy growth, development and education of the child so that he will be equipped to face the problems of life as a mature adult"'.[124] These purposes would be undermined, not advanced, by allowing pediatric MAID, in which the *only* outcome is the child's *death*, categorically denying them the very possibility of flourishing as a mature adult (especially if their death is otherwise not even "reasonably foreseeable"). As observed by legal scholar John Eekelaar:

> "We cannot know for certain whether, retrospectively, a person may not regret that some control was not exercised over his immature judgment by persons with greater experience. But could we not say that it is on balance better to subject all persons to this potential inhibition up to a defined age, in case the failure to exercise the restraint unduly prejudices a person's basic or developmental interests?"[125]

As noted above, the Supreme Court has recognized that the mature minor doctrine must balance recognition of the minor's autonomy with the need to actively guard against threats to that minor's life.[126] In addition, the *Mature Minors CCA Report* accepted that there are key cognitive distinctions between adults and adolescents: "In contrast to fully developed brains, adolescent brains demonstrate a lack of connectivity among regions involved in the control system, reward system, and

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[121] As the Expert Panel Working Group on MAID for Mature Minors (Mature Minors Working Group) observed, while "the mature minor doctrine has been tested in cases involving life-threatening healthcare decisions", the doctrine "did not arise in a life-and-death context." *Mature Minors CCA Report* at 41, referencing J Mosoff, "'Why not tell it like it is?': The example of P.H. v. Eastern Regional Integrated Health Authority, a minor in a life-threatening context" (2012) *University of New Brunswick Law Journal*, 63, 238. This is important, because the literature is clear that capacity is "treatment-dependent" (at 47).

[122] Scholars Mary J Shariff and Mark Gingerich have explained the "philosophical, clinical and legal distinctions between the practices of palliative care and termination of life" (i.e., MAID), reinforcing that a minor's capacity to consent to end of life treatment such as palliative care cannot simply be transposed into the MAID context and presumed to be identical. As Shariff and Gingerich explain, "*palliative care* is aimed at addressing the patient's symptoms as well as their 'needs, hopes and fears' including physical, psychological, social, cultural, spiritual, and existential threats or needs, so that the patient can live life 'fully to the very end with dignity and respect.' […] Consistent with the 'life-affirming' philosophy, the second principal pillar of *palliative care* is that it seeks neither to hasten nor postpone death. This is in stark contrast to the intention and sole goal of *termination of life* which is to cause immediate death. […] The preponderance of evidence reveals a critical difference between the practices of *palliative care* and *termination of life*: between care that is directed toward a pain-free life, however long it may continue, and care directed toward the ending of pain and suffering through death." Mary J Shariff and Mark Gingerich, "Endgame: Philosophical, Clinical and Legal Distinctions between Palliative Care and Termination of Life" (2018), 85 SCLR (2d) 225 at 246-247, 250, and 291 (emphasis in original, footnotes omitted).

[123] *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 88 (Abella J, for the majority), quoting Justice L'Heureux-Dubé in *Young v Young*, [1993] 4 SCR 3 at 65 (emphasis added by Abella J).

[124] *Ibid*, citing *King v Low*, [1985] 1 SCR 87 at 101 (per Justice McIntyre) (emphasis added by Abella J).

[125] John Eekelaar, "The Emergence of Children's Rights" (1986), 6 *Oxford Journal of Legal Studies 6*:2, 161 at 181-82, quoted in *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 79 (Abella J, for the majority).

[126] "'The difficulty lies in establishing a formula which authorizes paternalistic interventions to protect adolescents from making life-threatening mistakes, but restrains autocratic and arbitrary adult restrictions on their potential for autonomy.'" *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 106 (Abella J, for the majority), quoting Jane Fortin, *Children's Rights and the Developing Law*, 2nd ed (London: LexisNexis UK, 2003) at 26-27.

emotion processing".[127] As a result, "the way that adolescents respond to environmental factors may affect their decision-making abilities, particularly in situations laden with emotion or the influence of peers".[128]

For similar reasons, experts have also noted that the voluntariness of a mature minor's decision may be questionable, since "voluntariness is closely tied to many of the non-cognitive factors that shape the minor's maturity, such as life experience and social environment".[129] In *AC v Manitoba*, the Supreme Court identified "that '[t]here is considerable support for the notion that while many adolescents may have the technical ability to make complex decisions, this does not always mean they will have the maturity and independence of judgment to make truly autonomous choices'".[130]

Experts acknowledge that "'young people are easily influenced and swayed by others because of their family relationships, economic position and stage of development'".[131] This is "particularly true for minors under 16 years of age, where 'a variety of laws and social norms […] make them more dependent on their immediate families and peers in their daily lives than older adolescents'".[132]

A recent report of the Federal/Provincial/Territorial Heads of Prosecutions Subcommittee on the Prevention of Wrongful Convictions (cited last year by Justice Abella) identified that "youthful brains are wired differently, and those underdeveloped brains result in young persons being poor decision-makers, in contrast to adults."[133] That report also pointed to "scientific evidence that young persons are less mature, less able to assess risks and long-term consequences of their conduct, more vulnerable to external pressures and more compliant to authority. As a result, the traits that make young persons different from adults cognitively, socially and emotionally, may also make them particularly susceptible to the recognized systemic factors that contribute to wrongful convictions."[134] These same factors are relevant in considering the risks of wrongful deaths caused by pediatric euthanasia.

All of this suggests that minors would be particularly susceptible to external expectations and pressures and could be at a greater risk of accepting MAID in the face of such pressures, including those that are particularly subtle and even undetectable. In light of this information, limiting MAID

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[127] *Mature Minors CCA Report* at 75, citing P Grootens-Wiegers, I M Hein, J M van den Broek, and M C de Vries, "Medical decision-making in children and adolescents: Developmental and neuroscientific aspects" (2017) *BMC Pediatrics* 17:1, 120.

[128] *Ibid*, citing L Steinberg, "Cognitive and affective development in adolescence" (2005) *Trends in Cognitive Sciences, 9*:2, 69-74. See also *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at paras 70-79 (Abella J, for the majority) and para 143 (McLachlin CJ and Rothstein J, concurring).

[129] *Ibid* at 47, citing J Guichon and I Mitchell, "Medical emergencies in children of orthodox Jehovah's Witness families: Three recent legal cases, ethical issues and proposals for management" (2006) *Paediatrics & Child Health, 11*:10, 655.

[130] *Ibid*, quoting AC *v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 71 (Abella J, for the majority).

[131] *Ibid*, citing J Mosoff, "'Why not tell it like it is?': The example of P.H. v. Eastern Regional Integrated Health Authority, a minor in a life-threatening context" (2012) *University of New Brunswick Law Journal, 63*, 238.

[132] *Ibid*, citing *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 145 (McLachlin CJ and Rothstein J, concurring).

[133] Federal/Provincial/Territorial Heads of Prosecutions Subcommittee on the Prevention of Wrongful Convictions, *Innocence at Stake: The Need for Continued Vigilance to Prevent Wrongful Convictions in Canada* (2018), online: https://www.ppsc-sppc.gc.ca/eng/pub/is-ip/is-ip-eng.pdf at 243, cited in *R v CP,* 2021 SCC 19 at para 86 (per Abella J).

[134] *Ibid.*

only for "competent adults" (as the Supreme Court did in *Carter*[135]) would not necessarily violate the equality rights of minors, insofar as it takes into full account their unique characteristics,[136] is "ameliorative, not invidious", and "aims at protecting the interests of minors as a vulnerable group."[137]

This similarly addresses some s. 7 concerns. As Chief Justice McLachlin observed in *AC v Manitoba*, "the s. 7 liberty or 'autonomy' right is not absolute, even for adults" and may be constrained by law if such limits "are shown to be based on rational, rather than arbitrary grounds."[138] Conversely, *expanding* access to minors could actually impose "an increased risk of death on [them], either directly or indirectly",[139] which would infringe their *Charter* rights to life, liberty, and security of the person.

There are also unique practical challenges with assessing the capacity of mature minors. During its consultation on capacity assessments, "the Law Commission of Ontario 'heard that particular attention should be paid to the challenges of assessing the decision-making abilities of youth'".[140] In *AC v Manitoba*, the Supreme Court "acknowledged that determining an adolescent's maturity must include a range of factors that assess 'the extent to which a child's wishes reflect true, stable and independent choices'".[141] While the Mature Minors Working Group recognized that "pediatricians are constantly evaluating the maturity of their patients, including those at end of life, no standardized approaches are available to assess minors' capacity or psychosocial maturity", and it accepted that "'the mere fact that somebody does something frequently, does not necessarily mean that they do it well'".[142] This raises specific concerns in the context of pediatric MAID, since the consequences of an erroneous finding of adequate capacity are lethal, depriving a child of their entire future.

Only two countries in the world permit MAID for minors (the Netherlands and Belguim), and their regimes have been the subject of some international concern. In 2015, for example, the UN Committee on the Rights of the Child expressed concern that "euthanasia can be applied to patients

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[135] *Carter v Canada (Attorney General)*, 2015 SCC 5 at paras 2-4, 40, 68, and 127; see also *Carter v Canada,* 2012 BCSC 886 at paras 207-220, 258, 313, and 1393.
[136] *Withler v Canada*, 2011 SCC 12 at para 39.
[137] *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 152 (McLachlin CJ and Rothstein J, concurring). Whether these matters are best addressed under s. 15(1) as part of a "contextual inquiry", having "regard to the full context of the situation of young persons" [*R v CP*, 2021 SCC 19 at para 153 (per Wagner CJ); see also *Fraser v Canada (Attorney General)*, 2020 SCC 28 at para 42 (per Abella J)], or as an ameliorative purpose protected under s. 15(2), or as part of the balancing exercise in s. 1, they are undoubtedly relevant considerations for Parliament.
[138] *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 137 (McLachlin CJ and Rothstein J, concurring). See also para 160: "It is argued that once the judge presumed capacity, he was bound under the *Charter* to give effect to [the minor's] wishes. The order for treatment, it is argued, therefore violates s. 7. The flaw in this contention **is the assumption that autonomy under s. 7 is absolute and trumps all other values. As discussed above, this Court has rejected this contention**" (emphasis added).
[139] *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 62.
[140] *Mature Minors CCA Report* at 78, quoting Law Commission of Ontario, *Legal Capacity, Decision-making and Guardianship: Final Report* (2017) Toronto (ON): LCO.
[141] *Ibid* at 81, quoting *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 96 (Abella J, for the majority).
[142] *Ibid*, quoting K Van Assche, R Kasper, B Vanderhaegen, and S Sterckx, "'Capacity for discernment' and euthanasia on minors in Belgium" (2018) *Medical Law Review*.

under 18 years of age" in the Netherlands and recommended that the government consider abolishing the practice.[143]

Finally, as noted by the Mature Minors Working Group and others, "little is known about how mature minors make meaning of end of life care."[144] There is a lack of Canadian research on MAID for mature minors. Such information is vital in order "to distinguish the intentions of the minors requesting MAID and whether their requests could have been alleviated with available life affirming-measure such as withdrawing from disease-modifying therapy to specialized paediatric palliative care which may include palliative sedation".[145]

In *Truchon,* the court acknowledged that "no system other than total and absolute prohibition will ever be able to prevent every error".[146] The "error", in this context, would be the wrongful death of an innocent child. The Supreme Court of Canada refused to accept such a risk in the context of state-facilitated death via capital punishment, finding that the loss "of even one innocent person is one too many."[147] Neither should such a risk be accepted in the context of state-facilitated pediatric euthanasia.

MAID MD-SUMC and Mature Minors

When considering whether mature minors should have similar access to MAID as adults, it is also important to consider the unique, intersecting vulnerabilities experienced by youth.[148] As discussed above, the *MAID MD-SUMC CCA Report* notes that youth "have higher rates of mental health problems than the Canadian average".[149] Statistics Canada reveals that "[s]uicide is the second-leading cause of death for those in Canada aged 15 to 24, and the leading cause of death among those aged 10 to 14".[150] This is relevant because, of the almost 4,000 people who die by suicide each year,

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[143] Committee on the Rights of the Child, "Concluding observations on the fourth periodic report of the Netherlands", CRC/C/NDL/CO/4 (8 June 2015), online: https://tbinternet.ohchr.org/Treaties/CRC/Shared Documents/NLD/INT_CRC_COC_NLD_20805_E.pdf at para 28. See also Committee on the Rights of the Child, "Concluding observations on the combined fifth and sixth periodic reports of Belgium", CRC/C/BEL/CO/5-6 (28 February 2019), online: http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsk8r1vpHio%2Fg7Mp83cTcS1cUBTPal6pQqSnnKAt9zXb2Uv8VuBfYxEYQYjA%2Fz79vUKAIWS%2FklvSy5rZHWCgoGOIQOqVsDyB%2BuVUGyTsbSJVM at para 18.

[144] Christina Marie Lamb, "Paediatric euthanasia in Canada: New challenges for end of life care", *Paediatrics and Child Health 26*:2 (Apr-May 2021), online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7962718/, citing the *Mature Minors CCA Report*.

[145] *Ibid.*

[146] *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at para 623.

[147] *United States v Burns*, 2001 SCC 7 at para 102.

[148] As is required by the legal framework for assessing substantive equality; see discussion above re: *Kapp* and *Withler*.

[149] *MAID MD-SUMC CCA Report* at 45, referencing Government of Canada, *The Human Face of Mental Health and Mental Illness in Canada* (2006), Ottawa (ON); Statistics Canada, Table 13-10-0092-01, "Mental Health and Well-being profile, Canadian Community Health Survey (CCHS), by age group and sex, Canada and provinces" (2013) online: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009201; and Statistics Canada, *Aboriginal Statistics at a Glance: 2nd Edition* (Ottawa: 2015).

[150] *Ibid* at 175, citing Tanya Navaneelan, "Suicide rates: An overview", Statistics Canada Catalogue No 82-624-X, online: https://www150.statcan.gc.ca/n1/pub/82-624-x/2012001/article/11696-eng.htm.

more than 90% were people—including minors—living with a mental or addictive disorder.[151] "Mood disorders were most prevalent in youths aged 15-24 with 8.2% having experienced a mood disorder over the past year".[152] Considering the fact that "a person's capacity for making decisions can be impaired by [a mental] disorder's impact on their mood and emotions",[153] it becomes apparent that youth as an already vulnerable group are uniquely impacted by these intersecting axes of vulnerability.

Healthcare experts and researchers have also identified that the challenges (and lack of medical consensus) around determining the irremediability of mental illnesses are even further heightened in paediatric contexts. According to the MAID MD-SUMC Working Group, "it is even more difficult for a clinician to confidently determine whether a minor's mental disorder is irremediable as compared to an adult over 25."[154]

For these reasons, CLF urges Parliament not to expand MAID MD-SUMC to include mature minors. CLF is not alone in this position: "Submissions obtained through the CCA's Call for Input expressed concerns that permitting more MAID MD-SUMC would put psychologically unstable young people are risk".[155]

As per the *MAID-MD SUMC CCA Report*, the Mature Minors Working Group "found that when one considers the natural history of mental disorders that begin in childhood, it is highly unlikely that a mental disorder would be deemed irremediable before a capable minor reaches the age of majority"; this possibility becomes even less tenable when considering the lack of medical consensus on the irremediability of mental disorders generally, as mentioned above.[156] The MAID MD-SUMC Working Group and the Mature Minors Working Group both acknowledged that this overlap—a mature minor accessing MAID for mental illness—would be ethically problematic, but assumed that such scenarios would likely not arise based on existing eligibility criteria around "irremediability".[157]

To ensure that such a scenario never becomes a reality, CLF urges Parliament to explicitly state that MAID for mature minors with a mental illness will not be permitted. Such a provision would respect Canada's obligations under the UN *Convention on the Rights of the Child*, "which states that a child with a disability 'should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community' and obliges Canada to pursue the 'maximum inclusion in society' of disabled children".[158]

Ultimately, this is not a matter of deciding *whether* to help alleviate the suffering of mature minors, but rather of determining *how* to do so. As Dr. Christina Lamb has observed:

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[151] Tanya Navaneelan, "Suicide rates: An overview", Statistics Canada Catalogue No 82-624-X, online: https://www150.statcan.gc.ca/n1/pub/82-624-x/2012001/article/11696-eng.htm, referencing E Weir, "Suicide: The hidden epidemic" (2001) *Canadian Medical Association Journal 165*:5, 634 and EK Mościcki, "Epidemiology of completed and attempted suicide: Toward a framework for prevention" (2001) *Clinical Neuroscience Research 1*, 310.
[152] *MAID MD-SUMC CCA Report* at 44.
[153] *Ibid* at 64.
[154] *Ibid* at 175
[155] *Ibid.*
[156] *Ibid*; *Mature Minors CCA Report* at 124.
[157] *MAID MD-SUMC CCA Report* at 175; *Mature Minors CCA Report* at 118 and 124: "No evidence was found to suggest the irremediability of mental disorders prior to the age of 18."
[158] *Ward v Quebec (Commission des droits de la personne et des droits de la jeunesse)*, 2021 SCC 43 at para 198 (per Abella and Kasirer JJ, dissenting but not contradicted by the majority on this point).

> "A middle ground may provide a more robust way forward whereby healthcare providers can appreciate the subjective quality of mature minors' requests for MAID in salience with life-affirming practices that can take into consideration minors' subjective as well objective clinical needs."[159]

There is also an immense need for research into medical practices to support paediatric populations. For example, "Canadians need to understand more about end of life care including specialized paediatric palliative practices".[160] It would be irresponsible and potentially harmful for MAID eligibility to be expanded to include mature minors without these knowledge gaps being addressed first.

IV. MAID and Advance Requests

Expanding MAID to include advance requests goes further than the Supreme Court's declaration in *Carter*. In *Carter*, the Supreme Court specifically contemplated that assisted death be made available only where a *competent* adult person "clearly consents to the termination of life", necessarily implying a *concurrent* granting of consent.[161] This requirement was applied by the British Columbia Court of Appeal in deciding not to give effect to a patient's prior directive to be deprived of "nourishments or liquids" because her present wishes suggested otherwise.[162] The Court of Appeal emphasized the need to be "assiduous in seeking to ascertain and give effect to the wishes of the patient in the 'here and now', even in the face of prior directives".[163]

In *Truchon,* the court was explicit that the question of whether incapable persons "be allowed access to medical assistance in dying […] on the basis of medical instructions given ahead of time" was "not at issue" in the case and would not be addressed in the judgment.[164] Thus, no court has indicated that the *Charter* requires MAID to be permitted on the basis of an advance request.

There are both practical and ethical issues with providing MAID via advance requests. Practically speaking, it creates the risk that individuals who have changed their minds (but who struggle to or are unable to express this change) could have their lives ended without their actual consent.[165] The federal government's First and Second Annual Reports on Medical Assistance in Dying in Canada both reveal that many patients—263 and 232 individuals, respectively—withdrew their requests for MAID. Many of these individuals withdrew their request *immediately* prior to the provision of MAID (53 patients in 2019 and 51 patients in 2020).[166] Therefore, performing MAID on individuals based on an advance request "raises the possibility that a person might receive MAID against their wishes."[167]

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[159] Christina Marie Lamb, "Paediatric euthanasia in Canada: New challenges for end of life care", *Paediatrics and Child Health 26*:2 (Apr-May 2021), online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7962718/.
[160] *Ibid*
[161] *Carter v Canada (Attorney General)*, 2015 SCC 5 at paras 127 and 147.
[162] *Bentley v Maplewood Seniors Care Society*, 2015 BCCA 91.
[163] *Ibid* at para 18.
[164] *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at para 16.
[165] The Expert Panel Working Group on Advance Requests for MAID, "The State of Knowledge on Advance Requests for Medical Assistance in Dying", Council of Canadian Academies (2018) Ottawa (ON), ISBN: 978-1-926522-51-7 at 173 and 176 [*Advance Requests CCA Report*].
[166] *First Annual MAID Report* at 6 and 38-39; *Second Annual MAID Report* at 31-33.
[167] *Advance Requests CCA Report* at 176.

Indeed, independent and informed consent for the termination of one's life may be impossible in this context, where it is based on an *assumption* of what one's future state might be (rather than what it *actually* is). For example, in the context of dementia, research indicates that many assumptions about the condition are unfounded:

> "Despite the fact that dementia is accompanied by a lot of negative feelings, the literature on the perspective of the patient offers no solid support to the widespread assumption that dementia is necessarily a state of dreadful suffering, or a disaster without consolation as some clinical psychologists suggest. […] the adaptive processes which people with dementia go through should be carefully considered in discussions on advance directives, because there is a good chance that, **in the end, people with dementia will not act in accordance with their earlier values and anticipatory beliefs regarding a life with dementia**."[168]

Ethically speaking, permitting MAID via advance requests raises serious concerns about the impact of ableism. Despite progress to combat such discrimination, ableism continues to impact the lived realities of Canadians.[169] It is unclear to what extent the influences of ableism will inform the decisions of individuals to make an advance request, based either on an incomplete understanding of what their life will be like at a given point in their prognosis, or on a presumption about how they will feel about themselves once they reach that diagnostic milestone.

According to the Expert Panel Working Group on Advance Requests for MAID: "There is a well-established discordance between the *predicted* quality of life of healthy people imagining a future health condition and the *actual* quality of life of people living with said condition […] a phenomenon termed the *disability paradox*".[170] The *Advance Requests CCA Report* explains that the disability paradox is "pervasive" and points to "a bias in the accuracy of predictions about future suffering".[171] "The disability paradox suggests that people may tend to overestimate the intolerability of a future health scenario, and may not actually desire MAID should they experience that scenario in the future."[172]

Lastly, permitting advance requests could effectively implement an "opt-out" system for those patients, creating situations where the patient is presumed to want to proceed with the MAID procedure unless he or she rebuts that presumption. Death should never be set as the default option for any individual, including those who are uniquely vulnerable due to precarious health conditions.

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[168] M de Boer et al, "Suffering from dementia – the patient's perspective: A review of the literature" (2007) *International Psychogeriatrics 19*, 1021 at 1033-1034 (references omitted, emphasis added).

[169] "The assumption that disability is a personal tragedy, and the further accompanying assumption that it constitutes a prima facie reasonable ground to end one's life, are symptoms of ableism, that is the belief that a 'disabled life' is worth less than a 'normal' one." See Jonas-Sébastien Beaudry, "The Way Forward for Medical Aid in Dying: Protecting Deliberative Autonomy is Not Enough" (2018), 85 SCLR (2d) 335.

[170] *Advance Requests CCA Report* at 52 (emphasis in original), referencing PA Ubel, G Loewenstein, N Schwarz and D Smith, "Misimagining the unimaginable: The disability paradox and health care decision making" (2005), *Health Psychology, 24*(4S), S57-62; and GL Albrecht and PJ Devlieger, "The disability paradox: High quality of life against all odds" (1999) *Social Science & Medicine, 48*(8), 977-988.

[171] *Ibid* at 52-53.

[172] *Ibid* at 52.

V. Conclusion

Drawing on the work of medical experts and legal scholars, as well as existing provincial, national, and international data, CLF respectfully submits that it would be irresponsible to further expand Canada's MAID regime. MAID must not become a means to *initiate* an otherwise unforeseeable death as a "treatment" for potentially manageable suffering in *life*. As the Supreme Court of Canada stated in *R v Latimer*:

> "Killing a person — in order to relieve the suffering produced by a medically manageable physical or mental condition — is not a proportionate response to the harm represented by the non-life-threatening suffering resulting from that condition." [173]

Beyond the lack of medical consensus as to the irremediability of mental illnesses, permitting MAID MD-SUMC may have a disproportionate and detrimental impact on Canadians that already experience heightened barriers, marginalization, and inequalities. Similar concerns arise in the context of mature minors, who have consistently been recognized by the courts as an inherently vulnerable group. And the intersection of these two categories—MAID MD-SUMC for mature minors—raises even further concerns.

Any consideration of the *Charter*, and the principles of liberty, equality, dignity, and autonomy, must take into account not only the interests of those patients seeking the option of MAID, but also the ways in which the expansion of MAID may adversely impact the rights of others, as well as other societal interests. Appropriate safeguards and limits surrounding the provision of MAID, which take into full account the actual circumstances of various individuals and groups impacted by the law, can be constitutionally justifiable.[174] And ultimately, even if the *Charter* rights of those seeking MAID expansion *are* limited by legislative safeguards, those rights must be balanced with competing interests and rights under s. 1 of the *Charter*. The Supreme Court has acknowledged that "[c]omplex regulatory regimes are better created by Parliament than by the courts", and a "high degree of deference" will be shown to Parliament in weighing and balancing competing interests.[175]

For these reasons, CLF urges Parliament to, first and foremost, ensure the availability and accessibility of healthcare supports that give Canadians the ability to *live* with dignity. Until comprehensive, diversified, and culturally competent healthcare services are available to *all* Canadians, further expansion of Canada's MAID regime is pre-emptive and risks the lives of patients being ended prematurely, due to patients "choosing" MAID because no other meaningful healthcare options or other basic supports are accessible. There are already heartbreaking stories of this taking place, only some of which have been mentioned in this paper. CLF calls on Parliament to pay due attention to the needs of those who require assistance in *living* by improving palliative care, disability supports, mental health services, and accessible healthcare.

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[173] *R v Latimer*, 2001 SCC 1, [2001] 1 SCR 3 at para 41.
[174] *R v CP*, 2021 SCC 19 (per Wagner CJ): "The inquiry under s. 15(1) of the *Charter* into the perpetuation of a disadvantage requires attention to 'the full context of the claimant group's situation' and to 'the actual impact of the law on that situation' (*Withler*, at para. 43; see also *Taypotat*, at para. 17). The result of this contextual inquiry may in turn be to reveal that differential treatment is discriminatory because it perpetuates disadvantage, that it is neutral, or 'that differential treatment is required in order to ameliorate the actual situation of the claimant group' (*Withler*, at para. 39)."
[175] *Carter v Canada (Attorney General)*, 2015 SCC 5 at paras 98 and 125.

Appendix— About Christian Legal Fellowship

Christian Legal Fellowship ("CLF") is a national charitable association of over 700 lawyers, law students, law professors, retired judges, and others, with members in 11 provinces and territories from more than 40 Christian denominations. Our members are committed to promoting a national and international legal culture of respect for the dignity of all, especially the most vulnerable and marginalized.

CLF is a non-governmental organization in Special Consultative Status with the Economic and Social Council of the United Nations. CLF has appeared before Parliamentary committees and made submissions before provincial governments, regulators, and courts, including on end-of-life issues, freedom of conscience, human rights, and other issues affecting faith communities and their accommodation in a pluralistic society. CLF's work includes seeking to improve decisionmakers' understanding of Canada's international obligations, monitoring Canada's compliance with these commitments, and reporting on our work to the United Nations every four years. CLF continues to monitor and analyze the domestic and international human rights dimensions of Canada's expanding euthanasia regime, as well as the Canadian government's response to COVID-19.

As a public interest intervener in *Carter v Canada, Lamb v Canada,* and *Truchon v Procureur général du Canada*, CLF is well acquainted with the social and legal complexities surrounding Canada's legalization of euthanasia and assisted suicide through medical assistance in dying ("MAID").