

Brief to the House of Commons Standing Committee on Justice and Human Rights Re Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)

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This brief discusses in five subsections why Bill C-7:

- 1)** undermines the balance of Parliament's constitutional obligations under various Charter rights and violates the *International Convention on the Rights of Persons with Disabilities*, mentioned in the preamble to Bill C-7 as a human rights standard Parliament needs to respect;
- 2)** is discriminatory towards persons with disabilities and chronic illness as it infringes on their right to equal protection under the law. It also discriminates based on age, since older persons are disproportionately affected by disability and chronic illness;
- 3)** fundamentally alters health care providers' professional and legal obligations related to the *standard of care* by presenting the ending-of-life as another therapeutic option, without requiring that reasonable options are made available and explored first. In doing so, the Bill moves Canada beyond the most liberal MAiD regimes in the world and fundamentally alters long-standing legal and ethical norms of health care practice;
- 4)** fails to introduce sufficient assessment, data gathering, and monitoring practices;
- 5)** inappropriately cancels the safeguard, embedded in the 10-day wait period, that encourages careful reflection for people whose death is reasonably foreseeable. It thereby also introduces by stealth Advance Requests for MAiD, disrespecting a commitment under the current law for a careful Parliamentary review of the evidence related to this issue.

Introduction

We urge members of Parliament to carefully consider the serious implications of Bill C-7 on Medical Assistance in Dying [MAiD] for the life, health care, and wellbeing of people with disabilities and chronic illness; for how we value the life of people who are older, ill, or disabled; for the integrity of health care and the professional and ethical commitment of health care providers; and ultimately for the state's constitutional obligations to protect life and to do so without discrimination (sections 7 & 15 of the Charter). These concerns, some of which were highlighted in a recent report of the UN Special Rapporteur on the Rights of Persons with Disabilities, are the focus of this brief. They open up the legislation to a Charter challenge based on S. 7 and S. 15 of the Charter.

In the recent report on the Department of Justice online public consultations following the *Truchon* decision, the government states that Canada's MAiD system will "change from a regime that aims to enable people to have a peaceful death rather than a painful or prolonged dying process, to a regime that offers the choice of MAiD to relieve intolerable suffering, regardless of proximity to natural death."¹

The seriousness of this shift, which was never carefully debated in Parliament nor analyzed by the Supreme Court of Canada [SCC], cannot be overemphasized.² As the term suggests, "Medical Assistance in Dying" was originally presented as a means to facilitate a dying process and to allow people to control the manner and timing of dying. Bill C-7 transforms this into a tool to solve suffering in life. Presenting the Bill as offering 'choice to relieve suffering' is rhetorically powerful. Who could be against the relief of intolerable suffering, and even more so when, unlike any medical therapy, it is always 100% effective? But this rhetoric obscures the fact that causing death remains, as recognized in our criminal law, a most serious and irreversible harm, which already disproportionately impacts Canadians who are subject to the Bill's reach. Any state action that imposes an increased risk of death on a person (directly or indirectly) engages the right to life. Accordingly, equal protection must be given deliberate and sober consideration.

The Bill constitutes a prioritization of the liberty for some to end their life with medical and state support, over the rights and interests of others to be protected against premature death, and to have access to health care that supports them in life and addresses their pain and suffering while alive. Simply put, the Bill fails to ensure a proper balance between the different rights and interests at stake. The matter at hand is not only about facilitating an abstract notion of autonomy. It is about ensuring that our laws balance the right to make self-regarding decisions with the responsibility and obligation to protect the right to life and the right to equal protection under the law, particularly for already disadvantaged and marginalized people. It also fails to sufficiently take into consideration the social, economic and health care context that impacts on how persons make autonomous decisions, particularly when faced with the challenges of chronic illness and disability.

The current pandemic context has highlighted the seriousness and complexity of the challenges people and health care providers face when making health care decisions, as well as the disproportionate impact of these challenges on disadvantaged persons. Rather than rushing into a social experiment with the expansion of MAiD as a therapy for

suffering, Parliament should take seriously the issues that emerge from our current MAiD regime, even if this means not immediately responding to a judicial ruling from a Quebec superior court, which only has implications for the status and application of the law in Quebec. If it is indeed concerned about constitutional implications, Parliament should consider asking Cabinet to submit a revised MAiD bill, with strengthened safeguards, for reference to the Supreme Court of Canada.

Turning to each of the five points noted above:

1) The Bill undermines the balance of Charter rights and obligations.

The government claims the Bill is needed in response to the *Truchon* decision which found the restriction to ‘reasonably foreseeable death’ unconstitutional. But the Bill disrupts the balance that the existing law tries to achieve, particularly the balance between the state’s duties to protect the right to life and the right to liberty.

In *Carter*, the SCC explicitly rejected the claims that the “right to life include[s] a right to die with dignity” or the “right to determine whether to take one’s own life.”³ While ruling that an absolute prohibition violated, in certain respects, the right to life, liberty and security of the person, the SCC confirmed that the state continues to have a strong obligation to uphold the right to life. Suicide prevention, avoidance of premature death, and protection of the equal value of the life of persons who are older, ill, or disabled, remain crucial state obligations. Criminal law restrictions and strong safeguards are not constitutionally suspect; they are *essential* to protect the key Charter right to life.

The right to life remains a cornerstone of other rights, as it protects the very existence of the person who can exercise rights. The ‘reasonably foreseeable death’ criterion aims to protect all people regardless of disability, chronic illness, or age, from premature death. While, following *Carter*, facilitating the “passage to death”⁴ through MAiD can be seen as an important tool to allow people to control the timing and manner of death and relieve suffering, going beyond the end-of-life context trivializes the state obligation to protect life. The SCC neither explicitly demanded nor endorsed it.

Following her recent visit to Canada, the United Nations Special Rapporteur on the Rights of Persons with Disabilities already expressed concern about the implementation of Canada’s current MAiD law, and urged for better safeguards.⁵ Her 2019 report to the UN General Assembly further explicitly states that the expansion of MAiD law outside the end-of-life context violates the right to life:

If assisted dying is to be permitted, it must be accompanied by strong measures to protect the right to life of persons with disabilities. First, access to assisted dying should be restricted to those who are at the end of life; having an impairment should never be a reason for assisted dying to be permitted.⁶

The government thus ignores the Special Rapporteur’s expression of concern about applications under the current law, and moves explicitly in the opposite direction, by

removing the essential safeguard of restricting MAiD access to end-of-life, and by diminishing other safeguards. The Bill thereby violates the right to life.

We recommend maintaining the safeguard of restriction to reasonable foreseeable death, or the introduction of another, more precise end-of-life restriction. We further recommend that other safeguards in the current law be strengthened to respect the state’s obligations under sections 7 and 15 of the Charter.

2) The bill discriminates against persons with disabilities and chronic illness

With the removal of the restriction to ‘reasonably foreseeable death’, a state-supported and health care provider organized system of ending-of-life of people who may have years or decades to live is being introduced and indirectly promoted, but only for persons with disabilities or chronic illness. For them, since it is potentially deadly, the system introduces a most troubling form of discrimination. Others will continue to be protected to a greater degree by the restriction of MAiD (and thus third party involvement in a person’s death) to situations where their death is reasonably foreseeable. The Bill thus exposes the law also to a Charter challenge based on S. 15.

The government argues exactly the opposite, i.e. that the Bill addresses discriminatory exclusion from MAiD. But *no SCC decision has ever deemed a restriction of MAiD to be discriminatory*. The Bill’s expansion to all persons who are disabled or chronically ill is based on the questionable finding in *Truchon* that the ‘reasonable foreseeable death’ restriction discriminates against persons with disabilities and chronic illness whose death *is not* reasonably foreseeable, as compared to persons with disabilities and chronic illness whose death *is* reasonably foreseeable.⁷

The SCC has emphasized that a discrimination analysis involves “a flexible and contextual inquiry into whether a distinction has the effect of *perpetuating arbitrary disadvantage*.”⁸ There is, however, no arbitrary, long-standing history of disadvantaging persons with disabilities and chronic illness whose deaths *are not* reasonably foreseeable, as compared to those whose deaths *are* reasonably foreseeable. The trial judge suggested that the restriction perpetuates long-standing stereotypes that persons with disabilities cannot decide for themselves. But this ignores the fact that the restriction applies to all - not only to persons with disabilities and chronic illness - and *is focused on protecting the life of all those who still have years or decades to live*. The judge in *Truchon* failed to appreciate how such a restriction reflects a constitutional duty to protect the equal value of the lives of all Canadians.

In the health care context, the arbitrary and stigmatizing disadvantaging of persons with disability and chronic illness lies precisely in *not* providing adequate accommodation to facilitate living, *not* providing adequate access to care, and in making health care decisions or recommendations for care that devalue the life of people who are ill, disabled or older (e.g. offering MAiD in response to a request for care, or Do-Not-Resuscitate orders). That is the lived experience of many persons with disabilities.

The Bill problematically adds to this historical and systemic disadvantaging of persons

with disabilities by facilitating their premature death, and by depriving them of the protection against premature death that the criminal law will continue to offer to those who are not disabled or chronically ill. While no doubt well intended, it is based on - and further fuels - stereotypes based on misleading and deeply troubling ableist perceptions of the value and tolerability of a life with disability or chronic illness. The fact that some empowered persons with disability or chronic illness have asked for MAiD does not mean that protective measures are constitutionally invalid. Very few equality-promoting and protecting measures would survive constitutional scrutiny if individual preferences are always prioritized over broader interests of a disadvantaged community. On the contrary, protective measures are required to ensure equal protection under the law.

The COVID-19 pandemic's impact reflects the reality of the deep marginalization and disadvantaging of persons with disability and chronic illness in Canada. It has brought to our attention the existence of discrimination and the lack of access to accommodation and care for persons with disabilities, frail older persons and those who are chronically ill. Reports of the situation in long-term care facilities reveal the inequality in access to proper health care. They also reveal how the failure to provide adequate options for home care and supported living directly threatens the life, as well as the physical and mental wellbeing of persons with disabilities or chronic illness and older persons. Pandemic response measures aimed at reducing the transmission of the virus disproportionately impact on people with disabilities and chronic illness, as well as older persons in long-term care facilities. Many have been abruptly deprived of essential support offered by family members or close others.⁹ Stigmatizing and discriminatory attitudes in health care planning are also arguably reflected in pandemic prioritizing plans for access to Intensive care.¹⁰

The pandemic clearly illustrates the need to consider the broader health care and socio-economic context in which persons with disability and chronic illness have to make their decisions. In addition to pointing to the discriminatory nature of enabling the ending of life on the basis of disability, the Special Rapporteur on the Rights of Persons with Disabilities emphasizes that

access to appropriate palliative care, rights-based support, home care and other social measures must be guaranteed; decisions about assisted death should not be made because life has been made unbearable through lack of choices and control.¹¹

3) The Bill fundamentally alters professional obligations related to standard of care

The new Bill relies on an assessment process to ensure that people whose death is not reasonably foreseeable are informed of and have *considered* all other available options. But unlike any other jurisdiction in the world — and less than a handful allow MAiD outside the end-of-life context — the bill will not require that these options are *made available and explored first*. The new Bill thereby fails to treat MAiD as the exceptional, last-resort option the few jurisdictions that allow MAiD rightly consider it to be. In Belgium and the Netherlands--currently the most liberal MAiD jurisdictions--physicians have to agree that there is no other option before providing MAiD.¹² And with reason: unlike other treatment choices, ending a person's life is irreversible and results in what

we, in all other situations, would clearly consider the most serious of harms. Moreover, it can impose a serious emotional and moral burden on health care providers and family members who are asked to provide it or participate in it. Health care providers have to be able to reconcile MAiD with their duty of care.

The SCC in *Carter* and the current law both recognize, at least in principle, the exceptional nature of MAiD practice. The law currently permits that in exceptional circumstances, helping the passage to death can be reconciled with health care providers' duty of beneficence. The law does indeed rely to a significant degree on patients' own determination of the reasonableness of treatment options. But a decision to forgo treatment and asking health care providers to support or facilitate an approaching death is one thing. Asking health care providers to actually end the life of patients who have years or decades to live when, in their professional opinion, several treatment or support options can provide cure and/or relief of suffering, is something very different. The impact of error, the risk of which cannot be excluded, is also clearly so much greater.

There is no other area of medical practice where health care providers can perform an active medical intervention that harms the person or puts the person's life at significant risk, when compared to standard medical interventions that offer a reasonable chance of recovery or relief from pain and suffering. Patients cannot insist that health care providers contribute to procedures that clearly run counter to the professional standard of care and that are not medically indicated. Even if patients insist on using novel, untested drugs or medical devices, for example, health care professionals would rightly be considered in violation of their professional duties if they provide them. With several high-risk medical interventions, patients also only have access if other options are explored first and fail. In other words: making access to some interventions conditional on trying others is not unusual, and seems a most minimal requirement when the intervention is irreversible and results in death.

Actively providing MAiD outside of an end-of-life context cannot be compared to non-interference when a patient refuses an intervention. Patients can always refuse treatment (even if the outcome is the patient's death), but this is based on the combination of two legal/ethical principles: the patient's right to make self-regarding medical decisions; and the prohibition against physically invading a person's body without consent (which constitutes assault).¹³ A patient's right to refuse treatment cannot fundamentally alter the *standard of care* in terms of the reasonableness of treatment options identified by the health care provider.

We therefore recommend as an essential safeguard, if Parliament lifts the restriction of reasonable foreseeable death, that all reasonable treatment options have to be made available and explored first. This does not affect the right of patients to refuse treatment.

The risk to the doctor-patient relation, in which the duties of beneficence and non-maleficence are central, is exacerbated by the suggestions that have been made by some who advocate for broad access to MAiD that physicians always have an obligation to raise MAiD as a clinical option (as if it were like any other evidenced-based medical treatment) with all people who *may* qualify under the law. On what basis could a

physician ever assert that a patient's condition would clinically improve with death? Clearly, a physician could never make such an assertion, therefore MAiD as a treatment option is exceptional and distinct from every other treatment option within the standard of care.

If the duty to introduce MAiD as option applied outside the end-of-life context, the new law could result in any person with disability and chronic illness, including older persons, being systematically counselled about MAiD. Those who assert that this inherently constitutes patient empowerment and promotes choice ignore the stigmatizing nature of such offers, and the potential impact of such counselling, taking into consideration the health-care provider-patient imbalance of power and knowledge. A person with a disability or chronic illness being offered death as therapy while having years or decades of life ahead- without having asked for it - is stigmatizing, taints the health care provider-patient relation, and risks creating undue pressure. Physicians who know that there are reasonable treatment options for their patient have as part of their professional duty the obligation to instill hope and support resilience in patients to promote their health and wellbeing - not stimulate a desire to die. Offering MAiD to a patient who has not raised it could effectively contribute to suicide. There is already anecdotal evidence, revealed to us by medical practitioners and family members, that patients may interpret an offer of MAiD by their trusted health care provider as an indication that their suffering will be intolerable and that MAiD is the recommended way out.

The government is obligated to protect vulnerable persons from being induced to end their lives. As part of MAiD practice, health care providers have an obligation to assess individual vulnerability. Given the power and knowledge differentials, health care providers who raise MAiD as an option to end the suffering of patients who have not expressly requested MAiD operate as a potential source of vulnerability, a vulnerability they are simultaneously tasked with assessing. Legally this is untenable.

We therefore recommend the introduction of an explicit provision in the Bill that health care providers should not offer MAiD when other clinically indicated treatment options exist; and that MAiD dialogue should only be triggered upon explicit patient request.

4) The safeguards in the existing legislation and in the new Bill are not sufficient.

As mentioned - restriction to end-of-life, triggering MAiD dialogue only on the basis of a patient's explicit request, imposing an obligation to make all other reasonable options available and have them explored first - constitute essential safeguards to protect patients and the integrity of the health care professions. But other safeguards are also essential, and become more so if Parliament decides to accept that MAiD is to be offered outside the end-of-life context. We discuss some of the safeguards in the Bill here:

The 90-day assessment period for people whose death is not reasonable foreseeable

Some have suggested that the 90-day assessment period for people whose death is not reasonably foreseeable is too long. We believe the 90-day period is insufficient to ensure that patients confronted with life-changing, catastrophic disability or chronic illness are given a significant chance to recover and to learn how to cope with these changes.

Some examples put this time frame in perspective:

- Treatment and rehabilitation for spinal cord injuries is a long-term process, involving multiple health care providers and interventions spread over months and years.¹⁴ People who experience such a life altering injury could obtain MAiD before treatment and rehabilitation start providing hope.
- Wait time for various specialized mental health care often exceeds 90 days.¹⁵ And as we are currently experiencing, wait times are significantly extended in a pandemic context. People with disability and chronic illness are disproportionately suffering from mental health issues. The new Bill all-too-easily presumes that mental health reasons underling a request to die will be identified properly by non-specialists and addressed in a 90-day period.
- Many people with disability and chronic illness need specialized long-term care, but people waited 126 days on average in Ontario in 2018-2019, for example, to have access to it.¹⁶ Adequate home care or supported living, preferred by most people with disabilities and safer in a pandemic context, are not or are insufficiently available in several provinces.
- The median wait time for access to specialized pain clinics was around 5.5 months in 2017-18, with some persons waiting up to four years,¹⁷ making it faster to obtain MAiD than to receive pain treatment.

These examples highlight the danger of relying on a 90-day assessment period as a tool to respond to the concerns raised by expanding MAiD to persons with disabilities and chronic illness. It also confirms the importance of our recommendations that all reasonable treatment options be made available and explored first, should the reasonable foreseeable death criterion not be maintained; and that other safeguards need to be strengthened.

Reporting and Monitoring: Need for Strengthening

We support the recommendations of the Vulnerable Person Standard group with respect to the need for more detailed reporting and monitoring of MAiD practice. A document submitted in response to Bill C-7 makes detailed recommendations with respect to the need for more thorough federal data gathering and monitoring than what is currently being undertaken across the country in various provinces.¹⁸ We endorse the recommendations for standard setting by the federal government under the federal criminal law power. Better mandatory reporting and monitoring as part of the criminal law-based regulation of MAiD is essential to respect the state's obligation to protect the right to life and to prevent discrimination.

5) The 10-day Reflection Period and Confirmation of Consent should be maintained

The Bill's proposal to diminish the already limited safeguard of a 10-day reflection period is problematic and requires further discussion. The removal of this reflection period is not at all required in response to *Truchon*. We note that this requirement is already flexible under the current law and that the waiting period can be waived, as has already been frequently done, when incapacity is imminent. But the principle remains

important and corresponds with the SCC's insistence on 'clear consent'.

Many people, disproportionately persons with disabilities and older persons, suffer from loneliness and isolation, which is amplified by the COVID-19 pandemic. Some are giving up on life because of the context in which they find themselves. Decisions about end-of-life (whether to accept or forgo treatment; whether to opt for MAiD or not) tend to be characterized by uncertainty, doubt, ambiguity, and decisional fluctuations. It seems unconscionable that Parliament would remove, particularly at a time of crisis in long-term care, a safeguard that may prevent, for example, an isolated older person requesting and receiving MAiD without loved ones or close others even being able to physically meet with the person or be given the time to explore alternatives that could instill a renewed desire to live.

We further note that some have argued that a flexible interpretation of the 'reasonably foreseeable death' criterion, combined with the abolishing of the need to reconfirm consent after 10 days, would now permit the use of an advance request for people with a diagnosis of Alzheimer's disease who want to have their life ended at some point in the future when they will no longer be capable of decision-making.

We find it concerning that the government hereby introduces Advance Requests [AR] for MAiD by stealth, when the current law explicitly requires parliament to study it in detail. The government asked the Council of Canadian Academies [CCA] to organize a review of AR for MAiD for that very purpose. The report of the CCA Subcommittee on AR for MAiD documents the evidence and the ethical and legal dilemmas ARs for MAiD raise.¹⁹ Only 4 jurisdictions explicitly allow AR for MAiD, three of which only allow it to be performed when a person has become permanently unconscious or is imminently dying. Only one country allows it for people who are conscious and not imminently dying, as Bill C-7 does.²⁰ It is rarely used and when it has, it has often evoked serious controversy. Ending the life of a person in those circumstances violates in our opinion the *International Convention on the Rights of Persons with Disabilities*.²¹

Bill C-7 reflects some realization of the concerns raised in relation to reported cases in the Netherlands of people who made an AR for MAiD but then physically resisted the MAiD procedure while lacking capacity.²² Bill C-7 indicates that a health care provider can only provide a substance to cause death if "the person does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration" (S. 3.2(c)). But the Bill completely undermines this requirement by introducing in S. 3.3 "For greater certainty, involuntary words, sounds or gestures made in response to contact *do not* constitute a demonstration of refusal or resistance for the purposes of paragraph (3.2)(c)." This provision clearly removes the already limited protection offered by S.3.2(c). A person who is performing a life-ending procedure of a now incapacitated person can *always* easily conclude that the words, sounds, or gestures were involuntary, since a finding of incapacity overlaps with a finding of lack of voluntariness. The Bill will thus disturbingly allow health care providers to end the life of patients who physically and in sound or words resist and are deemed no longer capable of decision-making, by facilitating a conclusion that the persons' resistance to the procedure to end her life is involuntary.

Nothing in the *Truchon* decision requires the 10-day reflection period to be abolished. Parliament should take the time to study the difficult legal and ethical challenges raised by AR for MAiD in detail, as it is required to do by law. The government commissioned the CCA Expert Committee's reports for that very reason. Including AR for MAiD by stealth in this bill is inappropriate.

We recommend that Parliament maintain the 10-day reflection period by removing s. 1.5.

We recommend that Parliament comprehensively study the ethical and legal challenges raised by Advance Requests for MAiD including the evidence as detailed in the Council of Canadian Academy Report, prior to making a decision on the introduction of AR for MAiD.

If Parliament removes the 10-day reflection period (and thus maintains s. 1.5 of the Bill), we recommend that s. 3.3 is replaced by: "For greater certainty, any word, sound or gesture that may reflect a demonstration of refusal or resistance to the MAiD procedure should result in a halting of the procedure."

List of Recommendations

- 1) The restriction of MAiD to situations of reasonable foreseeable death should be maintained or another more precise restriction to end-of-life should be introduced. Other safeguards in the current law should be strengthened to respect the state's obligations under sections 7 and 15 of the Charter.
- 2) If the restriction to end-of-life is not maintained, Bill C-7 should include a requirement that all reasonable treatment options have to be *made available and explored first*, and not just considered. This does not affect a patient's right to refuse treatment.
- 3) Bill C-7 should introduce a provision that health care providers should not be allowed to offer MAiD when other clinically indicated treatment options exist. MAiD dialogue should be triggered only by explicit patient request.
- 4) We endorse the recommendations by the Vulnerable Person Standard for more comprehensive assessment, monitoring, and data gathering standards, to be developed under the federal criminal law power.
- 5) Bill C-7 should not abolish a 10-day reflection period; s. 1(5) should be removed.
- 6) Parliament should comprehensively study the ethical and legal challenges raised by Advance Requests for MAiD, including the evidence as detailed in the Council of Canadian Academy Report, prior to making a decision on the introduction of AR for MAiD.
- 7) If Parliament removes the 10-day reflection period (and thus maintains s. 1.5 of the Bill), section should 3.3 read: "For greater certainty, any word, sound or gesture that could reflect a demonstration of refusal or resistance to the MAiD procedure should result in a halting of the procedure."

¹ Department of Justice, *What We Heard Report: A Public Consultation on Medical Assistance in Dying* (2020) online: <https://www.justice.gc.ca/eng/cj-jp/ad-am/wwh-cqnae/index.html>.

² The government has frequently invoked broad public support to justify its shift with Bill C-7. But public support is obviously a very poor justification for measures that infringe on human rights. Worth noting is that the public consultation was based on a questionnaire which started from the premise of broader access to MAiD outside the end-of-life context. In addition, the online consultation system had no measures in place to ensure representation validity. As such, the questionnaire is also a very weak basis for claiming public support.

³ See the discussion of these claims in *Carter v Canada (AG)* 215 SCR 331 at par. 59-62 [*Carter*]. See also Karine Millaire, “Le concept d’autonomie dans l’arrêt *Carter c. Canada* : Au-delà du libre-choix” (2017) 63:2 McGill L Rev 283 at 302.

⁴ *Carter*, supra note 1 at par. 63.

⁵ UN Special Rapporteur on the Rights of People with Disabilities, “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” (12 April 2019) online:

<https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=24481&LangID=E>; Canada ratified The Convention on The Rights of Persons with Disabilities (A/RES/61/106) in 2010 and acceded to the Optional Protocol in 2018, online: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

⁶ United Nations, General Assembly, Report of the Special Rapporteur on the Rights of Persons with Disabilities, Human Rights Council, 43rd session A/HRC/43/41, at para. 70 (references omitted); online: <https://undocs.org/en/A/HRC/43/41>

⁷ Trudo Lemmens & Laverne Jacobs, “The latest medical assistance in dying decision needs to be appealed: Here’s why” (9 October 2019), *The Conversation*, online:

<https://theconversation.com/the-latest-medical-assistance-in-dying-decision-needs-to-be-appealed-heres-why-124955>.

⁸ *Quebec (Attorney General) v. A*, [2013] 1 S.C.R. 61 at para. 331 [our emphasis]

⁹ Canadian Foundation for Health Care Improvement, *Better Together: Re-Integration of Family Caregivers as Essential Partners in Care in a Time of COVID-19* (Canadian Foundation for Health Care Improvement: Ottawa, 2020) online: https://www.cfhi-fcass.ca/docs/default-source/itr/tools-and-resources/bt-re-integration-of-family-caregivers-as-essential-partners-covid-19-e.pdf?sfvrsn=5b3d8f3d_2

¹⁰ See Chief Commissioner Ena Chadna, “Letter to the Minister of Health on Bioethics Table recommendations and proposed framework for a COVID-19 Triage Protocol” (Ontario Human Rights Commission, 30 October 2020) online: http://www.ohrc.on.ca/en/news_centre/letter-minister-health-bioethics-table-recommendations-and-proposed-framework-covid-19-triage; Robert Latanzio et al. *ARCH Disability Law Centre Submissions and Recommendations Regarding Ontario’s Triage Protocol Draft dated July 7, 2020* (20 July 2020) online: <https://archdisabilitylaw.ca/wp-content/uploads/2020/08/MASTER-Triage-Protocol-Submissions-FINAL-D.pdf>

¹¹ United Nations, General Assembly, Report of the Special Rapporteur on the Rights of Persons with Disabilities, Human Rights Council, 43rd session A/HRC/43/41, at para. 70 (references omitted). For discussion of meaningful choice and Canada’s obligations with respect to palliative care and the right to the enjoyment of the highest attainable standard of health under the International Covenant on Economic, Social and Cultural Rights (which entered into force in Canada in 1976) see, Mary J Shariff, “Navigating Assisted Death and End-of-Life Care” CMAJ April 05, 2011 183 (6) 643-644, <https://www.cmaj.ca/content/183/6/643>; and Yude M Henteleff, Mary J Shariff & Darcy L MacPherson, “Palliative Care, An Enforceable Canadian Human Right” (2011) 5(1) McGill Journal of Law and Health 107.

<https://mjlmcgill.files.wordpress.com/2017/07/mjlm-vol-v-no-1-shariff.pdf>.

¹² Belgium and the Netherlands, two jurisdictions often put forward as models for Canada, and reviewed in *Carter*, require physicians to determine that there is no medical option left and no reasonable alternative. In Belgium, the law requires physicians to determine that the situation is medically hopeless and that there are no other ways to alleviate suffering. In the Netherlands, they have to determine that there is no prospect of improvement, and no reasonable alternative. While there is ongoing discussion about how to reconcile the right to refuse treatment with the physician's obligation to determine whether there are other options, access to MAiD is explicitly stated to be a last resort; and physicians have to agree there is no reasonable option left. There is no systemic obligation to provide MAiD if physicians conclude there are other options, and no right to insist to have MAiD performed. See Trudo Lemmens, "Charter Scrutiny of Canada's Medical Assistance in Dying Law and the Shifting Landscape of Belgian and Dutch Euthanasia Practice" (2018) 85 *Supreme Court Law Review* (2nd) 453 at 471-472.

¹³ The Expert Panel Working Group on Advance Requests for MAiD, Council of Canadian Academies, *The State of Knowledge on Advance Requests for Medical Assistance in Dying*. (Ottawa, ON: Council of Canadian Academies, 2018) at 38-39, online: <https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf>; Sonu K. Gaiid *et al.*, *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 Report* (26 March 2020) (Toronto, Expert Advisory Group on Medical Assistance in Dying, 2020) at 22-23 & 27-29 online <https://www.eagmaid.org/report>

¹⁴ Kemal Nas *et al.* "Rehabilitation of spinal cord injuries" (2015) 6 *World J Orthop* 8

¹⁵ Rachel Loebach & Sasha Ayoubzadeh, "Wait times for psychiatric care in Ontario" (2017) 86 *UWOMJ* 48. See also: <https://www.cbc.ca/news/canada/kitchener-waterloo/wait-times-for-some-mental-health-services-up-to-a-year-long-in-waterloo-wellington-1.5441205>

¹⁶ Health Quality Ontario, "Wait Times for Long-term Care Homes" online: <https://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance/Wait-Times>

¹⁷ Canadian Pain Task Force, *Chronic Pain in Canada: Laying a Foundation for Action – A Report by the Canadian Pain Task Force*, (Ottawa: Minister of Health, 2019) at 18-19. Online <https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2019.html#a2.7>

¹⁸ Advisors to the Vulnerable Person Standard, "Failing People with Disabilities Who Experience Systemic Suffering: Gaps in the Monitoring System for Medical Assistance in Dying" (October 2020). Online:

<https://static1.squarespace.com/static/56bb84cb01dbae77f988b71a/t/5f90666476d4f07d2c0233dc/1603298916667/MAiD+Monitoring+-+Failing+People+with+Disabilities+-+Final.pdf>

¹⁹ The Expert Panel Working Group on Advance Requests for MAiD, Council of Canadian Academies, *supra* note 13.

²⁰ See the overview in *ibid.* at 74-115.

²¹ For example, in the Netherlands, the only country that allows AR for MAiD to be used with people who are conscious but incapable of decision making even, some people with Alzheimer's disease have been surreptitiously sedated prior to receiving a final injection. The Dutch High Court has further affirmed the legality of continuing a MAiD procedure even when a patient physically resists. Both practices constitute a violation of art. 12 (equal recognition before the law) of the International Convention of the Rights of Persons with Disabilities.

²² See the discussion in The Expert Panel Working Group on Advance Requests for MAiD, Council of Canadian Academies, *supra* note 13 at 127-133. See also David G. Miller *et al.*, "Advance Euthanasia Directives: A Controversial Case and Its Ethical Implications" (2019) 45 *Journal of Medical Ethics* 84.