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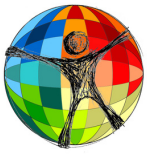
Autonomy & Expanded Access to Medical Assistance in Dying in Canada's Bill C-7: Moving Towards Substantive Liberty

Chloe Rourke

McGill Centre for Human Rights and Legal Pluralism



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ABSTRACT

This paper critically examines the impacts of expanding access to medical assistance in dying (MAID) to include individuals not close to death in Canada's Bill C-7, with a particular focus on individuals whose sole underlying condition is mental illness, and on the relationship between MAID and suicide prevention.

Part I examines the evolution of medical assistance in dying in Canada and the dialogue between the judiciary and legislative branches. It analyzes the justifications for decriminalizing access to MAID as outlined in the landmark court decisions *Carter* and *Truchon*. Part II analyzes the eligibility criteria and safeguards outlined in Bill C-7 through a critical disability perspective and a capabilities-based human rights framework. It also reflects on the potential societal impacts of expanding access to MAID drawing on data from Canada and from other jurisdictions. Part III outlines three different approaches to advancing MAID in Canada: a restrictive approach, a discretionary approach, and an emancipatory approach and considers how they support or limit the rights of people with disabilities. Finally, this paper interrogates the concept of autonomy in the context of MAID and advances the argument made by other scholars that judicial analyses of section 7 of the *Canadian Charter* must evolve from one of formal to substantive liberty.

CONTENTS

ACKNOWLEDGMENTS

I want to thank my friends, family, and colleagues for patiently listening and sharing their insights during the writing of this paper, particularly those who shared their own personal experiences. These conversations helped shape my own position and are reflected in my analysis. I would like to especially thank Jewelles Smith, whose mentorship during my internship at the Council for Canadians with Disabilities has challenged me to question my understanding of disability several times over.

INTRODUCTION

Bill C-7 expanded access to Medical Assistance in Dying (MAID) in Canada to individuals who are not close to death and provided additional safeguards for this population.[1] It also included a temporary exclusion for people whose sole underlying condition is mental illness to allow time for additional consultations and drafting of safeguards for this population.[2] However on March 17, 2023, the exclusion will expire and Canada will become one of only a few states in the world that provides MAID for mental illness.

Bill C-7 has faced staunch opposition from disability rights organizations and advocates in Canada and internationally.[3] They view the reasonably foreseeable death criterion as an essential safeguard and are primarily concerned that people with disabilities who are structurally vulnerable will seek MAID in the absence of other meaningful options to address their suffering and live a dignified life.[4] As they see it, the government is providing the option to die without first providing people with disabilities the resources that they need to live a full and meaningful life.[5] There

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[1] Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2021 (assented to 17 March 2021). MAID applicants whose death are not reasonably foreseeable are sometimes referred to as "Track 2" applicants because they must meet additional requirements.

[2] See *ibid*.

[3] See "Open Letter: Bill C-7 is not the answer," (23 February 2021), online: *Canadian Society of Palliative Care Physicians* <www.vps-npv.ca/stopc7>, which was signed by over 130 organizations.

[4] See Council of Canadians with Disabilities, "Bill C-14 Does Not Go Far Enough to Protect Vulnerable Canadians" (15 April 2016), online: *CCD Online* <www.ccdonline.ca/en/humanrights/endoflife/media-release-C14-15April2016> [CCD, "Not Far Enough"]. See also Jennifer Johannesen, "Why Bill C-14 must include the 'reasonably foreseeable death' clause" (17 June 2016), online: <johannesen.ca/2016/06/bill-c-14-must-include-reasonably-foreseeable-death-clause/>.

[5] See Inclusion Canada, ARCH Disability Law Centre and Inclusion International, "COSP 15 Side Event – Canary in a Coalmine: The Expansion of Medical Assistance in Dying/Euthanasia in Canada" (last visited 22 August 2022), online (video): *YouTube* <www.youtube.com/watch?v=HWujXGgZVa4&ab_channel=InclusionCanada>.

is anecdotal evidence to substantiate their concerns: stories of individuals who have sought out and been approved for MAID and whose suffering stems largely from poverty, inadequate housing, and a lack of access to specialized treatments and support for independent living.[6] They also worry that individuals, especially people with mental illness, will access MAID out of desperation or in a period of crisis.[7] Finally, they argue that Bill C-7 devalues disabled lives by framing a life with a disability as a life worse than death, thereby perpetuating ableism and legacies of eugenics.[8]

Proponents of MAID argue that it is critical to dignity and autonomy. They believe that robust safeguards can effectively prevent people from accessing MAID during a period of crisis. They argue that there is considerable public misconception regarding access to MAID, and that the evaluation process is rigorous.[9] Furthermore, they argue that the existence of structural vulnerability may not in itself be a valid reason to deny a person access to MAID if they are competent and able to consent. Some disability scholars, like Margrit Shildrick, contend that if we want people with disabilities, including people with mental illness, to have the same rights as everyone else in society, this should include the right to a dignified death on their own terms.[10]

Providing MAID for mental illness raises additional ethical and legal questions. While some medical associations have endorsed providing MAID for this population under specific

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[6] See Avis Favaro, "Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing", *CTV News* (14 April 2022), online: <www.ctvnews.ca/health/woman-with-chemical-sensitivities-chose-medically-assisted-death-after-failed-bid-to-get-better-housing-1.5860579>; Charlie Fidelman, "Saying goodbye to Archie Rolland who chose to die: 'It is unbearable' ", *Montreal Gazette* (21 October 2015), online: <montrealgazette.com/news/local-news/saying-goodbye-to-archie-rolland>. Notably, Archie Rolland was accepted for MAID under the previous MAID regime prior to Bill C-7.

[7] See Council of Canadians with Disabilities, *supra* note 4.

[8] See *ibid;* Inclusion Canada, *supra* note 5. *Ableism* is prejudice or discrimination towards people with disabilities.

[9] See Dying with Dignity Canada, "Bill C-7: Myths and Facts" (last visited 22 August 2022), online: <www.dyingwithdignity.ca/bill_c7_myths_and_facts>.

[10] See Margrit Shildrick, "Death, debility and disability" (2015) 25:1 Feminism and Psychology 155.

conditions, many clinicians are staunchly opposed to it.[11] They argue that it is in contradiction with their role to provide treatment, support, and hope during suffering.[12] The categorization of mental illness as irremediable is also highly controversial. Many argue this cannot be reliably predicted.[13] There is significant fear that providing access to MAID for mental illness will undermine recovery and suicide prevention efforts. Clinicians and disability advocates alike worry individuals who could have recovered or found other means to alleviate their suffering will access MAID during a period of crisis.[14] While many of these concerns are not exclusive to people with mental illness, they are elevated for this sub-population due to concerns about the effects of mental illness on a person's decision-making capacity. However, by relying on the discretion of medical practitioners to limit access, Bill C-7 also undermines the autonomy of people with mental illness. It perpetuates medical paternalism and the ongoing discrimination against people with mental illness that has unjustly prevented them from exercising basic human rights. This highlights a critical and thorny tension for disability rights organizations. While disability rights advocates continue to push for the unrestricted recognition of the legal capacity and autonomy of persons with disabilities, doing so also weakens a key mechanism that purportedly protects vulnerable populations: the capacity assessment.

This paper critically examines the impacts of expanding access to MAID to include individuals not close to death, with a particular focus on individuals whose sole underlying condition is mental illness and the relationship between MAID and suicide prevention. Part I examines the evolution of medical assistance in

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[11] See Association des Médecins Psychiatres du Québec, "Access to medical assistance in dying for people with mental disorders" (2020), online: <ampq.org/acces-a-laide-medicale-a-mourir-personnes-atteintes-de-troubles-mentaux/>; Council of Canadian Academies, "The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition" (2018), online (pdf): <cca-reports.ca/reports/medical-assistance-in-dying/>.

[12] See Sisco van Veen, Andrea Ruissen & Guy Widdershoven, "Irremediable Psychiatric Suffering in the Context of Physician-assisted Death: A Scoping Review of Arguments" (2020) 65:9 Can J Pscyhiatry 593.

[13] See Karandeep Sonu Gaind, "What Does "Irremediability" in Mental Illness Mean?" (2020) 65:9 Can J Psychiatry 604.

[14] See e.g. Council of Canadians with Disabilities, *supra* note 4.

dying in Canada and the dialogue between the judiciary and legislative branches. It analyzes the justifications for decriminalizing access to MAID as outlined in the landmark court decisions *Carter* and *Truchon*. Part II analyzes the eligibility criteria and safeguards outlined in Bill C-7 through a critical disability perspective and a capabilities-based human rights framework. It also reflects on the potential societal impacts of expanding access to MAID drawing on data from Canada and other jurisdictions. Part III outlines three different approaches to advancing MAID in Canada: a restrictive approach, a discretionary approach, and an emancipatory approach, and then it considers how they support or limit the rights of people with disabilities.

In this paper, I deliberately reject the supposition that MAID is entirely distinct from suicide. I do not mean to imply that physician-assisted dying and suicide are qualitatively similar experiences. They are not. However, I reject the conclusion drawn by the Court in *Truchon* that the reasons driving individuals to request MAID are categorically different than individuals who attempt suicide or that they can be reliably and objectively distinguished from one another once the end-of-life requirement is removed. The outcome is also the same: premature death by choice. In framing my paper in this way, I aim to provide a more honest depiction of the reality of people seeking relief from suffering in death, and to accurately position the stakes involved. My analysis also aims to dismantle assumptions embedded in the biomedical model and to interrogate the categorization of pathology, in particular psychopathology. Nonetheless, I have chosen to use layperson terms such as mental or psychiatric illness, while recognizing there are particular values embedded in them.

I am conscientious that a diversity of perspectives exists on MAID both inside and outside of the disability community. It engages important medical, social, and existential questions about the role of the government and medical institutions in facilitating access to death. While presenting my analysis of this controversial issue, I want to recognize the validity of the lived experiences of individuals requesting MAID. Their suffering is real and their right to autonomy and dignity must not be understated.

I. EVOLUTION OF MAID JURISPRUDENCE & LEGISLATION

Development of MAID Legislation in Canada

Medical assistance in dying (MAID), also referred to as physician-assisted dying, euthanasia, or assisted suicide, is legal in several countries around the world. Whereas some countries such as Belgium and the Netherlands have legalized access to MAID decades ago, it has only recently become legal in many jurisdictions.[15] Overall, there is a trend towards legalization and more jurisdictions can be expected to legalize MAID in the coming years. In many jurisdictions, such as Canada, legislation was prompted by court decisions declaring the criminalization of assisted dying to be unconstitutional and in violation of protected rights.[16] Consequently, legislatures were left to grapple with how to implement these court decisions and design effective regulatory frameworks that determine access to MAID. Many states have specific eligibility criteria designed to limit access to MAID.[17] With Bill C-7, Canada has become one of the most permissive MAID regimes in the world and is viewed by some as a "leader" in the development of MAID.[18]

Decriminalizing Medical Assistance in Dying: Bill C-14

In *Carter v. Canada,* the Supreme Court of Canada affirmed that a blanket prohibition against physician-assisted dying was unconstitutional and in violation of section 7 of the *Charter*—the right to life, liberty, and security of person.[19] The Supreme Court affirmed that capable adults with grievous and irremediable medical conditions causing intolerable suffering should be able to

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[15] See Julia Nicol, "Medical Assistance in Dying: The Law in Selected Jurisdictions Outside Canada" (2021), online: *Library of Parliament* <lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/2015116E>.

[16] See *Carter v Canada (Attorney General),* 2015 SCC 331 [*Carter*].

[17] See Nicol, *supra* note 15.

[18] See *ibid*.

[19] See *Carter*, *supra* note at para 16.

consent to physician-assisted death.[20] In response, the Trudeau government passed Bill C-14 in June 2016 authorizing MAID for capable adults. Bill C-14 required specific eligibility criteria to be met to qualify for access to MAID. Individuals must have a grievous and irremediable medical condition and be capable of providing consent. Bill C-14 included multiple safeguards to ensure informed consent and prevent abuse and an eligibility criterion that the person's death be "reasonably foreseeable."[21] The reasonably foreseeable death requirement was not outlined in *Carter*, but it was viewed by many in the disability community as essential as they believed that the other safeguards in Bill C-14 would not effectively protect structurally vulnerable individuals.[22] It was also intended to be interpreted flexibly in recognition that "some medical conditions may cause individuals to irreversibly decline and suffer for a long period of time before dying."[23]

Elimination of Reasonably Foreseeable Death Criterion

The reasonably foreseeable death criterion was challenged by two individuals, Jean Truchon and Nicole Gladu, in *Truchon v. Procureur Général (Canada)*.[24] Both applicants met the other criteria for a grievous and irremediable medical conditions and were determined to be capable of consenting, however their natural deaths were deemed not reasonably foreseeable.[25] Consequently, they were ineligible for MAID under Bill C-14. In this 2019 decision, the Superior Court of Quebec invalidated the reasonably foreseeable provision, prompting the drafting and approval of Bill C-7, which eliminates the eligibility requirement of a reasonably foreseeable death and adds additional safeguards.[26] Bill C-7 provides access to MAID to demographics

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[20] See *ibid*.

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

[22] See CCD, "Not Far Enough", *supra* note 4. See also Johannesen, *supra* note 4.

[23] Department of Justice, "Legislative Background: Medical Assistance in Dying (Bill C-14)" (last visited 22 August 2022), online: *Government of Canada* <www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/p2.html/>.

[24] *Truchon c Procureur général du Quebec*, 2019 QCCS 3792 [*Truchon*].

[25] See *ibid*.

[26] Bill C-7, *supra* note 1.

who were not eligible under the previous regime including people whose sole underlying condition is psychiatric illness. The medical and academic community is divided over Bill C-7, and, in particular, over whether providing MAID for mental illness is normatively desirable.[27]

Temporary Exclusion for Mental Illness

Due to concerns raised about providing access to MAID for mental illness, Bill C-7 included a temporary exclusion for people with mental illness to provide time for additional consultations and safeguards to be developed. In May of 2022, Health Canada published a report produced by an expert panel proposing modifications to the current MAID regime for people with mental illness including the interpretation of grievous and irremediable medical condition and assessing capacity in the context of mental illness.[28] Notably, the report affirms that all applicants whose deaths are not reasonably foreseeable (i.e. "Track 2" applicants) would benefit from additional safeguards, not just people with mental illness.[29] The temporary exclusion expires in March 2023, at which point people with mental illness will be able to request access to MAID.[30] This will make Canada one of a few jurisdictions in the world to permit access to MAID for psychiatric conditions.[31] The criteria and safeguards outlined by Canada will thus set an important precedent for the development of MAID legislation in other jurisdictions that may eventually follow.

Jurisprudential Analysis

Courts have played a central role in legalizing access to MAID. The reasoning in landmark decisions such as *Carter* and *Truchon* has greatly influenced the development of MAID legislation in Canada. In reviewing the jurisprudence, the

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[27] Council of Canadian Academies, *supra* note 11.

[28] See Health Canada, "Final Report of the Expert Panel on MaiD and Mental Illness" (2022), online: Government of Canada <www.canada.ca/en/health-canada/news/2022/05/final-report-of-the-expert-panel-on-maid-and-mental-illness.html>.

[29] See *ibid* at 12.

[30] Bill C-7, *supra* note 1.

[31] See Ashley Ferguson, "Global Perspective: A Cross-Jurisdictional Look at Medical Assistance in Dying" (2016) 40:6 LawNow 7; Nichol, *supra* note 15.

following themes emerged: the centrality of individual dignity and autonomy, the Court's rejection of categorical prohibitions to protect vulnerable persons, and a shifting characterization of MAID with respect to suicide. With respect to the third theme, I will also analyze the reasoning provided in an earlier Supreme Court decision, *Rodriguez v. British Columbia (Attorney General)*, in which a divided bench considered the rights engaged in MAID over two decades prior to *Carter*.[32]

Dignity, Autonomy and section 7 Analysis

In both *Carter* and *Truchon*, dignity and autonomy feature predominantly in the Courts' section 7 analysis of the individual right to liberty and security:[33]

> An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The prohibition [of medical assistance in dying] denies people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenches on their liberty. And by leaving them to endure intolerable suffering, it impinges on their security of the person.[34]

The Court states that the "right to life" does not equate to a "duty to live" and points to a large body of jurisprudence that affirms the right to bodily autonomy, including the rights of individuals to make decisions regarding their bodily integrity without state interference, even when such decisions offend society's morals or lead to death.[35] *Truchon* draws similar conclusions relying on the reasoning outlined in *Carter*.

Dignity and autonomy are also cited consistently by proponents of MAID to justify its legalization.[36] Dignity and autonomy are complex legal constructs. They are inherent to personhood and human rights and they are inviolable, indivisible,

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[32] *Rodriguez v British Columbia (Attorney General),* [1993] 3 SCR 519, 107 DLR (4th) 342 [*Rodriguez*].

[33] *Canadian Charter of Rights and Freedoms,* Part 1 of the *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

[34] See *Carter*, *supra* note 16 at para 335.

[35] See *ibid* at paras 63–67.

[36] For example, Dying with Dignity Canada is an organization that advocates for access to MAID.

unconditional, and interconnected with the value and worthiness of life.[37] People with disabilities have fought for the recognition of their right to autonomy and to exercise rights on an equal basis with non-disabled people.[38] However, there is minimal analysis in both *Carter* and *Truchon* regarding structural factors that shape and constrain how people with disabilities are able to exercise their autonomy in society and how this may interact with a more permissive MAID regime.

Rejection of Categorical Prohibitions to Protect Vulnerable Persons

In *Carter*, the Court acknowledges that the objective of the prohibition of MAID is valid, namely, to protect vulnerable persons from being induced to end their lives in a moment of crisis. However, they conclude that a total prohibition is overbroad.[39] The Court determines the goal of "protecting people from themselves" is insufficient to justify the violation of section 7 rights of the applicant and other individuals in similar situations.[40] They also conclude that adequate regulatory safeguards can achieve the objective of protecting vulnerable persons without trenching on the liberty and security of individuals suffering from a grievous and irremediable medical condition who are capable of consenting.[41]

A similar conclusion is drawn in *Truchon*, where the Court determines that categorically excluding individuals who are not at "end of life", but who otherwise meet the requisite criteria for MAID, is overbroad and disproportionately violates the rights of individuals such as the applicants.[42] The Court emphasizes Canada's rigorous assessment process and its efficacy in

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[37] See Lucy Michael, "Defining Dignity and its Place in Human Rights" (2014) 20:1 New Bioethcis 12.

[38] See *Convention on the Rights of Persons with Disabilities*, 24 January 2007, UNTS 61 106, online: <www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> [CRPD].

[39] *Carter*, *supra* note 16 at 336.

[40] See *ibid* at paras 335–36.

[41] See *ibid*.

[42] See *Truchon*, *supra* note 24 at paras 577–85.

regulating access to MAID.[43] They conclude that physicians can reliably assess capacity to prevent vulnerable persons from accessing MAID in a moment of crisis.[44] Similarly, Colleen Shepherd and Derek Jones argue that categorically excluding people with mental illness from accessing MAID is over-inclusive and that individualized case-by-case assessments is more appropriate.[45]

Shifting Characterization of MAID in Relation to Suicide

The Court's characterization of MAID in relation to suicide has changed significantly over time. In *Rodriguez*, the Court uses the term "physician-assisted suicide" and "assisted suicide" in their analysis and positions MAID as a form of suicide.[46] In their dissent, Justices L'Heureux-Dubé and McLachlin argue that the criminalization of MAID infringes on section 7 *Charter* rights because it denies some individuals the choice of ending their own life:

> Parliament has put into force a legislative scheme which makes suicide lawful but assisted suicide unlawful. The effect of this distinction is to deny to some people the choice of ending their lives solely because they are physically unable to do so, preventing them from exercising the autonomy over their bodies available to other people.[47]

In Justice Lamer's dissent, he concludes that the prohibition of MAID also infringes on equality rights protected under section 15(1) of the *Charter*:

> [I]t prevents persons physically unable to end their lives unassisted from choosing suicide when that option is in principle available to other members of the public … it limits

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[43] See *ibid* at para 624.

[44] See *ibid*.

[45] See Colleen Shepherd & Derek Jones, "Bill C-7's Express Exclusion of Individuals Whose Sole Underlying Medical Condition is Mental Illness from Canada's Evolving MAiD Regime: (Un)Justified Human Rights Discrimination?" (February 2021), *Brief to the Senate of Canada Standing Committee on Legal & Constitutional Affairs*, online (pdf): <sencanada.ca/content/sen/committee/432/LCJC/Briefs/ColleenSheppardandDerekJones_e.pdf>.

[46] *Rodriguez*, *supra* note 32.

[47] See *ibid* at 523–24.

> the ability of those who are subject to this inequality to take and act upon fundamental decisions regarding their lives and person.[48]

Thus, in *Rodriguez*, the legalization of MAID is justified, in part, to provide access to suicide to those who would otherwise not have this choice. In *Carter*, the Court's conceptualization of MAID in relation to suicide is not as explicit. The Court recognizes that the prohibition on MAID engages the section 7 right to life because it "has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable."[49] Although the Court predominantly uses the term "physician-assisted dying," the terms "physician-assisted suicide" and "assisted suicide" are also used interchangeably at times.[50] This evolution in language reflects arguments advanced by organizations such as Dying with Dignity that aim to promote the legalization and social acceptance of MAID by distinguishing it from suicide.[51] They argue that suicide is "an act of self-harm that is almost always a byproduct of mental illness," which "is in no way comparable to hastening death via a methodical, sober process with a number of legal safeguards."[52]

This juxtaposition of MAID and suicide is advanced further in *Truchon*. The Attorney General argued that eliminating the foreseeable death requirement would jeopardize public health initiatives to prevent suicide and create risks of "suicide contagion."[53] Relying on expert testimony and evidence from Canada's existing MAID regime under Bill C-14, the Court concludes that "there are important distinctions between suicide

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[48] See *ibid* at 524–25.

[49] *Carter*, *supra* note 16 at para 335.

[50] See *ibid* at paras 10, 18.

[51] See Sarah Dobec, "Why medically assisted dying is not suicide" (23 September 2016), online: Dying with Dignity Canada <www.dyingwithdignity.ca/assisted_dying_is_not_suicide>.

[52] Andre Picard, "The importance of picking a vocabulary for dying", *The Globe and Mail* (18 June 2012), online: <www.theglobeandmail.com/news/politics/the-importance-of-picking-a-vocabulary-for-dying/article4338418/>.

[53] *Truchon*, *supra* note 24 at para 237.

and medical assistance in dying with respect to both the characteristics of the people involved and the reasons that motivate them." [54] The Court concludes that eliminating the foreseeable death requirement does not conflict with suicide prevention because "physicians involved are able to distinguish a suicidal patient from a patient seeking medical assistance in dying."[55] MAID is thus positioned as distinct from suicide.

The relationship between MAID and suicide is complex and will be explored in greater depth in Part 2. However, the conclusions drawn in *Truchon* obscure an important evolution in the jurisprudence. In *Carter* as well as the dissents in *Rodriguez*, MAID was justified in part on the basis that the applicants requesting it were or would soon become physically unable to end their own lives due to their medical condition. Notably, the applicants in *Truchon* are similarly physically restricted. [56] However, with the elimination of the foreseeable death requirement, MAID will become accessible to a larger demographic who are physically capable of ending their own lives without medical assistance. *Truchon* thus advances the right to die in a novel manner. For these individuals, access to MAID does not offer them the choice to die, which is at least in principle already available to them, but the choice to die under more dignified and humane circumstances.

II. CRITICAL ANALYSIS OF BILL C-7

This section outlines an analytical framework rooted in the social and human rights model of disability. It applies a critical disability lens and a capabilities-based human rights framework to examine the eligibility criteria and safeguards outlined in Bill C-7. It then reflects on the potential impacts of a more permissive MAID regime with reference to other jurisdictions. To the extent possible, given the parameters of this paper, it aims to center lived experience in its analysis.

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[54] *Ibid* at para 466.

[55] See *ibid*.

[56] See e.g. *ibid* at para 34. The Court notes that Mr. Truchon has considered ending his life via fasting, a long and painful process, because there are no other options available to him if his request for MAID is denied.

Constructing an Analytical Framework

Interrogating the Hegemony of Biomedicalism

Historically, biomedicalism represented the prototypical model of disability. The medical model positions disability as a functional impairment resulting from pathology or illness.[57] The goal is to cure the condition or manage symptoms through medical treatment to eliminate or minimize impairment. It positions disability as an objective individual defect rather than a social phenomenon. This perspective has been linked to human rights abuses including the widespread institutionalization of people with disabilities and the denial of basic legal rights.[58] The social and human rights models of disability emerged in opposition to biomedicalism. From this perspective, disability exists when the environment does not accommodate individuals with different functional capacities and is thus socially constructed.[59] It draws a clear dichotomy between disability and impairment and places the burden on the State and society as a whole to support the human rights of people with disabilities and their full inclusion and participation.[60] There are also some who have adopted a mixed model of disability that positions the biological, psychological, and social foundations of disability as interlinked and inseparable.[61] While the social and human rights models of disability have made important contributions to the advancement of the rights of persons with disabilities, biomedicalism remains prevalent and deeply embedded within public consciousness and social structures, including our medical system.

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[57] See David Wasserman et al, "Disability: Definitions, Models, Experience" (2016), online: *The Stanford Encyclopedia of Philosophy* <plato.stanford.edu/entries/disability/#ModDis>.

[58] See e.g. Tina Minkowitz, "The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions" (2007) 34 Syracuse J Intl L Commerce 405.

[59] See Wasserman, *supra* note 51.

[60] See *ibid*.

[61] See Jonas-Sébastien Beaudry, "The Vanishing Body of Disability Law: Power and the Making of the Impaired Subject" (2018) 31 Can J Fam L 7 at 21.

Conceptual models have discursive power. They shape societal perceptions of disability and our legislative and public policy responses.[62] They also impact the interpretation of one's own experience of disability.[63] YouTuber Molly Burke eloquently expresses the "life-changing" impact of reconceptualizing her own blindness within a social model after being indoctrinated with biomedicalism from a young age:

> The social model is the idea that I, as the blind person, is not the issue. Me, Molly, who I am is perfectly fine. What we need to change is the environment around me ... Growing up deeply immersed in the medical model I did grow up feeling ... that I was not whole. That I was in some way broken because I wasn't able-bodied. And if you can imagine growing up with that mindset, how deeply damaging that is to mental health, how stunting that would be to your own growth and development as a person ... the reality is that cures don't exist for most of us.[64]

Thus, it is important to be attentive to how MAID may further a particular conceptualization of disability and its normative impact on both individuals and society as a whole.

Critical Disability Theory

Critical disability theory (CDT) builds on the social and human rights models of disability as well as other critical scholarship like queer theory and critical race theory. Hall defines CDT as

> a diverse set of approaches that largely seek to theorize disability as a cultural, political, and social phenomenon, rather than an individualized, medical matter attached to the body ... It also reflexively considers the exclusions, framing, and normative presuppositions of disability studies,

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[62] CRPD, *supra* note 38.

[63] Jonas-Sebastien Beaudry, "Somatic Oppression and Relational Autonomy: Revisiting Medical Aid in Dying through a Feminist Lens" (2020) 53:2 UBC L Rev 241.

[64] Molly Burke, "Social Model vs. Medical Model of Disability (explained/my opinion)" (26 January 2021), online (video): *YouTube* <www.youtube.com/watch?v=aPEuYrtuxEk&list=PL_Xm8PicNxr07jQawtnp6pOYfAk_3jg5m& index=6&ab_channel=MollyBurke>.

> favoring intersectional approaches and expansive inclusion.[65]

CDT centers the lived experience of people with disabilities in its epistemology.[66]

Some CDT scholars have criticized the social model of disability for erasing the embodied experience of disability.[67] Furthermore, Beaudry argues that neither impairment nor disability are value-neutral. He rejects the implicit characterization of impairment within the social model as "true characteristics ... outside the reach of ideology, stigma, oppression, or disciplinary apparatuses."[68] He argues we must be attentive to not only how impairment shapes individual lived experience but also the conceptualization of impairment itself.

CDT scholars also highlight the importance of contextualizing conversations about dignity and autonomy. Jonas-Sebastien Beaudry calls for a reconceptualization of autonomy: just as legal understandings of equality evolved from formative to substantive equality, we must move from formal to substantive liberty.[69] CDT scholars recognize that the range of options available to people are shaped by structural factors and that human rights have material and social preconditions.[70]

Capability Human Rights Framework

Unlike many human rights frameworks that fail to account for the different functional capacities of people with disabilities or treat them as an afterthought, Martha Nussbaum's capability framework presumes that individuals in society do not have the

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[65] Melinda Hall, "Critical Disability Theory" (2019), online: *The Stanford Encyclopedia of Philosophy* <plato.stanford.edu/entries/disability-critical/#CritTheo>.

[66] See *ibid*.

[67] See *ibid*.

[68] Beaudry (2018), *supra* note 61 at 20.

[69] Beaudry (2020), *supra* note 63 at 290.

[70] See Shildrick, *supra* note 10.

same needs and abilities.[71] It recognizes that the social and material conditions required to exercise rights vary on an individual basis.[72] The capabilities approach "seeks to provide individuals with the means through which to develop their potential regardless of whether target recipients of resources elect to use them."[73] Embedding individual autonomy in this framework recognizes that allowing choice is critical to supporting human dignity without disregarding the impact of structural factors on vulnerable populations like the elderly, children, or people with disabilities. It provides a minimum theory of justice and aligns well with the social and human rights models of disability, as well as with critical disability perspectives.[74] Vulnerability, in this context, is not an inability to consent as it is traditionally conceptualized in the legal system.[75] Vulnerability is a confluence of political and socioeconomic factors that constrain a person's autonomy leading to a lack of meaningful choice.[76]

Critical Analysis of MAID Eligibility Criteria & Safeguards

Irremediable Disability and Intolerable Suffering

Bill C-7 specifies the same conditions that must be met to qualify for a "grievous and irremediable medical condition" as Bill C-14, except for the reasonably foreseeable death requirement. A person must meet all three conditions to be eligible:

a) "serious and incurable illness, disease or disability";

b) "an advanced state of irreversible decline in capability"; and

c) "that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering

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[71] See Caroline Harnacke, "Disability and Capability: Exploring the Usefulness of Martha Nussbaum's Capabilities Approach for the UN Disability Rights Convention" (2013) 41:4 JL Med & Ethics 768.

[72] See *ibid*.

[73] *Ibid* at 771.

[74] See *ibid*.

[75] See *Carter*, *supra* note 16 at para 114.

[76] Harnacke, *supra* note 71.

> that is intolerable to them and that cannot be relieved under conditions that they consider acceptable."[77]

This largely reflects a biomedical model of disability as there is limited differentiation between the person's medical condition (i.e. impairment) and their disability. It does not acknowledge the social construction of disability implicitly in the wording of the legislation or explicitly in its preamble, in sharp contrast to other disability legislation.[78] It also does not recognize how capability is shaped by access to resources. These are precisely the types of misconceptions that the social model aims to dismantle.

From a critical disability perspective, the relationship between suffering and disability is contentious.[79] Some scholars argue that the social model of disability downplays pain and that this is an important aspect of the lived experience of disability that must be considered.[80] Additionally, the biological, psychological, and social aspects of pain are highly interrelated such that they cannot be understood in isolation. Physical pain is associated with psychological suffering. Likewise, emotional distress often manifests physically in the body.[81] Social isolation causes suffering and impacts a person's ability to cope with physical pain.[82] Suffering, like disability, is thus a complex phenomenon mediated by biological, psychological, and social factors. In many cases, it may be difficult to disentangle the extent to which an individual's suffering stems from their medical condition as opposed to their broader socioeconomic context. However, conflating illness with disability and presuming a stable relationship between disability and suffering, as Bill C-7 does, is reductionist and erroneous. It risks perpetuating harmful misconceptions that suffering is an inevitable aspect of living with a disability.

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[77] Bill C-7, *supra* note 1.

[78] CRPD, *supra* note 38.

[79] See Hall, *supra* note 65.

[80] See *ibid*.

[81] See Wasserman, *supra* note 57.

[82] See Nicholas Karayannis, Isabel Baumann, John Sturgeon, Markus Melloh & Sean Mackey, "The Impact of Social Isolation on Pain Interference: A Longitudinal Study" (2019) 53:1 Annals of Behavioral Medicine 65.

A coalition of disability rights organizations represented by ARCH Disability Law Centre are challenging Bill C-7 internationally as a violation of the United Nations *Convention on the Rights of Persons with Disabilities*.[83] They argue that Bill C-7 discriminates on the basis of disability by creating an inequality between persons with disabilities and persons without.[84] People who are not disabled may be suffering intolerably, but they will likely not qualify for MAID under the current criteria for irremediable and grievous medical condition. Instead, they would be offered social services and suicide prevention programs to alleviate their suffering. They are thus challenging Bill C-7 on the basis of the discriminatory effects of the grievous and irremediable medical condition criterion. In comparison, other jurisdictions with permissive MAID regimes, such as the Netherlands, do not have an explicit focus on the applicant's disability or medical condition. Rather, the physician must be satisfied that "the patient's suffering is unbearable and that there is no prospect of improvement."[85] The emphasis is placed on the irremediability of suffering rather than the irremediability of the medical condition or disability. In doing so, it more precisely centers the key justifications for MAID: to provide relief in death from suffering when no other remedy is available. The legal arguments raised by ARCH Disability Law Centre and the Netherland's MAID regime raise important questions regarding the purpose of the grievous and irremediable medical condition criteria and how it can and should be used to limit access to MAID.

Structural Vulnerability & Inadequate Safeguards

As noted in disability scholar Shakespeare's testimony in *Truchon,* people with disabilities are generally able to enjoy a good quality of life and can adapt to their situation with appropriate supports.[86] However, the reality is that many people with disabilities do not have the resources required to exercise their rights as outlined in Nussbaum's capability framework.

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[83] See Inclusion Canada, *supra* note 5. See also ARCH Disability Law Centre, "Submission to the Special Joint Committee on Medical Assistance in Dying" (9 May 2022), online: <archdisabilitylaw.ca/resources/medical-assistance-in-dying-maid/>.

[84] See *ibid*.

[85] Nicol, *supra* note 15.

[86] See *Truchon*, *supra* note 24 at paras 275–80.

People with disabilities are disproportionately impacted by poverty, face discrimination in society, and are often institutionalized in long-term care homes due to a lack of support for independent living.[87] The lack of structural support restricts the autonomy and dignity of people with disabilities and can cause more suffering than the medical condition itself. [88] This conceptualization of vulnerability as structural is essential to understanding the full extent of critiques of Bill C-7. Disability rights activists argue that it is inappropriate, unjust, and dangerous to offer MAID to alleviate suffering without first remedying these structural inequities. Furthermore, if a person's suffering is structurally caused then it is not irremediable. However, addressing these structural sources of suffering requires action at the societal level (e.g. investment in housing, income support). It cannot be remedied by individuals and their physicians alone.

The safeguards in Bill C-7 do not prevent individuals from seeking MAID for structurally caused suffering, so long as they meet the eligibility criteria for irremediable and grievous medical condition and are capable of consenting. Anecdotal evidence indicates that individuals in these situations are already requesting and being accepted for MAID.[89] This is, in part, because the conceptualization of vulnerability as discussed in *Carter* is considerably narrower in scope: its emphasis is on decision-making capacity. Examples of vulnerability considered by the Court include "cognitive impairment, depression or other mental illness, coercion, undue influence, psychological or emotional manipulation, systemic prejudice (against the elderly or people with disabilities), and the possibility of ambivalence or misdiagnosis."[90] The Court concludes that existing assessments of informed consent and decision-making capacity more generally are able to manage these issues and in fact already do so on a regular basis in other important medical decisions with life and death consequences.[91] While disability rights advocates are also concerned with the potential for coercion in the context of consent

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[87] See Gaind, *supra* note 13.

[88] See *ibid*.

[89] See Favaro, *supra* note 6; Fidelman, *supra* note 6.

[90] *Carter*, *supra* note 16 at para 114.

[91] See *ibid* at 115.

to MAID, their concerns are broader. By situating medical conditions within their broader sociopolitical context, it is evident that individuals may feel pressured to access MAID in ways that are unrelated to their decision-making capacity. Safeguards that aim to protect so-called vulnerable people from accessing MAID on the basis of incapacity are thus inadequate.

Bill C-7 does include additional safeguards for people requesting MAID who are not close to death. Medical practitioners must ensure that the

> person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care.[92]

However, it provides no such guarantee that these services be adequate or sufficiently accessible to the person seeking MAID. Waitlists for specialized treatment range from months to years in Canada, particularly now due to the COVID-19 pandemic.[93] Community services are often under resourced and psychiatric palliative care is still an emerging concept. Failure to respond to conventional medical treatments constitutes a perilous basis to conclude that a person's suffering is irremediable if the individual also does not have access to adequate housing, community living, and opportunities to seek fulfillment and enjoyment in their daily life. Ensuring the individual is "informed" of their options does not guarantee the accessibility or viability of these choices. These proposed safeguards thus fail to ensure the person seeking MAID has the resources required to exercise a meaningful choice. In other words, they do not provide substantive liberty, only formal liberty.

Distinguishing Rational and Pathological Desires to Die

Applying a critical disability lens to the process of psychiatric assessments illuminates its social constructivist precepts

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[92] Bill C-7, *supra* note 1. This safeguard is required when the person's natural death is not reasonably foreseeable.

[93] See Mackenzie Moir & Bacchus Barua, "Waiting Your Turn: Wait Times for Health Care in Canada" (2021), online: *Fraser Institute* <www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2021>.

and undermines the conclusion drawn in *Truchon* that physicians can objectively distinguish suicidality from a supposedly reasonable desire to die via MAID. There is considerable risk that these assessments will be influenced by prejudicial beliefs of what types of lives are worth living. At its core, psychiatric pathology, as well as medical pathology more generally, is defined as a divergence from some norm. As Beaudry argues, the process of defining this norm is far from socially or politically neutral.[94] How it is defined and by whom matters greatly. The former pathologization of homosexuality and hysteria demonstrates how psychiatric pathology (also referred to as abnormal psychology) is contingent on evolving social and political norms.[95] Unlike other medical diagnoses, psychiatric diagnoses are not based on the presence or absence of relatively objective biological markers. They are instead determined based on a constellation of "symptoms."[96] The line between pathological symptoms (e.g. a "cognitive distortion") and an expected reaction to circumstances (e.g. sadness) requires a subjective clinical interpretation based on a normative analysis of what is reasonable and rational. In this way, psychiatric assessments are more comparable to legal analyses, which frequently employ an abstract "reasonable person standard," than other medical testing such as imaging or blood tests. This process of defining *reasonability* is thus subject to the potential bias and prejudice of individual clinicians.

This normative analysis is evident in the testimony of both Dr. Turcott and Dr. Naud in *Truchon*, who both assess Mr. Truchon's eligibility and capacity to consent to MAID. The following conclusions are drawn by the Court from Dr. Turcott's testimony:

> He continues to have symptoms of sadness and anxiety in anticipation of his future life, but these symptoms are entirely consistent with his current medical condition and are not

[94] See Beaudry (2018), *supra* note 61.

[95] See Carol North "The Classification of Hysteria and Related Disorders: Historical and Phenomenological Considerations" (2015) 5:4 Behavioral Sciences 496; Jack Drescher, "Out of DSM: Depathologizing Homosexuality" (2015) 5:4 Behavioral Sciences 565.

[96] See Association des Médecins Psychiatres du Québec, *supra* note 11.

> pathological … Mr. Truchon is not suicidal, despite his wish to die.[97]

In his testimony, Dr. Naud acknowledges that Mr. Truchon has "considerable psychological pain" and "is unable to find meaning in his life" but his testimony supports the same conclusion:

> Dr. Naud finds no element of depression or a cognitive disorder in Mr. Truchon. His sadness is entirely consistent with his situation … Mr. Truchon is not suicidal. He does not suffer from any psychiatric condition likely to affect his capacity to consent.[98]

Without making a judgment on the reasonability of Mr. Truchon's desire to die, these conclusions are striking. While clinical assessments of suicidality can vary, it seems an affront to common sense to suggest that a desire and intention to die does not qualify someone as suicidal. Research indicates that the reasons individuals want to die from suicide are not categorically different from the reasons for which individuals seek out MAID.[99] Overlap includes intolerable suffering, a lack of autonomy and dignity, hopelessness, and perceived poor quality of life.[100] As well, although suicide can be sudden, it is also often premeditated.[101] Many individuals who die by suicide also seek medical attention soon before their death.[102] Once the end-of-life requirement is eliminated and mental illness becomes an accepted basis to seek MAID, any distinctions between the two groups are likely to become further blurred.

To distinguish MAID from suicide as is proposed in *Truchon* requires redefining suicidality as a pathological desire to die in

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[97] *Truchon*, *supra* note 24 at para 39.

[98] See *ibid* at para 42.

[99] See Phoebe Friesen, "Medically Assisted Dying and Suicide: How Are They Different, and How Are They Similar?" (18 February 2020), online: *Hastings Center Report* <onlinelibrary.wiley.com/doi/full/10.1002/hast.1083#:~:text=Death%20with%20Dignity%20defines%20suicide,results%20from%20%E2%80%9Cexhaustive%20reflection%20and>.

[100] See *ibid*.

[101] See *ibid*.

[102] See Anna Pearson et al, "Primary care contact prior to suicide in individuals with mental illness" (2009) 59:568 British J of General Practice 1.

contrast with a supposedly reasonable or justified desire to die.[103] This distinction between "good" (justified) and "bad" (unjustified) reasons for wanting to die becomes a subjective normative evaluation. In the absence of other explicit criteria to distinguish the two, it appears that the presence of a disabling medical condition is sufficient.[104] This has prompted sharp criticism from disability rights organizations and leads to claims that MAID will contribute to the normative devaluation of the lives of people with disabilities:

> Bill C-7 sets apart people with disabilities and disabling conditions as the *only* Canadians to be offered assistance in dying when they are not actually nearing death … Canadians with disabilities are hearing MPs and Senators arguing that lives just like theirs featuring disabilities just like theirs are not livable. This is harmful and hurtful and stigmatizing.[105]

In the Health Canada report, the expert panel noted that the trends observed regarding MAID and suicide reported in *Truchon* are less clear-cut when the end-of-life requirement is eliminated, particularly in the case of mental illness.[106] To manage this, they recommend a comprehensive capacity assessment to assess the "consistency, durability and well-considered nature" of the request and that clinicians completing capacity assessments be self-reflective and proactive in establishing oversight and quality assurance.[107] However, there is minimal discussion for how to address the potential influence of biomedicalism and prejudicial beliefs about mental illness and disability on capacity assessments.

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[103] The term "rational suicide" has also been used to refer to MAID requests, however it is not commonly used: see e.g. Andre Picard, "The importance of picking a vocabulary for dying", *The Globe and Mail* (18 June 2012), online: <www.theglobeandmail.com/news/politics/the-importance-of-picking-a-vocabulary-for-dying/article4338418/>.

[104] See Jonas-Sebastien Beaudry, "Bill C-7, assisted dying and "lives not worth living" (14 December 2020), online: *Policy Options IRPP* <policyoptions.irpp.org/magazines/december-2020/bill-c-7-assisted-dying-and-lives-not-worth-living/>.

[105] See "Open Letter: Bill C-7 is not the answer", *supra* note 3.

[106] Health Canada, *supra* note 28 at 65.

[107] See *ibid* at 12–17.

Denying Access to MAID for People with Mental Illness

Another potential adverse impact of drawing this distinction between MAID and suicide is its potential to further stigmatize suicide and mental illness.[108] It presumes that people with mental illness who are labelled *suicidal* are not capable of rationally assessing their own situation and perpetuates harmful stereotypes of people with mental illness and risks trivializing their suffering. Limiting access to MAID on the basis that mental illness impairs individual capacity is also harmful. It perpetuates medical paternalism and undermines the autonomy of people with mental illness and their capacity to exercise basic rights. Affirming the agency of all people with disabilities, including people with mental illness, is essential to fully realizing human rights while recognizing that people with disabilities may require additional support and resources to exercise these rights.

The impacts of restricting MAID on the autonomy and dignity of people with mental illness should not be understated. Writing from his own personal experience, John Scully argues denying access to MAID for the mentally ill is unjustified and forces people to make cruel choices:

> Utter loss of hope, dignity, self-esteem … must not be cavalierly dismissed as "easily treated conditions." They're brutal realities of the viciousness of depression. And they defy the pious assertions of academics and panels and medical journals.
>
> No compassion, no relief, no death—unless the sufferer is then forced to die by suicide. This is one of the most undignified ways of dying, with botched attempts, finality by often brutal methods, followed by shock and intolerable pain for unprepared loved ones. That's the reality of denying MAID for the mentally ill.[109]

Medically assisted death and suicide by other means are very different experiences both for the individuals who die and for their loved ones.[110] As well, people with mental illness

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[108] Friesen, *supra* note 99.

[109] John Scully, "John's story: The truth about denying MAID to those suffering mental illness" (17 April 2020), online: *Dying with Dignity Canada* <www.dyingwithdignity.ca/john_scully_story>.

[110] See Friesen, *supra* note 99.

requesting MAID have likely contemplated suicide by other means. But having access to MAID and participating in the evaluation process also offers individuals an opportunity to consult with a team of medical professionals and make an informed choice after a period of reflection. While exploration of different options to alleviate suffering may in principle already be available in clinical contexts, mental health legislation permitting physicians to forcibly confine individuals at risk of suicide may deter individuals from disclosing suicidal ideation. Legalizing access to MAID for mental illness thus has the potential to has the potential to destigmatize conversations around suicide and permit open and frank conversations in non-judgmental environments.

However, expanding access could also normalize the decision to take one's own life in the face of significant suffering or loss of dignity and autonomy. As Mark Sinyor and Ayel Schaffer argue, "[e]ndorsing death as a sometimes desirable strategy for treating a painful life and lowering the barrier to accessing it are exactly counter to evidence-based suicide prevention efforts."[111] There is a real risk that individuals will die by MAID who would have not otherwise died by suicide. As well, due to uncertainty regarding the prognosis of mental illness, some of these individuals could have recovered or otherwise managed their condition and gone on to live happy and fulfilled lives.[112] The conclusion drawn in *Truchon*, that individualized functional capacity assessments are sufficient to guard against these potential adverse outcomes, is tenuous at best.

Societal Impacts of a Permissive MAID Regime

It is critical to consider the broader societal impacts of all legislation, especially legislation that has life and death consequences such as Bill C-7. By eliminating the reasonably foreseeable death requirement Canada has adopted one of the most permissive MAID regimes in the world. As MAID remains prohibited or heavily restricted in most of the world, it is difficult

[111] "The Lack of Adequate Scientific Evidence Regarding Physician-assisted Death for People with Psychiatric Disorders Is a Danger to Patients" (2020) 65:9 Canadian J of Psych 607 at 608.

[112] See *ibid*.

to predict the real-life societal impacts of Canada's new MAID regime. Many of the concerns brought forward by disability advocates and medical practitioners during the drafting of Bill C-7 were thus hypothetical. In *Carter* and *Truchon*, the Court finds it unreasonable to deny access to MAID to the applicants and others in a similar situation based on as-yet unproven concerns.[113] Nevertheless, disability rights groups see the stories of individuals such as Archie and Sophia as clear evidence that the current MAID regime is deeply flawed and dangerous and must be changed immediately.[114]

The limited data available from other jurisdictions with more permissive MAID regimes is considered in *Carter* and *Truchon*. It suggests that some fears, particularly the disproportionate representation of individuals from marginalized groups accessing MAID, have not materialized in other jurisdictions. In the Netherlands, Belgium, and Luxembourg, where there is no end-of-life requirement, the majority of deaths by MAID are cancer patients.[115] Seeking MAID for mental illness remains a small but growing percentage of total cases.[116] In contradiction to expectations, data from the Netherlands, Belgium, and Oregon reviewed in *Truchon* indicate the majority of people seeking MAID are socially and economically privileged.[117] The reasons for these trends require further exploration including how socioeconomic status and identity factors mediate access to MAID. That said, these data provide some proof that permissive MAID regimes do not inherently lead to increased deaths for marginalized groups. However, it is prudent to avoid drawing firm conclusions based on limited data. There are many empirical questions that remain unsettled and that require further exploration. As well, we should be cautious in assuming that data from other jurisdictions is applicable to the Canadian context. Variations in MAID eligibility criteria and safeguards as well as the availability of resources for people with disabilities to fully exercise their rights can vary greatly between jurisdictions. Additional study and monitoring are

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[113] See e.g. *Truchon*, *supra* note 24 at para 452–60; *Carter*, *supra* note 16 at para 26.

[114] See Favaro, *supra* note 6; Fidelman, *supra* note 6.

[115] See Nicol, *supra* note 15 at 16–17; 20–22.

[116] See *ibid*.

[117] See *Truchon*, *supra* note 24 at paras 451–53.

required to track the impact of access to MAID on structurally vulnerable populations in Canada.

It is also important to attend to the ways in which MAID could impact societal conceptualizations of disability. As noted above, the theoretical framing of disability has real psychological impacts. To the extent that MAID reinforces and perpetuates biomedicalism and harmful beliefs that life with a disability is inherently painful or undignified, it could serve as a major obstacle for both the personal growth and recovery of individuals and the progression of disability rights at the societal level. There is some concern this is already happening with individuals reportedly refusing additional treatments for mental illness in anticipation of the imminent availability of MAID.[118] Disability rights groups have also decried the ableist assumptions about experiences of disability present in debates around Bill C-7.[119] It is therefore critical that the conflation of irremediable medical conditions with irremediable and intolerable suffering, reduced autonomy and a poor quality of life be challenged within our legal and medical system as well as society more broadly.

Lastly, the relationship between MAID and suicide prevention efforts remains poorly understood.[120] As Sinyor and Schaffer argue there is simply insufficient high-quality research to demonstrate that expanding access to MAID would not exacerbate suicide contagion.[121] There are many other open questions in the literature. For example, should death by MAID be considered suicide when death is not reasonably foreseeable? As well, what about individuals who request MAID who do not have a defined physical or psychiatric illness? In the Netherlands, there are a small number of controversial cases of MAID including "life completion" cases where individuals seek MAID because they feel their life is finished despite not experiencing intolerable suffering due to a defined medical condition.[122] Monitoring deaths by MAID will remain critical however research must extend

[118] See van Veen, *supra* note 12.

[119] See Inclusion Canada, *supra* note 5.

[120] See van Veen, *supra* note 12.

[121] See Sinyor & Schaffer, *supra* note 111.

[122] See Nicol, *supra* note 15 at 14.

beyond reporting of demographic information (e.g. age, race, socioeconomic status, and medical condition) to include the reasons people report accessing MAID (e.g. loss of autonomy, intolerable pain, inadequate support, and resources to live). Nonetheless, due to the wide range of opinions on MAID, there will likely be disagreement on what constitutes desirable or undesirable outcomes.

III. APPROACHES TO ADVANCE MAID

A critical analysis of Bill C-7 illustrates there are many open questions regarding how access to MAID can be reconciled with the rights of persons with disabilities. In this section, I identify three potential avenues to advancing access to MAID: a restrictive approach, a discretionary approach, and an emancipatory approach. I consider briefly the potential of each to enhance or constrain the rights of persons with disabilities and in particular people with mental illness.

Restrictive Approach

A restrictive approach can range from a full prohibition of medical assistance to the use of eligibility criteria to limit access to specific populations. Categorical prohibitions are generally justified to protect some category of "vulnerable persons," however, as we have seen in *Carter* and *Truchon*, they are susceptible to invalidation on the basis of their overbreadth in favour of case-by-case assessments. For these reasons, as well as its discriminatory effects, a categorical exclusion of people whose sole underlying condition is mental illness from accessing MAID is likely to be overturned if challenged in the courts.[123] At present, the primary categorical limitation in Bill C-7 is the irremediable and grievous medical condition criteria which restricts access to MAID to people with disabilities or a serious medical condition.

For proponents of a more restrictive approach there may be other eligibility criteria that could be used to limit access to MAID. This could include pushing for more stringent interpretations of the

[123] See Shepherd & Jones, *supra* note 45.

existing eligibility criteria in Bill C-7 to effectively exclude certain populations. It remains an open question as to how "advanced state of irreversible decline" will be interpreted in the context of mental illness. Another option would be to introduce additional eligibility criteria that would be more likely to survive a *Charter* challenge. The criteria of "physically incapable of ending their own life" could be an option. Such a provision would allow access to MAID for applicants such as those in *Truchon* but would effectively prohibit access to MAID solely on the basis of mental illness and many other disabilities. However, unlike a categorical prohibition, it may be more likely to survive a constitutional challenge, particularly considering the section 7 and section 15 analysis outlined by the dissent in *Rodriguez* and the section 7 analysis of the right to life in *Carter*. It may be possible to justify such a provision by arguing that the infringements on an individual's section 7 rights to liberty and security by prohibiting access to MAID are outweighed by the deleterious effects of a more permissive MAID regime. However, by restricting access to MAID in such a manner, the only option available to individuals wishing to end their lives would be unassisted suicide. As highlighted by Scully, this denies individuals a more dignified and humane death.[124] As well, limiting access to MAID in it of itself does nothing to alleviate individual suffering, regardless of whether it stems from a person's medical condition or structural factors.

Discretionary Approach

Another approach to regulating MAID is to provide broad eligibility criteria and rely on the judgment of medical practitioners to protect vulnerable persons through their discretionary interpretation of the eligibility criteria and assessment of decision-making capacity. This is the case in the Netherlands where, despite few restrictions on eligibility, many requests for MAID are denied by the assessing physicians.[125] Bill C-7 similarly reflects a discretionary approach to MAID; the capacity assessment is an essential safeguard that limits access. There is also considerable

[124] Scully, *supra* note 109.

[125] Nicol, *supra* note 15 at 11-15.

discretion in how the eligibility criteria may be interpreted and applied to individual cases. This flexibility can be advantageous. It avoids arbitrarily barring individual access to MAID on the basis of general prohibitions while still protecting a purportedly vulnerable person from making an impulsive or poorly considered decision. However, while there may be near-universal agreement on the extreme ends of the spectrum (e.g. in which a person has suffered continuously from severe depression for decades), there is inevitably going to be a significant number of cases that fall into a grey area. There are some measures that could help improve consistency including rigorous and independent monitoring of its implementation and legal oversight.[126] Providing clear and binding definitions of eligibility criteria and additional guidance in clinical protocols could also constrain professional discretion.

On the one hand, while not perfect, capacity assessments can buffer the risks of permissive MAID regimes by preventing individuals from dying during a period of crisis or before exhausting other options to alleviate suffering. As highlighted in *Carter* and *Truchon*, capacity assessments are already used on a regular basis for critical life-and-death medical decisions. However, there is a real risk that professional discretion may be influenced by inaccurate and prejudicial beliefs about disability. Education for assessors that incorporates critical disability perspectives and the diversity of lived experience of disability is thus essential.

On the other hand, there is also the risk that relying on professional discretion will result in unjust or inequitable barriers to accessing MAID. As discussed previously, using capacity assessments to limit the autonomy of people with mental illness is dangerous and harmful. Supported decision-making regimes should be used when appropriate to ensure people with all types of disabilities can exercise their rights in the context of important medical decisions.[127] Denying access on the basis of structural vulnerabilities can also exacerbate existing inequities. Individuals with less resources may not have the privilege of travelling to another jurisdiction to access MAID if their request in Canada is denied.

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[126] See Vulnerable Persons Standard (2017), online: <www.vps-npv.ca/read-the-standard-20>; Health Canada, *supra* note 28 at 12–17.

[127] Health Canada, *supra* note 28 at 60.

Capacity assessments are not a complete or infallible safeguard. They are not designed to effectively address or remediate structural vulnerabilities and related suffering. Physicians who identify structural factors as the primary motivation for MAID are left in a difficult situation. They recognize the injustice of providing MAID without first providing the resources the individual needs to live, however, they do not have the power to remedy the situation. [128] As well, by denying their request they are not alleviating the person's suffering. Instead, they are further limiting the autonomy of individuals whose autonomy is already significantly constrained by medical or structural factors.

Emancipatory Approach

A third approach to advancing MAID would be to focus primarily on ensuring individuals have a meaningful choice (i.e., substantive liberty) and exploring all avenues to alleviate their suffering rather than striving to limit access to MAID through restrictive criteria or professional discretion. This recognizes that many of the people that will now have access to MAID under Bill C-7 are likely to also have access to and be at risk of suicide. It further recognizes that merely attempting to prevent their deaths (e.g., by denying MAID or via involuntary confinement in a hospital) is an inadequate response that does not address their underlying suffering and could even cause iatrogenic harm by undermining their autonomy. It presumes legal capacity and recognizes individuals as capable of assessing their own realities and positions the paternalistic gatekeeping role of physicians as inherently problematic and harmful. It also has the potential of destigmatizing suicidality by recognizing that suicide can be a reasonable option to consider in the face of intolerable suffering without normalizing this response to suffering.

An emancipatory approach would focus on supporting the full realization of the rights of persons with disabilities recognizing the diversity of experiences of disability and ensuring that individuals have the conditions to realize their full capabilities. It also rejects a purely biomedical conception of disability and challenges ableist assumptions about the types of lives worth living.

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[128] See e.g. Favaro, *supra* note 6.

Finally, it would address the types of structural vulnerabilities that are driving some individuals to seek MAID as a last resort. Individuals in these situations expressly state that they do not want to die, but cannot tolerate living with the structural injustices that they face due to their disability.[129] These stories should serve as an alarm bell signaling that Canada is systematically failing people with disabilities and must take immediate and substantive action to support the human rights of people with disabilities across a range of policy areas. Notably, an emancipatory approach grounded in substantive liberty can and should be pursued, irrespective of a jurisdiction's particular MAID regime. Embedding MAID within the context of an emancipatory approach provides the best protection for vulnerable persons by addressing the source of their vulnerability.

Concretely, implementing an emancipatory approach to MAID would include thorough assessments of the psychosocial factors influencing a person's suffering and ensuring access to the support they need. This should include connecting individuals requesting MAID with networks and services outside the medical system and in community. Additionally, all healthcare professionals involved in MAID assessments should be educated in critical disability perspectives and trained to recognize the harms of reductionist biomedical ideologies and ableism more generally. Engaging individuals with a diversity of lived experiences of disability would also be beneficial in developing and monitoring the MAID assessment process. However, to be truly effective, an emancipatory approach must extend beyond the medical system and include legal recognition of socioeconomic rights and the broader dismantling of societal barriers facing individuals with disabilities. [130] Informing individuals of services that could help them, as Bill C-7 requires, is meaningless if those services are not accessible. Within the legal system, it would mean adopting a lens of substantive liberty rather than formal liberty in section 7 *Charter* analyses similar to how Canadian courts' understanding of section 15 evolved from one of formal to substantive equality.[131] Under a substantive liberty

[129] Favaro, *supra* note 6; Fidelman, *supra* note 6.

[130] See as an e.g. *Disability Rights Coalition v Nova Scotia (Attorney General)*, 2021 NSCA 70.

[131] See Beaudry (2020), *supra* note 63 at 290.

frame, discussions regarding autonomy in court decisions like *Truchon* and *Carter* would have been better contextualized amidst the structural factors constraining people with disabilities' autonomy in their everyday lives. As it stands, many disability rights advocates resent how autonomy has been used to expand access to MAID and feel their critiques have been improperly dismissed by the courts and drafters of Bill C-7.[132]

Without an emancipatory approach, establishing a more permissive MAID regime is problematic and risks facilitating the premature death of people with disabilities, as well as entrenching harmful beliefs that living with a disability necessarily means enduring intolerable suffering. Under an emancipatory approach, individuals may still choose death. An individual may elect not to use the resources available to them to alleviate their suffering for any number of reasons. The important thing from a substantive liberty point of view is that this choice is a meaningful one.

CONCLUSION

This paper aims to provide insight into how MAID can be advanced alongside human rights, in particular the rights of persons with disabilities. It supports calls to action by other scholars for a more substantive approach to the section 7 analysis of liberty and outlines three approaches to advancing MAID: a restrictive, a discretionary, and an emancipatory approach. While each of the above approaches are analyzed in isolation, in practice, they are not mutually exclusive. A robust MAID regime could incorporate elements of each of them. Indeed, many of the recommendations to improve MAID blend all three approaches.[133] Moving forward though, it is critical to attend to a diversity of lived experiences. We should be cautious of allowing experts to dictate the parameters of public discourse. MAID raises existential questions and engages deeply held individual and societal values. Both advocates and opponents of MAID often base their claims in the right to dignity. They challenge us to

[132] Inclusion Canada, *supra* note 5.

[133] See Vulnerable Persons Standards, *supra* note 108.

redefine our relationship to both life and death, and to recognize that the right to autonomy must be substantive if it is to be just.

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