

A Bridge Over Troubled Waters: Should Canada Allow Mental Illness as the Sole Underlying
Medical Condition for Accessing Medical Assistance in Dying?

by

Michael Tino Rossi

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Author's Declaration

I hereby declare that I am the sole author of this Thesis. This is a true copy of the Thesis, including any required final revisions, as accepted by my examiners.

I understand that my Thesis may be made electronically available to the public.

Abstract

Canada's Medical Assistance in Dying (MAID) regime was set to expand its eligibility criteria on March 17, 2024, to allow mental illness as an acceptable sole underlying condition (MAID MI-SUMC) until Bill C-62 rapidly received Royal Assent in late February 2024, delaying this expansion until March 17, 2027. Those who oppose allowing mental illness as a sole condition for MAID often cite fears of what would happen in Canada should MAID MI-SUMC become legal. However, proponents counter these claims with relevant facts, statistics, and information to demonstrate that MAID MI-SUMC can be effectively incorporated in Canada. This study uses evidence from countries with MAID but that do not allow MI-SUMC (Australia, New Zealand, and the United States), and countries with MAID MI-SUMC (the Netherlands, Belgium, and Luxembourg) to examine why these countries oppose and allow this legislation, respectively. Using this evidence, this Thesis then focuses on the Canadian context to address the concerns of opponents on why they are adamant that MAID MI-SUMC should not become an acceptable part of Canada's MAID regime. Incorporating studies conducted by proponents and evidence from permissive jurisdictions helps to find that opponents' fears are unsubstantiated. Using a rights-based approach, this Thesis observes that the rights of individuals who solely suffer from a mental illness and wish to access MAID are infringed upon, resulting in a call for legislative changes to occur.

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Dedication

I dedicate this work to my late grandfathers, Valentino Rossi and Domenico Spadafora. I miss you both every day, thank you for shaping me into the man I am today. I hope I am making you both proud.

Table of Contents

Author's Declaration	ii
Abstract	iii
Acknowledgements	iv
Dedication	v
List of Abbreviations	vii
Chapter 1 Introduction	1
Chapter 2 Theoretical Framing and Methodology	14
Chapter 3 Dialogue Theory and Coordinate Constitutional Interpretation	20
Chapter 4 Countries with MAID but that do not Allow Mental Illness as a Sole Criterion	34
Chapter 5 Countries with MAID that Allow Mental Illness as a Sole Criterion	47
Chapter 6 The Canadian Context	62
Chapter 7 Discussion	87
Chapter 8 Conclusion	97
References	100

List of Abbreviations

MAID – Medical Assistance in Dying

MAID MI-SUMC – Medical Assistance in Dying where Mental Illness is the Sole Underlying Medical Condition.

Chapter 1 – Introduction

Recently, Canadian legislators have been severely cautious about making expansionary changes to Canada’s medical assistance in dying (MAID) regime. The legislative changes being discussed would allow mental illness as an acceptable sole underlying condition for an individual to access this service. Bill C-7 outlines the current eligibility requirements to access MAID. An individual seeking MAID

“must be 18 years of age or older, capable to make decisions with respect to their health and eligible for health services funded by the federal government, a province or a territory. They must make a voluntary request for MAID that is not the result of external pressure and must give informed consent, after having been informed of the means available to relieve their suffering. Finally, they must have a grievous and irremediable medical condition, as defined in subsection 241.2(2) [of the *Criminal Code*]” (Government of Canada, 2020).

Under Bill C-7, the amendments made to the eligibility criteria effectively repealed the reasonably foreseeable natural death requirement that was present under Bill C-14. These current eligibility requirements allow someone who suffers from a mental illness to access MAID; however, they must have an accompanying physical condition that would satisfy the requirements of Bill C-7. Presently, mental illness alone is insufficient for the purposes of accessing medical assistance in dying. There is a blanket prohibition in place that prohibits anyone who solely suffers from a mental illness from accessing MAID. This was poised to change with an expansion of the eligibility criteria initially scheduled for March 17, 2024. However, citing concerns about the healthcare system’s readiness, Health Minister Mark Holland announced a new legislative proposal that delayed MAID eligibility expansion until March 17,

2027 (CBC News, 2024). The Canadian healthcare system might not ever be truly prepared to deal with the repercussions of allowing mental illness as a sole condition for MAID. Opponents of this extension fear that allowing a psychiatric condition to be an acceptable illness for accessing this end-of-life service will result in vulnerable people feeling pressure to end their lives earlier than their natural death (Iverson, 2022). Protection of these vulnerable people who solely suffer from a psychiatric condition is one of the main concerns that opponents of this extension voice. Other concerns are centred around the idea that allowing a mental illness to be the sole condition for MAID will lead to a slippery slope (Rocca, 2022). This fear is often associated with the thought that the rate of Canada's medical assistance in dying rate will increase exponentially. As demonstrated in the jurisdictions around the world that allow psychiatric conditions as a sole condition for assisted death and explored later in this thesis, these fears are not supported by existing evidence.

The controversy over MAID transcends typical party politics in an era marked by political polarization. Maintaining the prohibition on mental illness as the sole condition for MAID access is a considerable mistake that should be corrected rather quickly. This matter is not just a policy debate but a pressing ethical and legal issue that Canada must address sooner rather than later. Continuing to prohibit mental illness as a sole condition for MAID is a violation of equality rights under section 15 of the Canadian Charter of Rights and Freedoms. As will be made clear, the enumerated grounds for equality rights are violated as people who solely suffer from a mental illness are ineligible to access assisted death. Bill C-7's Charter Statement addresses section 15, however, it is contradictory and thus should be reconsidered. The autonomy of an individual who is suffering solely from a mental illness needs to be considered as the current wording of the law excludes these individuals from accessing MAID should they feel

their respective psychiatric condition is impacting the quality of their life such that they live with intolerable pain or suffering. The study of jurisdictions that allow mental illness as a sole condition for assisted death provides a detailed examination of how the fears found in Canada are non-existent in these countries. With the apparent rights infringement and comparative record before it, Canada should allow mental illness as a sole condition for accessing medical assistance in dying.

Medical assistance in dying has been a significant bioethical and legislative issue that has been discussed in Canada for over thirty years. Since the early 1990s, Canada has been dealing with the healthcare politics and associated rights challenges of MAID. A 5-4 split Supreme Court decision in *Rodriguez* in 1993 upheld the complete prohibition of medical assistance in dying. Sue Rodriguez's challenge of Section 241(b) of the *Criminal Code of Canada* concerned the issue of assisted suicide. Assisting in another person's suicide was illegal under Section 241(b) of the *Criminal Code of Canada*. Ms. Rodriguez argued that this section infringed upon her *Charter* rights as guaranteed under Sections 7, 12, and 15(1) because these sections "prohibits a terminally ill person from committing 'physician-assisted' suicide" (*Rodriguez v. British Columbia*, 1993, p. 531). Ms. Rodriguez had been suffering from a debilitating medical condition that was rapidly deteriorating the quality of her life. As a result of this, she wanted to end her life with dignity before her condition worsened to a point where she could not live how she wanted to. The judges in the *Rodriguez* decision stated that the challenged *Criminal Code* section was constitutionally valid, and thus, MAID would remain illegal in Canada. *Rodriguez* was decided in a narrow 5-4 split decision in favour of upholding the constitutionality of the *Criminal Code* Section 241(b). This monumental decision in 1993 remained in place until the law was rechallenged over twenty years later.

The second time a Canadian challenged in favour of medical assistance in dying occurred in 2015, as Lee Carter had made similar arguments to those made in the *Rodriguez* decision. This appeal was allowed. In this case, the Supreme Court justices unanimously ruled that Section 241(b) and Section 14 of the *Criminal Code of Canada* unjustly infringed on the right to life, liberty and security of the person under Section 7 of the *Canadian Charter of Rights and Freedoms*. Between *Rodriguez* and *Carter*, the Court most notably cited that the principles of fundamental justice had changed over this period. In 1993, during the *Rodriguez* case, the principles of fundamental justice looked vastly different from those of the *Carter* case in 2015. This new understanding demonstrated that the concepts of “overbreadth” and “gross disproportionality” are explicitly recognizable as principles of fundamental justice. As Macfarlane et al. note (2023, p. 133), these new principles demonstrate that any law that infringes upon Section 7 of the *Charter* “must not interfere with conduct that has no connection to the law’s objectives or cause harm that is much more severe than the ameliorative objective the law seeks to address.” As a result of these new principles of fundamental justice, any prohibitions on MAID run counter to these two imperative principles. In the *Carter* decision, the prohibition of MAID in Canada was deemed overbroad by the Court in that it did not adhere to the principles of fundamental justice. In this instance, the object of prohibiting assisted dying was “to protect vulnerable persons from being induced to commit suicide at a moment of weakness,” yet the Court recognized “that not every person who wishes to commit suicide is vulnerable, and that there may be people with disabilities who have a considered, rational and persistent wish to end their own lives” (*Carter v. Canada* 2015, Para 86). MAID prohibition laws in the *Criminal Code* were thus a clear violation of Section 7 of the *Charter* (*Carter v. Canada*, 2015, Para 56). Aside from the recognition of the new principles of fundamental justice, another

major change occurred between 1993 and 2015. The Court in *Carter* recognized that comparative evidence in permissive jurisdictions disproved the slippery slope arguments first accepted in *Rodriguez*. There was “no compelling evidence that a permissive regime in Canada would result in a ‘practical slippery slope’” as these permissive jurisdictions do not show signs of any slippery slope (*Carter v. Canada*, 2015, Para 107). With the Supreme Court justices acknowledging that Sections 241(b) and 14 of the *Criminal Code* were unjustifiable infringements of Section 7 of the *Charter*, it became evident that amendments needed to be made. The monumental *Carter* decision in 2015 signalled a shift in the interpretation and understanding of the law.

The federal Liberal government introduced eligibility rules into the Criminal Code in 2016 via Bill C-14. More than twenty years after the initial challenge of Sue Rodriguez, Canada now had legislation in place which would allow certain individuals to request MAID and access this legal procedure. The purpose of Bill C-14 was to strike “the most appropriate balance between autonomy of persons who seek medical assistance in dying, on the one hand, and the interests of vulnerable persons in need of protection and those of society, on the other” (Nicol and Tiedeman, 2016, pp. 7-8). Although this statement is present in the Preamble of Bill C-14, the ultimate impact of Bill C-14 remained a severe infringement on the rights of individuals. The Court had articulated its MAID threshold in *Carter*. The Supreme Court ruled that

“the appropriate remedy is therefore a declaration that s.241(b) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the

circumstances of his or her condition. “Irremediable”...does not require the patient to undertake treatments that are not acceptable to the individual...We make no pronouncement on other situations where physician-assisted dying may be sought” (Carter v. Canada, 2015, Para 127).

With the Court’s remedy now articulated, the government still created Bill C-14 in a narrow manner (Macfarlane et al., 2023, p. 135). The government added the reasonably foreseeable natural death requirement for MAID which was not included in the Court’s initial threshold in *Carter*. As written, Bill C-14 drastically limited the Court’s anticipated threshold for who could access MAID under the Charter. The legislative response to *Carter* added four criteria under the qualifications of a grievous and irremediable medical condition. The most restrictive of these criteria is the ‘reasonably foreseeable natural death requirement’. This criterion “has generated the most interpretive difficulty” as the question that continues to arise “is when does natural death become reasonably foreseeable” (Downie & Chandler, 2018, p. 10). Whereas the Court was articulating a larger threshold for accessing MAID, the government effectively made it necessary for a person to have a terminal illness, even though the definition of reasonable foreseeability is quite difficult for doctors and physicians to interpret. A mere three years after it came into force, Bill C-14 was struck down for its narrow eligibility criteria after it was challenged in the *Truchon* case.

In 2019, *Truchon c. Procureur Général du Canada* contested the eligibility criteria outlined in Bill C-14. Jean Truchon and Nicole Gladu had applied to receive medical assistance in dying, but due to the narrow wording of Bill C-14, these two applicants did not qualify. Within Bill C-14 and Quebec’s *Act respecting end-of-life care*, the applicants did not qualify for MAID as these acts “respectively require that their natural death be reasonably foreseeable or that they

be at the end of life in order to obtain such assistance” (Truchon c. Procureur Général du Canada, 2019, Para 5). However, the *Truchon* decision was predicated on challenging the narrow eligibility criterion of Bill C-14. Bill C-14 altered Section 241.2(1) of the *Criminal Code* so that an individual must “have a grievous and irremediable medical condition” and that “their natural death has become reasonably foreseeable” as outlined in Section 241.2(2) (Rahimi, 2017, p. 462-463). As a result, the government needed to alter the MAID eligibility to ensure that the restrictions do not infringe upon the rights and freedoms of individuals who are suffering and wish to end their lives in a dignified manner.

A person’s natural death is always present in their lives as death is a part of being human. With that being said, it was difficult to fully interpret what the law meant when it says ‘reasonably natural death’ before an individual can access medical assistance in dying. With its incorporation of this requirement, Bill C-14, as challenged by Jean Truchon, was an infringement of an individual’s fundamental rights outlined by Sections 7 and 15 of the *Charter of Rights and Freedoms* (Truchon c. Procureur Général du Canada, 2019, Para 12). The Court ruled in favour of Truchon and Gladu since “the rationale is to allow a person suffering from a grievous and irremediable medical condition, who no longer has any hope of improvement, to end his or her suffering and to avoid living until the final agonizing breaths have been drawn, should the person so desire” (Truchon c. Procureur Général du Canada, 2019, Para 497). With this rationale now apparent, the Court’s ruling in *Truchon* ensured that the restrictions under Bill C-14 would be altered to reflect the Court’s decision.

The federal government decided not to appeal the trial court’s ruling in *Truchon*. Bill C-7 ultimately removed the reasonably foreseeable natural death requirement for an individual to access MAID. This legislation, however, created two alternative tracks as safeguards for

whenever a person's natural death is or is not reasonably foreseeable. Under this new MAID legislation, there is a "10-day waiting period that is currently required between the signing of a request for MAID and the day that MAID is provided is eliminated from the requirements where natural death is foreseeable" (Nicol & Tiedemann, 2021, p. 7). This was a positive step for medical assistance in dying legislation in Canada as there would be no hindrances to further infringe on the rights of suffering individuals who wish to end their lives with dignity. When an individual's natural death is not reasonably foreseeable, Bill C-7 introduced "a 90-day waiting period between when the first assessment is made and the provision of MAID," which was intended to ensure that vulnerable people would not be coerced into ending their lives prematurely (Nicol & Tiedemann, 2021, p. 7). The *Truchon* case expanded MAID legislation to ensure that the eligibility criterion did not infringe on the rights of Canadians who wish to access this medical procedure. It is noted that the impact of Bill C-7 went further than what the *Truchon* decision had intended since the main objective of this case was to remove the restrictive criterion which barred individuals from accessing MAID (Okinski & Grieger, 2021, p. 373).

Although Bill C-7 is an improved piece of legislation that is supposed to be less restrictive than Bill C-14, this amendment to the *Criminal Code* remains highly problematic. Bill C-7 is expansive in nature as it significantly broadened the scope of who could legally access MAID. The bill removed the troublesome barrier of the reasonably foreseeable natural death requirement. One significant group of individuals was explicitly ineligible to receive medical assistance in dying: those who were solely suffering from a mental illness. Bill C-7 explicitly states in section 241.2 of the *Criminal Code* "that a mental illness is not an illness, disease or disability for the purposes of section 241.2(2)(a)," which is an egregious infringement of the rights of these individuals that solely suffer from a debilitating psychiatric condition but want to

end their lives (Nicol & Tiedemann, 2021, p. 7). This new bill was supposed to be more inclusive and expansive for MAID. The continued exclusion of mental illness as a sole underlying condition for MAID is arguably unconstitutional. This exclusion in the *Criminal Code* and Bill C-7 effectively stigmatizes individuals suffering solely from psychiatric conditions as it suggests that these people “do not have the mental capacity to decide when their suffering has become intolerable and that their suffering is somehow less than that caused by physical illnesses” (Lazin & Chandler, 2023, p. 108). Effectively, this conscious decision to exclude mental illness as the sole underlying condition for MAID has seriously negative repercussions on this group of individuals.

Since Bill C-7 explicitly stated “that a mental illness would not be considered an illness, disease or disability for the purpose of paragraph 241.2(2)(a)(clause 1(2)),” the government’s Charter Statement on the bill outlines how this exclusion “is crafted narrowly” (Government of Canada, 2020). Recognizing that MAID is relatively new in Canada, Bill C-7’s Charter Statement foreshadows potential extensions of this law, namely, including mental illness as the sole condition. After Bill C-7 was created, the government has been debating this potential extension as they have claimed that there is a lack of research about how mental illness as the sole underlying condition for MAID would function in Canada. The government planned to incorporate this extension in March 2023; however, mass uncertainty caused the government to continuously advocate for more time to make an informed decision about MAID, where mental illness is the sole condition. Those opposed to opening MAID to mental disorders as the sole criterion focus on a couple of key arguments, namely how nearly impossible it is for psychiatrists to “accurately predict the long-term prognosis of a person with a mental disorder” since having a “grievous and irremediable medical condition” is part of the requirements for this medical

procedure, should a long-term prognosis be difficult, then these individuals would not satisfy this main requirement for MAID (Parliament of Canada, 2024, p. 12). Other concerns from opponents stress how “vulnerable groups, including women, Indigenous people, people with disabilities, people living in poverty, and people in geographically underserved areas” will potentially be negatively impacted by this extended legislation (Parliament of Canada, 2024, p. 14). Where mental disorder is the sole condition, opponents to this extension are focused on the overall protection of these vulnerable groups in society.

By delaying the expansion of assisted dying eligibility until 2027, people who suffer solely from a mental illness must wait for at least three years before legislation allows them to access this service. Even though these people may satisfy other criteria, such as intolerable suffering from an irremediable condition, they still will not qualify for MAID under the current formatting of the legislation. It is apparent that MAID legislation was developed rapidly to ensure that there was no continued infringement on the rights of individuals who wish to end their lives with dignity before their conditions quickly deteriorate. Unlike the first attempts at creating Canada’s MAID regime, it is only now that legislators are taking their time to consider both sides of the debate before making any hasty decisions. This debate is the basis for this Thesis. The guiding research question seeks to address whether prohibiting mental illness as a sole underlying condition for MAID is a serious rights infringement that needs to be altered so that this legislation is no longer restrictive in nature. There are countries around the world that permit mental illness as the sole condition for medical assistance in dying (the Netherlands, Belgium and Luxembourg), and there are countries that provide MAID but have decided not to extend it to those with mental illness as a sole criterion (the United States, Australia and New Zealand). It is the goal of this paper to discover whether Canada can trek the muddled waters of

the ongoing national debate and those within these other countries to determine whether mental illness as a sole underlying condition for someone to access medical assistance in dying should be advanced in this country.

The main problem of this issue goes back to the caution that the government exhibits when considering mental illness as the sole condition for MAID. Intra-caucus uncertainty within the government and debate created a significant divide among even the opposition parties, which ultimately caused the extension of MAID legislation to be halted. Since this social issue is highly divisive, the government wants to be absolutely certain that they have the necessary research and information before allowing mental illness to be the sole condition for MAID. As evidenced by the multiple deadline extensions, the government does not feel they are at a point where they can confidently agree to this new acceptance of who can access MAID. Another plausible reason for the government's continued delay is to avoid any controversy prior to the next federal election. Continuing to delay this decision could be due to the government's unwillingness to expend political capital on this highly divisive matter as the country waits for a new election in this highly polarizing time.

Similar to the legislators who are continuously debating this controversial matter, psychiatrists involved in the MAID process are divided in their opinions about this new law. Some of these psychiatrists advocated for the federal Health Minister Mark Holland and Justice Minister Arif Virani to postpone the March 2024 deadline again for this new legislation (Kirkey, 2023). MAID proponents had reservations before Bill C-14 was created, as there were Liberal MPs who did not vote in favour of this legislation. Former justice minister David Lametti expressed his concern for MAID legislation as he believed this law was too restrictive in nature, and thus, he did not vote in favour of Bill C-14 (Downie & Gilbert, 2019). Other opponents of

MAID, like Trudo Lemmens and Laverne Jacobs (2019), argued that the *Truchon* decision “undermines Parliament’s power to issue broad legislation aimed at protecting the rights and interests of people who are elderly, ill or disabled, and at preventing suicide” as these groups of people are more likely to be coerced into making this life-altering decision in a time of susceptibility. Due to the high relevancy of MAID and mental illness as the sole underlying condition, this thesis will address the long-standing and repeated concerns of those who are vehemently opposed to allowing this legislation to come to fruition. This issue is vast, as both sides have extensive reasons for their positions. However, it will be made clear that further denying mental illness as the sole condition for MAID is a severe infringement of the Section 7 and 15 rights of this group of individuals as outlined by the *Canadian Charter of Rights and Freedoms*.

Apart from the Introduction and Conclusion, the chapters throughout the thesis will cover all the necessary aspects to address the question of whether Canada can trek the muddied waters of the MAID debate so that mental illness can be an eligible sole underlying condition for accessing this end-of-life service. The first chapter will cover the methodology used to complete the Thesis. The subsequent chapters will examine the other jurisdictions that incorporate physician-assisted dying to examine their respective regimes. Relying on government reports and documents for each of the seven countries examined (Canada, the Netherlands, Belgium, Luxembourg, the United States, Australia, and New Zealand) will help facilitate an understanding of why or why not each of these jurisdictions allowed mental illness as a sole underlying condition for accessing physician-assisted death. Following this will be the theoretical section. Here, the inter-institutional relationships between the legislative, judicial, and executive branches of government are examined to show that there have been major court

decisions that lead to understanding how much leeway the court has in interpreting and, subsequently, the legislative response to meet the objectives of the court. From there, the Canadian chapter will examine what opponents and proponents have said when it comes to mental illness as the sole condition for MAID here in Canada. This section of the Thesis will look at section 15 of the Charter to identify the infringement of the right at play when mental illness is not an acceptable sole criterion for MAID. All of this work will lead to the overall conclusion, that mental illness should be an acceptable sole criterion for accessing medical assistance in dying in Canada.

Chapter 2: Theoretical Framing and Methodology

For the theoretical section of this thesis, the work of notable political scientists will be explored to ground the answer to the thesis question. When it comes to dialogue theory, Peter Hogg and Allison Bushell are the two who first wrote about this theory, which highlights the inter-institutional relationship between the legislative and judicial branches of Canada's government. Hogg and Bushell's article, *The Charter Dialogue Between Courts and Legislatures (Or Perhaps the Charter of Rights Isn't Such a Bad Thing After All)*, will demonstrate how this theory has been utilized to develop Canada's present MAID legislation. The use of dialogue theory between the legislators and the judiciary has been present over the years as Canada's MAID legislation has been developed and altered. This thesis will incorporate the accounts of the former Minister of Justice and Attorney General of Canada, Jody Wilson-Raybould, as she was the minister who was primarily responsible for ensuring that medical assistance in dying became legal. Minister Wilson-Raybould makes explicit reference to the theory that the government incorporated to respond to *Carter* as it crafted Bill C-14. Additionally, this thesis will incorporate the report of the Special Joint Committee on Medical Assistance in Dying, which appears to be invoking the dialogue theory. This report is useful as it was the last notable government report published before the government's decision to pass Bill C-62 to grant Canadian legislators until March 17, 2027 to decide on allowing mental illness as a sole condition for MAID.

The second theory incorporated in this thesis is coordinate constitutional interpretation. As made popular by Dennis Baker's book *Not Quite Supreme: The Courts and Coordinate Constitutional Interpretation*, this theoretical approach to interpreting the Constitution ensures that all three branches of the government must fulfill their constitutional obligation of deciphering what the Charter entails. Baker's study "demonstrates that coordinate interpretation, properly understood,

rejects the very notion that a single institution must be supreme in favour of a more robust understanding of institutional relations that appreciates the interplay of formal and informal powers” (Baker, 2010, p. 150). Aside from using Baker’s book, this section of the thesis will also examine the understanding of this work from Eleni Nicolaides and Matthew Hennigar. These authors push coordinate interpretation theory forward by making the claim that the Liberal government utilized this theory to ensure that Canada’s MAID regime is more restrictive. Using the work of these authors is necessary as it was published after the *Carter* decision. Thus, Nicolaides and Hennigar provide insight into how this case demonstrated the invoking of coordinate interpretation for medical assistance in dying.

Canada is one of several jurisdictions in the world that has considered allowing MAID where mental illness is the sole underlying condition. Presently, there are ten countries that allow medical assistance for those dying of physical conditions, with an additional three countries that have recently removed bans on assisted dying. As of July 2022, the Netherlands, Belgium, Luxembourg, Switzerland, Spain, Colombia, the United States, New Zealand, Australia, and Canada have MAID regimes with clear eligibility criteria and safeguards, whereas Germany, Italy and Peru have legalized MAID in their respective courts but do not have these criteria and safeguards (Doelle, 2022). Relatively few countries have MAID legislation for psychiatric conditions. With this being the case, there are a handful of countries that explicitly prohibit this extension into its respective medical assistance in dying or physician-assisted death regimes. As such, a portion of this thesis will focus on examining why these countries have agreed to allow or not allow psychiatric conditions as a sole criterion for assisted death. Canadian legislators can examine the records and reservations experienced in other countries that allow mental illness as the sole condition for MAID. Additionally, this thesis will examine the secondary literature on

the issue of mental illness as the sole underlying condition for MAID access, and engage in an analysis of the relevant Charter issues to show that Canada can navigate the muddled waters of this issue to create a metaphorical bridge to incorporate this into its legislation.

Throughout the thesis, arguments from both critics and advocates of MAID, where mental illness is the sole condition, will be examined through a rights-based approach to facilitate analysis. Both sides of this debate are very outspoken with their respective views. As such, an examination of the work by both advocates and critics will demonstrate the complexity of the matter. Looking at the positives and negatives of this matter will allow this thesis to highlight the critics' fears, but it will also show that these reservations are not evident in the jurisdictions that will be covered in the comparative sections. Although these same fears may have been prevalent when these countries were creating their respective physician-assisted dying legislation, it will be clear that these fears have subsided over the years in the countries that have permitted access, including by drawing on relevant records and statistics that show the relatively low frequency of a psychiatric condition being the sole reason for requesting assisted death. These countries thus provide a reasonable snapshot of what Canada can expect when or if its law is extended to allow mental illness as the sole underlying condition for requesting MAID.

Extensive media coverage also highlights both sides of the debate. News articles will be utilized to highlight the most current and up-to-date information that best informs what the government was doing as the March 17 deadline, which was set to incorporate mental illness as the sole condition for MAID, approached and passed. Ultimately, the government rushed Bill C-62 to receive Royal Assent on February 29. This piece of legislation "serves to pause until 2027 consideration of expanding our laws to allow medical euthanasia to include those whose sole underlying medical condition is mental illness" (Schipper, 2024). The use of news articles

leading up to and just after this bill was passed into law will allow this thesis to capture the response of Canadians to this matter. Additionally, this time frame will highlight the relevancy of the matter. To avoid capturing a particular editorial slant, a range of news sources thought to cover a spectrum of ideological perspectives will be relied upon, including the Globe and Mail, the Toronto Star, and the National Post. Each source has published a plethora of articles on MAID, where mental illness is the sole underlying condition.

Following this is a comparative analysis that will look at critical jurisdictions worldwide incorporating medical assistance in dying or physician-assisted dying legislation. Among these countries, there are six examined in total. The first three allow a psychiatric condition as the sole condition for accessing this medical service. In contrast, the latter three have expressly legislated against incorporating this extension. The countries favouring mental illness as the sole condition for MAID and subsequently have legislation that makes this procedure legal are Belgium, the Netherlands, and Luxembourg. These three countries allow for mental illness as the sole condition for MAID, but their methods of providing this service differ. As of July 2022, Belgium provides MAID through euthanasia. This process is the ending of the life of a patient who has been suffering, which is carried out with the help of a doctor. Both the Netherlands and Luxembourg, like Canada, offer both euthanasia and assisted suicide. Assisted suicide is when medical professionals provide the necessary steps and measures so that the patient can safely end their suffering.

This thesis will look at why these jurisdictions agreed to allow mental illness as the sole underlying condition for this medical procedure. Scholars have argued that the main criterion among the jurisdictions that allow for MAID and mental illness as the sole condition “is that the patient must be experiencing intolerable physical or psychological suffering” (Stoll et al., 2021,

p. 2). Incorporating these jurisdictions into the thesis will allow for a grounded comparison that Canada can draw upon when deciding its MAID future. As Canada is not the first country to look into allowing mental illness as the sole condition for MAID, incorporating the countries where this practice is legalized and established will provide this thesis with a necessary insight into how Canada can effectively incorporate this into its healthcare system. Using relevant statistical data, peer-reviewed journal articles, and news sources from the respective country will offer this thesis a deeper insight into how these countries have handled a psychiatric condition as a sole condition for accessing physician-assisted death. In addition to these sources, this thesis will examine government documents to pinpoint why legislators agreed to allow a psychiatric condition to be a sole condition for accessing assisted death. Incorporating this collection of countries into this thesis will show how the fears experienced in Canada were present in the Netherlands, Belgium and Luxembourg. However, it is the physician-assisted death records of these countries that effectively mitigate fears of what could happen if a psychiatric condition is an acceptable condition by itself for accessing this medical service.

The other three cases that will be compared to the countries listed above are Australia, New Zealand and the United States. These jurisdictions each allow for medical assistance in dying in some capacity, yet they all explicitly do not allow for mental illness as the sole underlying condition. Examining why these jurisdictions oppose MAID, where mental illness is the sole condition, will provide this thesis with counterarguments that Canadian legislators are dealing with as they try to address this issue. Using these three jurisdictions can ground the assessment made in the thesis to determine what Canada could do to avoid an indefinite suspension of this legislation. Ensuring that both sides of the argument are portrayed will be highlighted throughout the thesis. Understanding why other jurisdictions are opposed to this

medical procedure will demonstrate the hesitancy that Canada is facing as it looks to make mental illness a sole condition legal for medical assistance in dying. In this section, government documents and debates are observed to pinpoint why each of these jurisdictions is explicitly opposed to mental illness as a sole condition for accessing MAID. Additionally, peer-reviewed articles will provide a deeper analysis of these three countries and their wanting to allow mental illness to be an eligible condition for assisted death.

Chapter 3: Dialogue Theory and Coordinate Constitutional Interpretation

As the legislative debate surrounding medical assistance in dying in Canada evolves, the two constitutional interpretation theories, dialogue theory and coordinate interpretation, highlight the inter-institutional relationship that exists in Canada. Following the *Carter* decision, the judicial branch offered its policy prescription. The legislature responded. As a response, Bill C-14 was crafted narrowly by parliament, which ultimately restricted the initial threshold set out by the Court. When *Truchon* challenged the narrowed eligibility of Bill C-14, it sparked another round of constitutional interpretation. Canada's present MAID regime emerged following *Truchon*, under Bill C-7. Once again, however, the eligibility requirements were restrictive. This time, the legislation explicitly states that a mental illness as the sole underlying condition does not qualify for MAID. It is important to make this note because both *Carter* and *Truchon* are monumental cases that require constitutional interpretation. As evidenced in these two cases, the courts interpreted what the prescription is to address the issues at play. What occurred after the judicial decisions was the legislature's response in order to meet their respective legislative objectives. As witnessed by the Special Joint Committee for Medical Assistance in Dying report, which came out in January 2024, all three branches of government were communicating about how to proceed with this controversial topic. Unfortunately, the decision by the government following this report demonstrates how a monopoly in one branch over the other branches can often lead to unconstitutional legislation, such as a restrictive MAID regime.

Dialogue Theory and MAID

Peter Hogg and Allison Bushell first popularized dialogue theory in their 1997 article *The Charter Dialogue Between Courts and Legislatures (Or Perhaps the Charter of Rights Isn't Such a Bad Thing After All)*. In this article, Hogg and Bushell (1997, p.79) suggest that "where a

judicial decision is open to legislative reversal, modification, or avoidance, then it is meaningful to regard the relationship between the Court and the competent legislative body as a dialogue.” This understanding highlights how dialogue theory begins with the judicial decision. Without the judicial decision sparking the dialogue, there is no debate about which Charter values are the most important for legislation to be devised (Hogg & Bushell, 1997, p. 79). Proponents of dialogue often reject the notion that legislatures should have an obligation during interpretation. Rather, these advocates for dialogue theory state that constitutional interpretation is in the purview of the courts.

Once the Court in *Carter* ruled that a complete prohibition on physician-assisted suicide was unconstitutional, the judicial policy recommendations for Canada’s MAID regime were followed by the response of the legislature. Dialogue theory holds that “the decisions of the Court almost always leave room for a legislative response,” which is apparent in how Canada’s MAID legislation began (Hogg and Bushell, 1997, p. 105). Hogg and Bushell further outline how judicial review in Canada is the starting point for dialogue. Dialogue theory following judicial review is labelled as the best avenue “to reconcile the individualistic values of the *Charter* with the accomplishment of social...policies for the benefit of the community as a whole” (Hogg and Bushell, 1997, p. 105). Applying dialogue theory to the legislative response to *Carter* demonstrates how beneficial this theoretical approach is to constitutional interpretation. Allowing the judicial branch to make its policy prescription for MAID, followed by the legislative response to this proposal, highlights how dialogue theory works in practice. However, for MAID, where mental illness is the sole condition, dialogue theory alone is insufficient.

Dialogue theory emphasizes a legislative response to court decisions. This is witnessed through the repeated mention of allowing legislatures to modify or reverse a judicial decision.

Eric Adams (2012, p. 326) recognizes that “legislatures have a significant role to play in responding to judicial constitutional determinations,” however, in the wake of Bill C-14, the legislative response was neither *Carter*- nor Charter-compliant. Instead of following the Court’s policy recommendation, the legislature crafted Bill C-14 in a considerably narrower manner than initially suggested. Following *Carter*, the Department of Justice added an addendum to Bill C-14’s Charter Statement. The addendum defended the legislature’s narrow interpretation of Canada’s MAID regime. Canada’s Department of Justice demonstrated how the judicial deference in Bill C-14 “was a valid constitutional response that need not mirror or echo the Court’s ruling in Charter jurisprudence” (Macfarlane et al., 2023, p. 147). Incorporating this addendum highlighted dialogue theory in the early stages of Canada’s MAID legislation. Since the legislature modified the judiciary’s decision to strike down the complete prohibition of physician-assisted death, dialogue theory is evident in the subsequent crafting of Bill C-14. Dialogue theory, when creating MAID legislation, was utilized as a measure to protect vulnerable people. Invoking dialogue theory ultimately created a problematic MAID regime that would be challenged years later.

Dialogue theory has its limitations. This theory has often been referred to as more of a monologue than a dialogue between the judicial and legislative branches. Critics of dialogue note how this theory fails in practice. It is a “two-way communication in which the parties involved listen to each other,” however, this theory “fails because its proponents defend judicial supremacy in terms of final authority to offer the ‘correct’ interpretation of the Charter” (Macfarlane, 2012, p. 41). Those who favour this theory agree that the judiciary should have the final say on constitutional interpretation. More often than not, the legislature took the ruling of the judiciary word for word, which ultimately became law. Critics argue this should not be

regarded as a dialogic response. A common sentiment for when dialogue should count is when the legislature disagrees with the judicial ruling on the interpretation of the Constitution and Charter rights, thus leading to a new legislative outcome (Macfarlane, 2012, p. 42). When the legislature modified the judiciary's recommendation following *Carter*, this is evidently regarded as a valid form of dialogue. Even with this being true, the dialogue in this case significantly impacted the rights of individuals who wanted to request MAID but did not qualify due to the narrowly construed legislation. The construction of Canada's medical assistance in dying regime differed from what was initially recommended by the Supreme Court. Although it is within the legislature's constitutional obligation to disagree and ultimately change the judiciary's recommendation, the legislative response highlights a total disregard for what was proposed after *Carter*. This calls into question the legitimacy of dialogue theory as only two branches of government are involved when interpreting the Constitution or Charter rights.

Although there was a dialogic response following *Carter*, this theory led to an unfavourable MAID regime for Canada. The judicial review process in Canada is statistically one of judicial supremacy due to how infrequently the legislature responds to a judicial ruling. It is recorded that in less than one-fifth of the cases that require the Supreme Court's Charter ruling, there is a dialogic response by the legislature (Macfarlane, 2012, p. 51). Due to the infrequency of dialogue after a court ruling on a Charter issue, the legislature did not know how to adequately respond when it significantly altered the requirements of Canada's MAID legislation. In addressing medical assistance in dying, where mental illness is the sole condition, dialogue theory does not lead to a favourable legislative prescription. Focusing Canada's constitutional interpretation on a coordinated construction model will allow for a greater understanding of the rights at play in this issue. Whereas the legislature remains heavily divided

on the matter, involving the other two branches to provide input can reinforce the system of Canada's judicial review. All three branches of government have a constitutional obligation to interpret the wording of the Constitution and the Charter. Continuing to keep the dialogue metaphor alive after its relative lack of use over time is troubling for future cases that require constitutional interpretation. In one of the few times it has been used, the legislature diverted considerably from the judiciary's recommendation for Canada's MAID regime, which led to the legislation being an unjust infringement on the rights of people who want to access MAID but did not meet Bill C-14's restrictive criteria.

Coordinate Interpretation and MAID

Coordinate interpretation ensures that each branch of government fulfills its constitutional obligation to interpret the wording of the Constitution. Eleni Nicolaides and Matthew Hennigar write about how this model ensures that no one branch of the government maintains a monopoly over constitutional interpretation. Unlike dialogue theory, coordinate interpretation ensures that each branch "has a continuous responsibility to abide by the constitution when it acts, and doing so necessitates interpretation of the constitution by each branch" (Nicolaides and Hennigar, 2018, p. 315). With the executive, legislative and judicial branches of government fulfilling their constitutional obligations of interpreting Charter rights, the coordinate interpretation model could result in a different interpretation of what the Charter requires by each individual branch. Although coordinate interpretation advocates for all three branches of government to fulfill their obligations, Dennis Baker (2010, pp. 151-152) acknowledges how the judiciary plays a leading role in constitutional issues, making it easy to understand how the judiciary is regarded as the appropriate branch to interpret problems like the MAID debate.

Although the coordinate interpretative model means that each branch fulfills its obligations to exercise its constitutional obligations, Macfarlane et al. (2023, pp. 22-23) note how “this does not translate into legislative finality of interpretation any more than it means judicial finality.” This quote demonstrates how coordinate interpretation does not lead to a monopoly occurring in one branch of the government over the others. Regarding medical assistance in dying, it appears the Liberal government had inadvertently invoked this coordinated constitutional interpretation model to defend Bill C-14 (Macfarlane et al., 2023, p. 23). The initial defence of Bill C-14 by the Liberal government was under the guise of the dialogue metaphor. As the bill moved through the steps to receive Royal Assent, the Minister of Justice stated that this legislation needed to comply with the Charter more than repeat the *Carter* decision verbatim. At the report stage, before receiving Royal Assent, the Minister of Justice had improperly cited the dialogue theory when it was noted that “nobody has a monopoly on interpreting the Charter,” which is commonly associated with the coordinate interpretation model (Macfarlane et al., 2023, p. 149). This demonstrates that even those responsible for creating MAID legislation believed they were incorporating dialogue theory when, in fact, they were always using a coordinate model. Although this was in the context of Bill C-14, Bill C-7 was construed in a manner that was, once again, narrower than what the *Truchon* court had decided.

Bill C-7 was created in another questionable manner. The court disagreed with the federal government’s changes to the law. Explicitly stating that persons suffering solely from a mental illness would not qualify for medical assistance in dying was not part of the court’s policy prescription; however, the government implemented this restriction anyway. In defence of Bill C-7, the federal government believed that the law was striking a balance between accessing MAID and protecting vulnerable populations; meanwhile, the court labelled this balancing act as a

broad protection that would discriminate people from accessing MAID due to their mental illness (Macfarlane et al., 2023, p. 150). This difference in interpretation between the government and the court demonstrates how coordinate interpretation could result in three different interpretations of what the Charter requires for this legislative issue. Implementing this restriction in legislation highlights the legislative branch's monopoly in this instance. Both theoretical frameworks cause problems when one of the three branches of the government do not take what the other branches are doing seriously. The main problem rests with the legislature persistently restricting MAID access through the narrower interpretation following the second round of litigation, *Truchon*, which created Bill C-7. With the legislative branch continuing to implement its policy objectives into who can access medical assistance in dying, then no progress will be made in ensuring that mental illness will become an acceptable sole criterion for accessing MAID. When debating whether Canada's MAID regime should allow for mental illness as the sole criterion for access, dialogue theory should be left in the past. Dialogue encourages a monopolistic approach to policy prescriptions. Coordinate interpretation could result in this as well; however, this theoretical approach to constitutional interpretation requires that each branch of the government hold the Charter above all else. Even with the MAID debate being a significant back-and-forth process, both the Charter and the decisions of the court cannot be disregarded by any of the branches of the government.

Coordinate interpretation is fully utilized, as the government's recent ruling gives the government until March 17, 2027, to decide whether to allow mental illness as the sole condition for MAID. Although there was a rare Special Joint Committee on Medical Assistance in Dying, the report's final recommendation reflects dialogue theory. This report shows how, once again, the legislative branch maintains monopolistic control over enacting legislation. In its report, the

Special Joint Committee had heard from countless medical doctors, senators, and other members of Parliament. This attempt at facilitating a discussion on the future of Canada's MAID regime had the makings to replicate the coordinate interpretation model. The dissenting opinion held that "the majority report disregarded this testimony and instead chose to prioritize the testimony of five witnesses who either opposed [MAID where mental illness is the sole medical condition] or had little or no knowledge of the preparedness criteria" (AMAD Committee Report, 2024, p. 25). Even though these experts are not associated with any branches of government, this lack of acknowledgment of the experts dealing with MAID requests regularly mirrors the legislative branch's monopolistic control over creating MAID legislation. Later in the report, Senator Dalphond dissented against the majority of the report as excluding mental illness as the sole underlying condition. The Senator proposed to put a reference forward to the Supreme Court of Canada to ensure excluding mental illness as the sole condition for MAID is constitutional. This report was intended to gain more information on the potential inclusion of mental illness as the sole condition for MAID; however, the ultimate finding of the Special Joint Committee shows a complete lack of coordinated interpretation.

The Special Joint Committee took the opinions of the committee members who did not necessarily have the relevant expertise on MAID MI-SUMC. Allowing the testimony of those without relevant experience, and casting aside the testimony of the committee members with relevant experience on MAID MI-SUMC demonstrates how unlikely this committee was to allow this extension to occur. One dissenting opinion to this joint committee's report highlights the majority report's errors when deciding on MAID MI-SUMC. It is said that

"the committee heard testimony from 21 individuals and organizations who spoke as witnesses over the course of three meetings. The committee heard from 15 witnesses

who had fulsome knowledge of the completion of the preparedness criteria and each witness testified that all the preparedness criteria had been met. However, the majority report disregarded this testimony and instead chose to prioritize the testimony of five witnesses who either opposed [MAID MI-SUMC] or had little or no knowledge of the preparedness criteria. Therefore, the majority report chose to ignore the most pertinent and compelling evidence regarding the federal government's own criteria for preparedness" (Parliament of Canada, 2024, p. 25).

Disregarding this undeniable evidence supporting MAID MI-SUMC in Canada shows how far the legislative and executive branches will go to ensure this extension does not occur in Canada. It is undeniable that Canada's medical system is prepared to handle this extension. However, using the testimony of a few individuals who do not have extensive knowledge of this matter, the government easily decided to continue this prohibition of MAID MI-SUMC.

By recommending the Special Joint Committee to refer to the Supreme Court of Canada on the constitutionality of excluding mental illness as the sole condition for MAID, Senator Dalphond effectively argued for greater involvement of the other branches of the government. Without explicitly calling for it, the Senator implied that coordinate interpretation is required to deal with this constitutional matter. Coordinate interpretation, in this instance, would allow the judges to continue leading the constitutional interpretation, but it would also ensure that judicial decisions would function in an influential manner as this voice that the legislature hears during constitutional interpretation (Adams, 2012, p. 330). Ensuring that the judicial branch has a more prominent role in interpreting the Constitution for medical assistance in dying, where mental illness is the sole underlying condition, would give this legislative option a greater chance of

succeeding in Canada. Legislative supremacy hinders the opening of MAID access. This monopoly held by the legislature will continue to prohibit mental illness as the sole condition for MAID, as evidenced by the recent pushback of the MAID deadline day to March 17, 2027. Once coordinate interpretation is genuinely implemented and followed during constitutional interpretation, the legislation for medical assistance in dying will finally be Charter-, *Carter*- and *Truchon*- compliant.

Discussion

Following the *Carter* decision in 2015, Canada's medical assistance in dying regime has created and changed its legislation. The changes to this legislation occurred after the 2019 *Truchon* decision, which challenged the narrow crafting of Bill C-14. In creating Bill C-14, Hogg and Bushell's dialogue metaphor prevailed as the prominent theory which outlined who could access MAID in Canada. Canada's judiciary ruled in *Carter* and recommended how the MAID regime should be shaped once created. Dialogue theory occurs after the judicial branch makes a ruling in a case interpreting the Charter or the Constitution, and the legislative branch responds by either modifying or creating a new alternative to what was recommended. Although this theory was once highly regarded, the dialogue metaphor should be left in the past. It has been stated that "the dialogue metaphor may no longer be in vogue, it is not yet obsolete," however, this theory is no longer appropriate to deal with complex constitutional interpretation issues such as medical assistance in dying, where mental illness is the sole underlying condition (McMorrow, 2018, p. 98). Dialogue theory was utilized in the creation of Bill C-7. The legislature again modified the judiciary's recommendation for Canada's MAID regime, which is well within their constitutional obligation. Even the advocates of the dialogue theory "object to legislative assertions premised on alternative interpretative judgements about what the Charter

requires. Thus, where critics see rare instances of genuine dialogue occurring when legislatures push back against judicial interpretation, proponents see a ‘dangerous’ and unacceptable practice” (Macfarlane et al., 2023, p. 22). Over time, dialogue theory became obsolete as this interpretative mechanism is no longer sufficient for addressing major constitutional interpretations, such as medical assistance in dying.

Coordinate interpretation, on the other hand, is the better interpretive mechanism for addressing Canada’s ongoing debate about MAID, where mental illness is the sole underlying condition. This constitutional interpretation model advocates for all three branches of government – the executive, judicial and legislative – to fulfill their constitutional obligation to interpret the Constitution. Unlike the dialogue theory, coordinate interpretation “allows for a degree of power sharing by treating judicial interventions as discrete and finite acts to which the non-judicial branches can respond using alternative interpretations in future cases” (Baker, 2010, p. 6). Although this power-sharing seems like a necessary component for ensuring MAID legislation is accepted by the three branches of government, the executive branch dominates the legislative process. As a result, the executive has been politically cautious while handling the potential inclusion of mental illness as a sole criterion for MAID. Macfarlane et al. highlight the major constraint hindering the advancement of MAID legislation. This constraint is “the presence of intra-party disagreement within the Liberal caucus, or even between the cabinet and the PMO,” which could be where the legislature is significantly held up before committing to allow mental illness to be the sole condition to access MAID (Macfarlane et al., 2023, p. 158). Due to cabinet solidarity, it will remain uncertain if the executive branch is the determining factor that has prolonged the extension of MAID legislation. Coordinate interpretation appears problematic in nature in this matter. As it stands, the government is not addressing this Charter

rights issue in a serious manner as it continues to ignore the courts' policy prescription, thus leading to a serious violation of rights. Due to this, coordinate interpretation has not worked thus far. However, unlike with dialogue theory, coordinate constitutional interpretation could work if the rights considerations of individuals whose sole underlying condition for MAID is a mental illness were more pronounced.

The nature of Canada's separation of powers muddies the waters when it comes to who should maintain a slight edge when it comes to interpreting the Constitution. Dialogue theory habitually leaves the executive branch out of fulfilling its constitutional obligation. Baker's coordinated interpretation is claimed to eliminate the possibility of judicial interpretive supremacy (Adams, 2012, p. 324). Both theories contain their respective drawbacks.

Incorporating the executive branch into constitutional interpretation is present when determining whether mental illness can be an acceptable sole condition for medical assistance in dying. Canada's cabinet is regarded as "the key decision-making forum in the Canadian government," which in turn "develops policies to govern the country and introduces bills to transform these policies into law," such as MAID (Parliament of Canada). The government recently ruled to grant a three-year extension until March 2027 to ensure enough information is gathered before allowing MAID MI-SUMC.

The creation of Bill C-7 was done rapidly. This legislation is troubling as it prohibits individuals who solely have a mental illness from accessing MAID. In this instance, dialogue theory took control here. The legislature again modified the judicial ruling in *Truchon*, which demonstrates complete parliamentary sovereignty. Even here, the dialogue theory is not an effective model for constitutional interpretation. Not allowing a single branch of government to maintain a monopoly over interpretation is vital to ensuring every piece of legislation, even

MAID legislation, is constitutional. Canada's present medical assistance in dying legislation evidently was created in a manner that is consistent with dialogue theory with a degree of parliamentary sovereignty regarding this policy outcome. Proponents of dialogue hold that judicial supremacy should outweigh all else when interpreting the Constitution. Although Nicoladies and Hennigar (2018, p. 315) suggest coordinate interpretation occurred when creating Canada's MAID regime, this theory failed in practice when the executive branch ultimately failed to live up to the normative demands of seriously engaging with the rights of individuals who wish to access MAID but whose sole underlying condition is a mental illness. The Charter's requirements were seemingly disregarded by the government and, thus, demonstrates a lack of coordinate constitutional interpretation.

The time the government had after *Carter* and *Truchon* to create MAID legislation was insufficient, as the government's response was rushed. This three-year extension could lead to opposite interpretations of what the Charter requires for MAID by the executive, legislature and judiciary. Even with this three-year extension, these three branches may become farther apart on their respective views of MAID, where mental illness is the sole underlying condition. Even until recently, the Special Joint Committee on Medical Assistance in Dying felt Canada was ill-prepared to allow mental illness as the sole condition for medical assistance in dying, hence why the committee recommended delaying this legislation to give the government more time to understand the issue at play better (AMAD Committee Report, 2024, p. 17). Now that more time has been granted for the government to examine this issue in depth, the coordinate interpretation model can effectively be utilized to ensure that the government can finally allow mental illness as the sole condition for medical assistance in dying. Mental illness as the sole condition for medical assistance in dying can and should become part of Canada's MAID legislation once

coordinated interpretation is implemented correctly. Canada's MAID regime needs to be Charter, *Carter*-, and *Truchon*-compliant.

Chapter 4: Countries with MAID but that do not Allow Mental Illness as a Sole Criterion

Australia

Australia's medical assistance in dying regime is present in its six states. Across Australia, this medical regime is uniformly referred to as voluntary assisted dying (VAD), and each state has its own VAD or End-of-Life Choices Act. States enforce their respective VAD regimes, as Australia's federal and state governments are responsible for implementing health care policies. It is noted that the Australian healthcare system is rooted in the federal government, "which initially left the states with primary responsibility for providing health services" (Australian Government, 2018, p. 3). Within this, each level of government has their respective responsibilities for the Australian health system. The federal government "is responsible for leading the development of national health policy" (Australian Government, 2018, p. 3), whereas state and territorial governments "are responsible for...providing oversight of local health networks, delivering public community-based and primary health services" to their respective constituents (Australian Government, 2018, p. 4). Each Australian state and territory created their respective Voluntary Assisted Dying legislation after Canada created Bill C-14 in 2015. As a whole, Australia used evidence from the Canadian regime to ultimately shape its respective VAD Acts when it came to addressing mental illness as a sole condition for accessing this medical assistance.

Being Australia's first state to legalize VAD, Victoria had a solid pushback to this regime from the start. This state prohibited mental illness as a sole condition for accessing voluntary assisted dying back in 2017 when the legislation was created. Victoria's strong opposition to voluntary assisted dying in the context of mental illness stems from a belief that medical misdiagnoses are significantly more prevalent when the medical cause for requesting VAD is a

psychiatric condition (Parliament of Victoria, 2017, p. 5027). In the Parliamentary Debate of October 2017, the Honourable Richard Dalla-Riva urged other members to read the Voluntary Assisted Dying Bill 2017 report. It is within this debate that Victoria cited the Canadian MAID regime when it was in the process of creating its own assisted dying system. Mr. Dalla-Riva noted how:

“in the Canadian scheme enacted in 2016 there is clear evidence that the coordinating medical practitioner must be satisfied that the consulting practitioner is not a mentor to the other practitioner or responsible for supervising their work, does not know or believe that they are a beneficiary under the will of the person making the request and does not know or believe that they are connected to the other practitioner or to the person making the request in any way that would affect their objectivity”

(Parliament of Victoria, 2017, p. 5027).

They took an unhurried approach to developing Australia’s first VAD Act. Victorian legislators were methodical in their development of the Voluntary Assisted Dying Act and ensured that it was not created in a rushed manner. Victoria was the first Australian state to say that mental illness alone is insufficient for accessing voluntary assisted death.

Western Australia followed Victoria’s approach when developing its Voluntary Assisted Dying Act of 2019. As the second Australian state to create VAD legislation, Western Australia did not differentiate its regime. Section 16(2) of the Voluntary Assisted Dying Act outlines that a person is ineligible to access VAD because they have a disability or they have been diagnosed with a mental illness (Government of Western Australia, 2019, p. 14). The wording of this VAD Act is strategic in nature. As Michaela Okninski (2023, p. 15) reports, requiring that the underlying medical condition is on a serious and deteriorating trajectory is necessary to ensure

those whose lives are likely to end within a short time period can access VAD. In its Final Report, Western Australia's Ministerial Expert Panel on Voluntary Assisted Dying suggested that the appropriate training for non-psychiatrically trained professionals by psychiatrists to screen "for mental disorders and neuropsychiatric conditions" is a safeguarding measure to protect vulnerable people (Government of Western Australia Final Report, 2019, p. 97). Although mental illness as the sole condition for accessing VAD in Western Australia is illegal, an individual can still suffer from a psychological disorder and qualify for VAD should they meet all of the other requirements.

Tasmania prohibits mental illness as the sole condition for accessing voluntary assisted dying within the meaning of the Mental Health Act 2013. This VAD Act makes it illegal for mental illness as the sole condition to be the grounds for requesting this service under section 10(2)(a). An important distinction here is that under section 10(3)(b), "a person who has a mental illness...is eligible to access voluntary assisted dying if the requirements of subsection (1) are satisfied in relation to the person" (Tasmanian Government, 2021). This distinction is the same as what is present in Western Australia. Although mental illness is a prohibited ground for accessing VAD in Tasmania, an individual can have a mental illness and request this service so long as they are at least 18 years of age, have decision-making capacity, are acting voluntarily, and are suffering intolerably with a relevant medical condition (Tasmania Government, 2021). The Minister of Health in Tasmania, at the time, ensured that the amendments to this bill promoted "access and support for those wishing to access VAD while striking an appropriate balance with the rights of those not wishing to participate" (Parliament of Tasmania, 2021, p. 27). Out of the states of Australia, Tasmania and Western Australia are the only ones to recognize

that a person with a psychological disability can request VAD should they meet the other requirements of eligibility.

South Australia's VAD Act 2021 diverges from Tasmania's. Section 26(2) of South Australia's act outlines the strict prohibition on mental illness being the sole condition for accessing this service (South Australian Government, 2021, p. 25). There is no mention of there being any potential circumstance where a person can access voluntary assisted dying should they solely suffer from a psychological disorder. In its decision to continue its prohibition on mental illness as the sole condition for requesting VAD, the Parliament of South Australia established a Joint Committee on End-of-Life Choices before creating its VAD Act. This committee heard strong opposition to this act, which focused on the potential slippery slope that would lead to the eventual coercion of vulnerable individuals, in particular, those with mental illness (Parliament of South Australia, 2020, p. 7). Following this, the report praised Victoria's unhurried approach to its Act. However, it stated that South Australia would not mirror Victoria. Instead, it would "devise legislation that is more efficient and responsive to the patient's needs" while also ensuring that vulnerable populations, like people with psychological disorders, cannot access voluntary assisted dying (Parliament of South Australia 2020, p. 7).

Queensland's Voluntary Assisted Dying Act follows the same vein as the Australian states that enacted this legislation before them. People solely suffering from a mental illness are ineligible to access this medical service. To clarify any confusion on who could qualify for this VAD Act, section 10(2) of Queensland's Act defines what 'suffering' refers to in this context. It is stated that "**suffering**, caused by a disease, illness or medical condition includes – (a) physical or mental suffering," however, mental illness remains a prohibited sole condition for accessing VAD (Government of Queensland, 2021, p. 14). Section 13 of the Act states that "to remove any

doubt...a person with a disability or mental illness – (a) may be eligible under section 10(1)(a); but (b) is not eligible under section 10(1)(a) only because the person has the disability or mental illness” (Government of Queensland, 2021, p. 16). The clarification of this section demonstrates how people in Queensland who solely suffer from a mental illness are unable to access voluntary assisted dying. This state’s VAD Act is similar to the other Australian states in terms of its prohibition of mental illness as an acceptable condition for assisted dying.

New South Wales is the last Australian state to have enacted its Voluntary Assisted Dying Act. This state followed the footsteps of the other Australian states regarding its eligibility requirements. Under section 16(2)(b)(c) of New South Australia’s VAD Act of 2022, it is written that “a person is not eligible for access to voluntary assisted dying merely because that has – (b) dementia, or (c) a mental health impairment within the meaning of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*” (New South Wales Government, 2022). The decision by New South Wales to exclude mental illness as a sole underlying condition stems from reports of stakeholders who spoke out about the matter. These stakeholders held that the VAD scheme in the act “does not adequately screen people who may be suffering from a mental illness such as depression which may affect their decision-making capacity, and therefore, could result in people wrongfully accessing VAD” (Parliament of New South Wales, 2022, p. 28). By providing this input into the development of the New South Wales VAD Act, mental illness as a sole criterion for accessing voluntary dying remains illegal in this Australian state.

Across Australia, the sentiment towards mental illness as the sole condition for voluntary assisted dying is uniform. Although it is phrased differently across each state, the meaning is unanimous. Mental illness alone does not meet the requirements for voluntary assisted dying in Australia. A primary concern of Australia is that vulnerable populations, namely people suffering

from mental illness, will be coerced into ending their lives prematurely with VAD. Many opponents of Australia's voluntary assisted dying regime are concerned with the slippery slope argument. Peta Credlin (2024) points out how "euthanasia starts as a good way to ease the pain of patients in their death agonies and is then steadily extended to anyone with a terminal illness, a debilitating condition, or even chronic depression." To avoid this slippery slope, Australia deemed it necessary to continue its prohibition on VAD when mental illness is the sole underlying condition throughout all of its states.

Further concerns in Australia from senior psychiatrists is that an eligibility requirement results in natural death within half a year. These senior psychiatrists warn that "there is no such thing as a 'terminal mental illness' and that every mental illness could be treated and alleviated" (Credlin, 2024). With there being no such thing as a terminal mental illness, then the eligibility requirement found across all the states, that their condition be terminal within a matter of a couple of months, would be a problem for a person solely suffering from a mental illness. In addition to this, the Australian states also outlawed mental illness as the sole criterion because this alone is "not recognized as underlying medical conditions for the purpose of the law" (Okninski, 2023, p. 15). The strict position held by the Australian states ultimately led to a consistent understanding that voluntary assisted dying and mental illness as the sole condition could lead to the potential coercion of vulnerable populations into premature deaths.

The entirety of Australia's voluntary assisted death regime was created after Canada's first medical assistance in dying legislation was introduced back in 2015. Australia's states had used the Canadian model to mould their own VAD regimes after Canada and other international systems. By using Canada's system and statistics to help create its own voluntary assisted dying regime, Australia shares Canada's general reservations about mental illness as the sole criterion

for accessing this medical service. Like Canada, Australia took a cautious approach while developing its VAD acts across its states. The concerns that Australia has towards mental illness as the sole condition are valid in that a slippery slope can occur should their eligibility broaden to allow for this change. As evidence from other international jurisdictions demonstrates, Australia's concerns are valid, yet the caution here appears problematic. Australia lacks a national bill of rights. Although no direct discussions have been made about mental illness as a sole condition for VAD, sources have argued that there are significant barriers to equal access (McDougall & Pratt, 2020, p. 2). The Australian Human Rights Commission notes how the Disability Convention "requires States parties to provide people with disability equal protection under the law as those without disability," and that these individuals with a disability "enjoy legal capacity on an equal basis with those without disability, and are entitled to support in exercising that capacity" (Australian Human Rights Commission, 2016, p. 32). With there being a known barrier to equal access to VAD in Australia, the Australian Human Rights Commission's acknowledgement that individuals with a disability, including a mental illness, have equal protection and access to the law is contradictory to what each of Australia's respective VAD acts set out.

New Zealand

New Zealand's healthcare policies are centralized, unlike Australia and Canada, where the respective states and territories enact their healthcare policies with the help of their federal governments. In New Zealand, it is the responsibility of the central government to create and set the overall direction and policy objectives for healthcare services, such as its End of Life Choice Act 2019 (Cumming, 2022, p. 67). Although New Zealand's central government enforces the creation of healthcare policies, the End of Life Choice Act here resembles Australia's and

Canada's MAID regimes. Section 5, subsection 2(a) of New Zealand's End of Life Choice Act 2019 outlines how someone is ineligible for assisted dying "by reason only that the person is suffering from any form of mental disorder or mental illness" (Parliament of New Zealand, 2019). This section mirrors what is witnessed in the medical assistance in dying and voluntary assisted death regimes in Canada and Australia. Although mental illness as the sole condition is ineligible for accessing the End of Life Choice Act in New Zealand, people who have a mental illness can still access assisted death if they fulfill the other eligibility requirements, which are identical to Canada's and some of the Australian states current MAID legislation (Health New Zealand, 2024).

Keeping in line with both Australia and Canada, New Zealand legislators share similar sentiments for why they chose not to allow mental illness as the sole criterion for accessing assisted dying. Protecting vulnerable populations is, again, one of the main concerns that New Zealand legislators have with voluntary assisted dying. This concern for vulnerable people stems from the belief that these individuals are "susceptible to coercion" and would be an easier target to be pressured into requesting VAD because they were compelled by another to do so (Report of the Health Committee, 2017, p. 47). Instilling the prohibition of mental illness as the sole condition for voluntary assisted dying keeps in line with the reasoning of legislators in Australia and Canada. A second common concern is the accuracy of diagnosing a grievous mental illness. Opponents of the End of Life Choices Act highlight how some mental illnesses can be temporary or even easy to hide, therefore leading to a misdiagnosis and a premature death of an individual who was not necessarily suffering (New Zealand House of Representatives, 2019, p. 23). New Zealand's legislators aim to protect vulnerable populations with the prohibition of mental illness as the sole condition for voluntary assisted dying. Aside from this, opponents of the bill in New

Zealand also argued that those suffering from a mental illness and wishing to end their life “should be supported and cared for” as this could alter the individuals’ perception and ultimately lead them to not want to request VAD (New Zealand House of Representative, 2019, p. 24). With New Zealand’s End of Life Choice Act being enacted relatively recently, it can be said that legislators have modelled their regime after Canada’s MAID legislation.

New Zealand is not considering extending the eligibility of its End of Life Choice Act. This relatively new act is in the midst of its periodic review, as outlined by the terms of the initial outline of the bill. It is still being determined whether legislators there will consider allowing mental illness to be the sole condition for VAD. Considering Canada is contemplating this extension within its MAID regime, discussions in New Zealand about the broadening of these requirements should occur sooner rather than later.

The United States

In the Western world, the United States was among the first nations to have some of its states legalize medical assistance in dying. Similar to Australia, the United States’ healthcare policies are individualized. Each state creates and enforces its healthcare guidelines. Oregon was the first state to enact its Death with Dignity Act in 1994. It is interesting to note that Oregon’s Death with Dignity plainly states that an individual “suffering from Alzheimer’s, dementia, or for some other reason is mentally deficient, is incapable of making an informed decision and thus is not eligible to use the Act” (Oregon Legislature, 2012, p. 2). Out of the eleven American states that have legalized MAID, Oregon is one of the only states which explicitly states that any mental deficiency does not meet the eligibility requirements for accessing this medical service. A few years after this act was put into force, Raphael Cohen-Almagor and Monica Hartman (2001, p. 283) stated that a potential revision “should be to include a mandatory referral to a psychiatrist

to assess individuals' mental capabilities and to determine that the patients do not suffer from depression.” Since Oregon was the first state in the United States to legalize MAID, the next ten states followed suit in creating their respective MAID regimes, using this first Death with Dignity Act as the mould which others have used.

The following three states to legalize medical assistance in dying, Washington State, Montana, and Vermont, are similar in their respective eligibility criteria. In 2008, Washington State's Death with Dignity Act required that an individual be diagnosed with a terminal illness that will “produce death within six months” (Washington State Department of Health). However, the individual must be mentally competent to decide to access MAID. Mental illness is not mentioned as the sole condition for accessing this medical service. Montana's Death with Dignity Act is under constant threat of being overturned by its legislators. Judge Dorothy McCarter ruled that Montana has a constitutional obligation to allow “a competent terminally ill patient to die with dignity” (Compassion & Choices). This state's MAID regime once again emphasizes the individual's mental competency as part of the requirement to access this service. Again, this legislation does not address the potential for mental illness as the sole condition for MAID. Finally, Vermont's 2013 Patient Choice and Control at the End of Life Act also gives individuals with a terminal illness a choice to access MAID. This state modelled its system after the medical assistance in dying regimes of Oregon, Washington State and Montana. Kathryn Tucker (2014, p. 690-691) notes how Vermont limits its MAID eligibility “to ‘capable’ patients,” with capable being defined “as having the ability to make and communicate health care decisions.” The words of this act have an underlying message to them: mental illness as the sole condition for MAID is insufficient. These three states make no mention of mental illness or

psychiatric conditions that could be present when an individual requests medical assistance in dying. All these states require mental competency when making a MAID request.

The remaining seven states with medical assistance in dying legislation share an interesting caveat that Canada should consider incorporating into its current system. The MAID regimes of these states were enacted from 2015 through 2021. California's End of Life Option Act of 2015 lays out the same eligibility requirements that the first four states did: an individual must be suffering from a terminal disease. No mention of mental illness as a sole criterion exists in this Act. In Colorado, the End of Life Option Act of 2016 ensures that an individual's terminal illness has a prognosis of six months or less (Colorado Office of Legislative Services, 2016). The District of Columbia's Death with Dignity Act 2016 has the same six-month prognosis as the other states, and it also notes that a patient is ineligible for this service if they are "suffering from impaired judgment as a result of depression or a psychiatric or psychological condition" as this would impair their mental competency to decide if MAID is the right course of action for them (Government of the District of Columbia, p. 1). The last four states, Hawaii, New Jersey, Maine, and New Mexico, all share the same sentiment towards mental illness as the condition for accessing MAID. These remaining states' respective medical assistance in dying legislation says that the patient must be terminally ill and mentally competent to make this decision free from coercion (State of Hawaii 2018, New Jersey Health 2019, & Maine Death with Dignity 2019, Legislature of New Mexico 2021).

Although the following seven states differ slightly in their eligibility requirements, they all share a common feature when mental illness or a psychiatric condition is present when a patient requests medical assistance in dying. It is interesting to note that each of these states has a requirement if a doctor believes that their patient suffers from a psychiatric disorder or mental

illness. The doctors are responsible for referring said patient to a mental health professional or counselling. Considering how this obligation can be applied to the Canadian context is fascinating. In the United States, requiring this full psychiatric consultation is a measure whereby psychiatrists could potentially identify treatable psychological conditions that can relieve some of the patient's suffering (Bourgeois et al., 2018, p. 449). This standardized protocol that began with California's End of Life Option Act in 2015 is evident in various capacities in the next six states that legalized physician-assisted death. California is the only state of these seven states to refer a patient for a mental health assessment. In Colorado, Hawaii, New Jersey, and New Mexico, doctors in these states have to refer their patients to a mental health professional, ideally for a mental health assessment, before agreeing to move along with the medical assistance in dying process. Maine and the District of Columbia are the only states that require psychiatrists to refer their patients to counselling. Regardless, the obligations of psychiatrists and psychologists in these seven states to refer their patients to mental health services can be an essential takeaway that could be implemented elsewhere. Ensuring that a psychiatrist or a psychologist examines an individual who could be suffering from a mental illness and requesting MAID has the potential to be an important safeguard that Canada should consider for its regime.

The eleven states to legalize physician-assisted death in the United States do not address mental illness as the sole condition for wanting to access this medical service. Each of these states requires mental competency; however, mental illness as the sole condition is left out of each of the respective state legislations. Although the states do not bring up mental illness as the sole criterion for MAID, it is noteworthy that seven of the eleven states which legalized MAID require doctors to refer their patients who may be suffering from a mental illness to a mental

health professional. Canada should take note of this aspect of the American system and potentially incorporate it to create this hypothetical bridge over troubled waters.

Chapter 5: Countries with MAID that Allow Mental Illness as a Sole Criterion

The Netherlands

The first country to legalize euthanasia was the Netherlands. Like Canada, the Dutch state's power is not consolidated in one branch. There is a separation of powers where the judicial branch is "independent of the legislative and executive," however, "legislative power...is shared between the parliament, consisting of two chambers, and the government...[and] the government is the executive" (Hesselink & Parren, 2008, p. 11). In November of 1984, the Dutch Supreme Court ruled on its initial euthanasia case, which outlined the requirements physicians are to follow to not be criminally liable when assisting in the death of another individual. The Dutch Supreme Court states that

"although euthanasia and assisted suicide are subject to criminal prosecution, a physician will not be found guilty when performing euthanasia or assisting with suicide based on a conflict of duties. Such a conflict of duties arises when the physician's professional obligations force him or her to act against the formal provisions of the penal code but in accordance with the explicit wish of the patient, and the viewpoints developed in medical ethics. Based on this conflict of duties the physician may invoke the defense of necessity as laid down in the general provisions of the Dutch Penal Code. When the court decides that this defense should be honored, the physician will be discharged from further criminal prosecution" (Legemaate & Gevers, 1997, p. 176).

It is essential to note this separation of powers in the Netherlands because the Dutch euthanasia act that allowed mental illness as a sole condition originated from the Supreme Court of the Netherlands decision in the *Office of Public Prosecutions v Chabot* case. In this case, the

psychiatrist, Dr. Chabot, aided in the death of his patient, Ms. B., who had been suffering from an intense, long-term psychiatric condition that had made her want to end her life with the help of a doctor (Downie, 2000, p. 125). Although euthanasia was illegal, the Supreme Court of the Netherlands made significant conclusions that ultimately resulted in psychiatric suffering being an acceptable condition for accessing PAD. The Dutch Supreme Court concluded in *Chabot* that “1) suffering need not be physical; 2) a patient need not be terminally ill; and 3) a patient may be a psychiatric patient,” which ultimately set the standard for the forthcoming euthanasia law, even if it was practiced before the act was put into power in 2002 (Downie, 2000, p. 126).

In the Netherlands, euthanasia and physician-assisted suicide have been practiced for over fifty years, as early reports state that this medical assistance has occurred since the 1970s (Cohen-Almagor, 2002, p. 141). The Termination of Life on Request and Assisted Suicide (Review Procedures) Act was passed in 2001 and came into force and effect on April 1, 2002 (World Federation Right to Die Societies, Nd). The contents of this bill are a review of the procedures to ensure that a physician fulfills their due diligence when completing a request for assisted suicide. The act outlines a physician’s requirements to ensure due care is followed during this process. It is evident in the act that there is a significant emphasis on guaranteeing that the participating physician completes every aspect of due care. Although it is not explicitly stated in the act, physician-assisted suicide in the Netherlands “is possible for patients who have a voluntary and well-considered death wish and who suffer from a medical or psychiatric condition that is unbearable and irremediable” (van Veen et al., 2022, p. 1). An individual suffering from a psychiatric condition has been able to access MAID “since the 1990s,” which demonstrates how early on, the Dutch regime was willing to allow mental illness as the sole condition for physician-assisted suicide (van Veen et al., 2022, p. 1).

For the first twenty years of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, a psychiatric condition alone was insufficient for accessing both euthanasia and physician-assisted suicide in the Netherlands. Advocates for the incorporation of allowing a psychiatric condition to access physician-assisted death (PAD) were the Dutch Psychiatry Association and the Royal Dutch Medical Association. These associations issued a statement declaring “that if PAD is allowed for somatic suffering, it should also be allowed for psychiatric suffering,” which was then supported by the Dutch Supreme Court after its 1994 ruling in the *Chabot* case (van Veen et al., 2022, p. 2). Within this case, the Dutch Supreme Court held “that the defendant acted in a situation of necessity...that, confronted with a choice between mutually conflicting duties, he chose to perform the one of greater weight” (Griffiths, 1995, p. 236). Ultimately, the Supreme Court rejected Chabot’s defence of necessity; they argued “that when the case involves a person whose suffering is not based on a somatic disease or condition, trial judges may accept the claim of necessity only when – among other things, they can base their decision on the judgment of an independent medical expert who has seen and examined the person,” which did not occur in *Chabot* (Legemaate & Gevers, 1997, p. 181). The Dutch parliament followed *Chabot* by asking if the legislation would be affected after the ruling in this case. In its response, the Dutch government stated that there would be no changes to how the legislation is worded or functions (Legemaate & Gevers, 1997, p. 182). In its justification, the Dutch Supreme Court’s *Chabot* ruling not only made psychiatric suffering a sole condition for PAD, but it also inspired the safeguard that the consultation of another expert is mandatory when an individual is only suffering from a psychiatric condition.

Although assisting in one’s death is still illegal in the Netherlands, a physician can be exempted from criminal prosecution if they follow all the criteria of due care outlined in the act.

When the physician assists an individual with a physical condition, there are only six due care requirements; however, when psychiatric suffering is involved, a seventh due care criteria is required as a safeguarding measure. Van Veen et al., (2022, p. 3) note how

“the physician must: (1) be satisfied that the patient’s request is voluntary and well-considered; (2) be satisfied that the patient’s suffering is unbearable and that there is no prospect of improvement; (3) inform the patient of his or her situation and further prognosis; (4) discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution; (5) consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the due care criteria listed in the four points above; (6) exercise due medical care and attention in terminating the patient’s life or assisting in his/her suicide.”

When psychiatric suffering is involved, the seventh due care obligation states that “a second opinion must be performed by an appropriate expert,” which is typically a psychiatrist who specializes in the disorder that the individual requesting PAD is suffering from (van Veen et al., 2022, p. 3). These safeguards have been in place since the Netherlands euthanasia act was created in 2002.

It is interesting to note that the Netherlands has a regional euthanasia oversight committee to which the physician performing assisted suicide or euthanasia reports. This oversight committee confirms that the physician followed all six or seven due care requirements, depending on the type of assisted suicide that occurred. In the Netherlands, the euthanasia oversight committee is comprised of a physician, an ethicist, and a lawyer, who need to be satisfied that the physician assisting in a person’s death completed all the due care requirements

(van Veen et al., 2022, p. 4). This committee determines whether or not the physician should be clear from prosecution. If there is any doubt about the care of the physician, additional information may be required to be sent to the committee for review; and again, if there are grave reservations about the physician's involvement in the death of another person, then further investigation and even prosecution may occur (van Veen et al., 2022, p. 4). Although the safeguards in the Netherlands seem significantly less stringent than those in Canada, the number of people successfully receiving PAD for a psychiatric condition in the Netherlands is not as concerning as critics in Canada fear it would be. Psychiatric patients requesting medical assistance in dying were estimated to be around 1,100 and 1,150 from 2015 to 2016, yet only an estimated 60 or 70 of these requests effectively resulted in PAD (Dom et al., 2020, p. 664). This data shows that the number of requests is significantly higher than what is actually performed.

Including psychiatric suffering in the Dutch euthanasia act is a positive step in the right direction for recognizing this type of pain can be unbearable, but its inclusion was also met with hostility. The concerns about this inclusion in the Netherlands are the same as those in Canada today. Protecting vulnerable populations remains the biggest worry when it comes to allowing psychiatric suffering as an acceptable condition for PAD. Psychiatrists assessing a patient's suffering note how difficult it is to find an accurate prognosis or if a patient meets the legal criteria to access this service (Kim, 2019). Other experts in the field are concerned with how the threshold for suffering is being measured in patients who have an unbearable psychiatric condition. This fear is linked with the common sentiment that the rate at which euthanasia cases for psychiatric suffering are growing. As Senay Boztas (2016) notes, "the Netherlands has seen a sharp increase in the number of people choosing to end their own lives due to mental health problems" as "euthanasia cases rose 75% in the past five years, from 3,136 in 2010 to 5,516 [in

2015]. Cases for psychiatric reasons grew from just two people (0.1% of the total) in 2010 to 56 people... (1%)” in 2015. The frequency of these cases increased again over the next five years. Van Veen et al. (2022, p. 4) report that in 2020, the total number of physician deaths was 6938; in 65% of the cases, the patient had cancer, and in less than 1.5% of the cases, the suffering was the result of a psychiatric disorder. There is an apparent increase in the frequency of instances where a psychiatric disorder is the reason for wanting to access PAD. However, the common concern about incorporating psychiatric suffering as an eligible condition for PAD is that there would be an exponential increase in the number of cases. As evidenced by the data, the number of requests for PAD for psychiatric suffering is significantly higher than the times that it occurs in the Netherlands. This discovery proves that the PAD regime ensures that only those who meet the outlined criteria are gaining access to this service, which in turn lends evidence against the common fear that a slippery slope will occur.

The Dutch model of euthanasia is progressive as it was the first country to legalize physician-assisted death, so long as the physicians fulfilled every aspect of their due care requirements. Although the act came into force in 2002, the practice of PAD began decades prior. As noted above, in the 1990s, psychiatric suffering was regarded as being an unbearable pain that would be a sufficient condition for a patient to access physician-assisted death in the Netherlands. This Dutch model is open-minded, especially considering when mental illness became an accepted condition for accessing PAD.

A notable safeguard of the Dutch model is the regional euthanasia oversight committee. Following its passing in 2002, the Euthanasia and Assisted Suicide Review Act ultimately “gives these Committees a quasi court-like status as interpretations of the due care and attention criteria are within their remit and are likely to remain unchallenged” (Pakes, 2005, p. 80). Holding this

relative weight when reviewing euthanasia cases, the Regional Euthanasia Review Committees is an effective safeguard for the Netherlands. In its 2022 Annual Report, the Regional Euthanasia Review Committees state that of the more than 8,500 cases of physician-assisted death, patients suffering from a psychiatric condition occurred in 115 cases, which accounts for 1.3% of all cases in the Netherlands, the least of all conditions listed (Regional Euthanasia Review Committees, 2023, p. 3). Since its inception, the Dutch Regional Euthanasia Review Committees on euthanasia and physician-assisted suicide have proven to be an effective safeguard. Studies of the Dutch euthanasia and physician-assisted suicide “system have found little evidence of abuse and praise the ‘scrutiny’ of the ‘rather rigid evaluations’” as this committee holds physicians accountable for fulfilling all the necessary due care requirements (Miller & Kim, 2017, p. 9). In their study on the judgements of the review committee, David Miller and Scott Kim examine the instances when the committee deemed the actions of the physician did not meet the due care criteria. Out of the 49,287 cases between 2002 and 2016 that Miller and Kim studied, it was found that 0.18% of these cases did not meet the due care criteria, meaning that in the significant majority of cases, the physicians followed all required criteria when assisting in someone else’s death (Miller & Kim, 2017, p. 9).

Belgium

The Belgian euthanasia act came into force almost two months after the Dutch physician-assisted death act was passed. With over twenty years of being in force, the Belgian Act of physician-assisted death provides insight into how this system has operated while allowing mental illness as the sole condition for accessing this service. Other aspects of this law have been referred to as “a ‘slippery slope’” as “updates to the law have seen Belgium become the first and

only country in the world to have no lower age limit enforced for children,” which is beyond the scope of this study (ADF International, 2022). There are additional safeguards present in Belgium’s Act on Euthanasia, which alleviate the concerns that allowing mental illness as the sole condition would drastically increase the MAID cases seen in the country yearly.

After the turn of the century, Belgium created “The Belgian Act on Euthanasia on May 28th, 2002,” which not only protected physicians who perform euthanasia from a criminal offence but also allowed people suffering from a psychiatric disorder to access this service. Section 3 of this act states that “the physician who performs the euthanasia commits no criminal offence when he/she ensures that...the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident” (The Belgian Act on Euthanasia of May 28th 2002, p. 182). Since this act allows individuals who are mentally suffering to access euthanasia, there are safeguards in place which protect this group of people. It is the required due diligence of the Belgian physicians to ensure they follow the ‘Conditions and Procedure’ section of the euthanasia act. The first role of the physician when a patient considers euthanasia is that both parties must go over all potential care options. The parties must be under the belief that the patient’s condition does not have any possible alternative that would make the condition less unbearable (The Belgian Act on Euthanasia of May 28th 2002, p. 182). The physician and patient must be of the same understanding that the patient’s condition, whether physical or psychiatric, is significantly unbearable to the point where no care option could alleviate the suffering that said patient experiences daily.

It is interesting to note the similarity between a safeguard found in the Belgian Euthanasia Act and Canada’s MAID Act. When a patient’s death is not reasonably foreseeable in

Belgium, then physicians are required within its act to do an extra step before proceeding with this service. Subsection 3 of the act states that the physician must also:

- 1) Consult a second physician, who is a psychiatrist or a specialist in the disorder in question, and inform him/her of the reasons for such a consultation. The physician consulted reviews the medical record, examines the patient and must be certain of the constant and unbearable physical or mental suffering that cannot be alleviated, and of the voluntary, well-considered and repeated character of the euthanasia request. The physician consulted reports on his/her findings. The physician consulted must be independent of the patient as well as of the physician initially consulted. The physician informs the patient about the results of this consultation. (The Belgian Act on Euthanasia of May 28th 2002, p. 183).

By bringing in a psychiatrist who specializes in the disorder that the patient is suffering from, the Belgian Act on Euthanasia certifies that an unbearable condition accompanies the patient's request for assisted death. Guaranteeing that a patient's condition is intolerable ensures that the patient's choice to access euthanasia is made as a result of the said condition and not because of a rash decision.

The second notable safeguard Belgium incorporated for when a person's death is not reasonably foreseeable is considerably different from Canada's. Whereas Canada's safeguard for when an individual's death is not reasonably foreseeable is a 90-day waiting period, Belgium's is less than that. It is documented that the physician must "allow at least one month between the patient's written request and the act of euthanasia" (The Belgian Act on Euthanasia of May 28th 2002, p. 183). This sixty-day difference between Belgium's and Canada's safeguard waiting

periods is substantial enough to warrant a change. Canada's 90-day waiting period is arbitrary, and there is no reason for it to be longer than a month than the Belgian period. It is interesting to see this difference amid these pieces of legislation. It is unclear why the Belgian Act on Euthanasia set its waiting period at one month when the patient's natural death is not reasonably foreseeable. This shorter waiting period does not appear to result in a higher frequency of people requesting euthanasia for a psychiatric or non-terminal condition.

Euthanasia in Belgium is a thought-provoking case for assessing end-of-life regimes and psychiatric conditions. Before the act was entered into force and effect, illegal euthanasia still happened in the country. While euthanasia was prohibited, it "was relatively common and well documented," however, "before 2001 there were 'no or hardly any cases of persecution [sic], let alone, punishment, of any physicians that have performed euthanasia.'" (Saad, 2017, p. 185) Since it was practiced frequently, assisted death became an acceptable practice in Belgium. Saad (2017, p. 185) notes how there was "little willingness on the part of the authorities" to prosecute physicians who performed euthanasia before the act became enforced and "that Belgium's *ex post facto* legislation was simply a natural development in the practice of euthanasia." In the first twenty years after the euthanasia act was created, it is stated that "370 patients received euthanasia for unbearable suffering caused by a psychiatric disorder (1.4% of the total number of euthanasia cases)" (De Hert et al., 2023, p. 1). Over these two decades, the number of psychiatric cases has been less than 1.5% of the total euthanasia cases, which indicates that Canada's primary concern is not supported by evidence from other countries. The safeguards that have been implemented in Belgium are adequate in that they do not allow someone to request physician-assisted death without unbearable suffering from a psychiatric or physical condition.

Similar to the Dutch regime, the wording of Belgium's Act on Euthanasia can be problematic when it comes to determining that there are no other treatments to alleviate the suffering of the patient. The pushback to euthanasia is that there could be alternative paths a patient could take instead of ending their life. As Saad (2017, p.196) states, the “‘no reasonable alternative’ phrase is surely too prone to differing interpretation to be useful legislation,” which shows how the threshold on a reasonable alternative is undefined and open to be understood on a case-by-case basis. Alternatively, the pushback to the Belgian Euthanasia Act surrounds the legitimacy of an unbearable psychiatric condition. Psychiatric disorders and the suffering they cause can fluctuate over time, frequently leading to a problematic prognosis from a physician (Dierickx et al., 2017, p. 2). This is a common fear that is expressed in Canada as well. Even though diagnosing a psychiatric condition has been labelled as a challenging task for physicians and psychiatrists, this concern is relatively unsubstantiated. There are reports from studies that state that “mental capacity in psychiatric patients show that mental capacity can be reliably assessed” (Dierickx, 2017, p. 6). Since Belgium's Act on Euthanasia requires that a second physician, namely a psychiatrist who specializes in the disorder in question, needs to be consulted when the patient is not expected to die soon, this requirement can ensure that the mental assessment of the patient demonstrates an unbearable psychiatric condition and not a rash decision made in the heat of the moment.

Luxembourg

Luxembourg's political system is similar to those examined earlier. Seven years after the Netherlands and Belgium enacted their respective euthanasia legislation, Luxembourg then created its system for dealing with assisted death. Named the Law of 16 March 2009 on Euthanasia and Assisted Suicide, a patient can access this service should they be suffering from a

physical or psychological condition with no prospective improvement (Official Journal of the Grand Duchy of Luxembourg, 2009). This act outlines the required steps that a doctor must follow so as not to be criminally liable for any actions that could result should they not follow the steps of the procedure. After examining this legislation, Luxembourg followed the same path the Netherlands and Belgium had paved for them years prior. The legislation did not stem from a case that challenged a lack of legislation like what occurred in the other countries. Rather, this law was “introduced by socialist and green deputies” as they saw what occurred in the Netherlands and Belgium and how this legislation could help suffering individuals in Luxembourg (Welt, 2008).

Under the ‘Request for Euthanasia or Assisted Suicide, Conditions and Procedure’ section of the act, Luxembourg effectively mimics the eligibility criterion of the countries that enacted their respective legislation first. Before the doctor can carry through with the patient’s euthanasia or assisted suicide request, they must be complicit with the conditions set out in the act. Doctors in Luxembourg, like the doctors in both Belgium and the Netherlands, must inform the patient of their life expectancy and the severity of their condition while also ensuring “the persistence of the patient’s physical or psychological suffering and his will expressed recently respectively reiterated” (Official Journal of the Grand Duchy of Luxembourg, 2009). What is interesting about the Luxembourg legislation is that there is nothing stating what needs to happen when an individual’s death is not reasonably foreseeable. Regardless of how close an individual is to death, the Luxembourg Act on Euthanasia or Assisted Suicide ensures that the doctor, in every case, must “consult another doctor about the serious and incurable nature of the condition” to ensure that the suffering of the patient is “unbearable and without the prospect of improving his physical or psychological suffering” (Official Journal of the Grand Duchy of Luxembourg,

2009). Since this is the requirement for every case, the Luxembourg model expands on Belgium's requirement that a second physician must be consulted only when a patient's death is not expected to occur soon.

Luxembourg mimics the Dutch and Belgian euthanasia regimes in more ways than just through its safeguards and the development of its Act on Euthanasia or Assisted Suicide. These three countries all "have review committees designed to ascertain if the Act is being used with 'due care' by involved clinicians," which holds participating doctors accountable for following each of the requirements of this legislation (McCormack & Fléchais, 2012, p. 321). Having review committees in these three countries ensures that no vulnerable person is coerced into ending their life by an external party. Each step of Luxembourg's Act on Euthanasia or Assisted Suicide protects susceptible parties by ensuring that the proper procedures and consultation from other physicians occur before going through with this end-of-life procedure. When it comes to dealing with mental disorders as the sole condition for accessing euthanasia, the doctors of the Benelux countries (Belgium, the Netherlands, and Luxembourg) have an obligation when deciding that the patient's request for assisted suicide or euthanasia that this decision is constant with the individual's lifelong values (McCormack & Fléchais, 2012, p. 324). Having this commitment from doctors to ensure that the patient's request to access euthanasia or assisted suicide is consistent with the individual's values demonstrates how the safeguards of this legislation are correctly functioning.

It should be noted that there is a general lack of research into Luxembourg and its Act on Euthanasia or Assisted Suicide. The limited data presented does not show any insight into why Luxembourg's assisted suicide statistics are considerably less than the other countries studied. The first instance of assisted death in Luxembourg occurred between 2009 and 2010, where only

“5 patients died under the Luxemburger act and all had cancer. Therefore, no patient had exclusive mental disorder” (McCormack & Fléchais, 2012, p. 322). This small statistic was only studied for a year, demonstrating a lack of information on the prevalence of Luxembourg’s Euthanasia or Assisted Suicide Act. McCormack and Fléchais’ 2012 study provides statistics for the number of psychiatric referrals for each jurisdiction with assisted dying legislation. The statistics for other countries are present; however, neither the Netherlands nor Luxembourg’s psychiatric referral numbers have been published (McCormack & Fléchais, 2012, p. 322). The last statistics to be published for Luxembourg’s assisted suicide or euthanasia cases occurred a decade after McCormack and Fléchais’ study. Luxembourg’s National Commission for Control and Evaluation published a report with statistics from 2009 until 2022. Throughout this time, there have been 170 total cases of assisted death or euthanasia cases, of which only 29 of these cases were due to a neurodegenerative or psychiatric condition (Commission Nationale de Contrôle et d’Évaluation, 2023, p. 9). These statistics were taken over a thirteen-year period, and thus, the rate at which individuals suffering from a psychiatric condition were requesting PAD is relatively low on a yearly basis. The limited statistics demonstrate that an individual suffering from a psychiatric condition who wishes to request assisted suicide or euthanasia is considerably less than an individual requesting this service who is suffering from a physical condition.

Since these Benelux countries have very similar legislation on assisted suicide and euthanasia, there is little to no variation in the requirements to request this service. The only difference in Luxembourg’s act is that they do not address what happens when an individual’s death is not reasonably foreseeable. Even with this being the case, the statistics from Luxembourg demonstrate that there has not been an increase or a disproportionate number of individuals requesting this service because they suffer from a psychiatric condition. This may not

be true in Canada, but it is thought-provoking to see what could happen in Canada should the legislators remove the reasonably foreseeable natural death requirement from its MAID regime. Ultimately, Canada should examine what has transpired in these countries that have legalized assisted suicide and euthanasia for psychiatric conditions. The lessons learned from these countries can prove to be instrumental for Canada as its legislators decide on whether or not to allow mental illness to be an acceptable underlying medical condition to access MAID.

Chapter 6: The Canadian Context

As has been evidenced throughout the Thesis, the issues surrounding medical assistance in dying where mental illness is the sole underlying condition (MAID MI-SUMC), come from polarizing viewpoints. Those who oppose mental illness as a sole condition for MAID argue against this extension for a variety of reasons that are echoed throughout the leading scholarship on the matter. The themes of this opposing view surround “capacity, value of life, vulnerability, stigma, irremediability, and the role of physicians,” as these arguments are aimed at protecting individuals whose psychiatric condition may not lead to their eventual death like a severe physical condition would (Dembo, Schuklenk, & Reggler, 2018, p. 451). One of the major concerns of opponents of MAID MI-SUMC is the mental capacity of a patient when making this request. Louis Charland, Trudo Lemmens, and Kyoko Wada (2016, pp. 2-3) focus their study on how mental illness can impact the mental capacity of an individual who wishes to end their life, as this request differs from an individual who is suffering from a life-threatening physical condition. Further, opponents to this extension argue that an individual’s desire to end their life “may be compromised by the cognitive or emotional state of people with mental health disorders,” as their ability to provide consent could be called into question (Buote et al., 2022, p. 130). Modern ethical and legal concerns note how “decision-making capacity is one of the core elements of the doctrine of informed consent,” which opponents of this extension argue is lacking within individuals who have a mental illness and wish to access MAID (Charland, Lemmens, & Wada, 2016, p. 4). Ensuring that individuals are mentally competent when making this life-ending decision is a key concern that opponents fear, especially when a mental illness could be an eligible criterion on its own.

Opponents have also stated that MAID MI-SUMC should continue to be prohibited as this criterion is not constitutionally required. After the Special Joint Committee on Medical Assistance in Dying released its report earlier this year, opponents were quick to produce an article to further support their side of this contentious debate. Mary Shariff, Derek Ross, and Trudo Lemmens outline how constitutional jurisprudence does not necessarily lead to incorporating mental illness as a sole condition for MAID. After having reviewed “existing constitutional jurisprudence, the claim that the courts require a MAID MI-SUMC regime is not accurate,” as there have been “no court that has stated that Canadians have a ‘Charter right’ to medical assistance in dying where mental illness is the sole underlying condition” (Shariff, Ross, & Lemmens, 2024, p. 9). These assertions by opponents have cast considerable doubt regarding what has been prescribed by the judiciary following both *Carter* and *Truchon*. Additionally, by claiming that constitutional jurisprudence has not prescribed what Canada’s MAID regime should entail, opponents follow this up by quoting the Charter and how this prohibition can be justified by the government. Opponents argue that “whether s. 7 of s. 15 of the Charter can be interpreted to require the government to allow MAID for mental illness remains...an unadjudicated question. So too is the question of whether the government could justify a legislative decision not to offer MAID MI-SUMC as a ‘reasonable limit’ in a ‘free and democratic society’ under section 1 of the Charter” (Shariff, Ross, & Lemmens, 2024, p. 9). It is very possible that the government could ultimately invoke the reasonable limits clause of section 1 of the Charter to justify this continued infringement of the rights of individuals who solely suffer from a mental illness and wish to access MAID. The following subsections highlight the main arguments opponents have for not allowing this extension to occur within the Canadian context.

Protecting the Vulnerable

A second major concern that opponents raise is that individuals who solely suffer from a mental illness are a vulnerable population and must be protected from making a rash decision to end their life, or worse, being coerced into MAID. Potentially allowing mental illness as a sole condition for medical assistance in dying can have adverse consequential impacts on these vulnerable populations in society. In the Report of the Special Joint Committee on Medical Assistance in Dying, it is argued by opponents that “women, Indigenous people, people with disabilities, people living in poverty, and people in geographically underserved areas” are among those in society who are the most likely to be pressured by others to request MAID when these vulnerable individuals do not want to end their lives (Parliament of Canada, 2024, p. 14). The groups of individuals referred to in the report of the Special Joint Committee on Medical Assistance in Dying are more likely to be coerced into making this rash decision because they are the ones who are inadvertently suffering from a mental illness. There are even reports from advocates for Canadians with disabilities about how these vulnerable individuals are coerced into MAID for a variety of reasons. These groups warn legislators that expanding access to medical assistance in dying will, in turn, “devalue the lives of vulnerable people” (Harris, 2020). Opponents of MAID, where mental illness is a sole criterion, often cite a need to ensure that the safeguards in place fulfill their requirements. The safeguards are a necessary measure to prevent vulnerable people from being coerced into requesting MAID when they do not wish to die.

The Role of Physicians

Further concerns from opponents surround the role of the physician. Opponents are concerned about the role of the physician as it has been unclear how this will alter should the legislation change in the near future. Associated with this fear is that if mental illness as a sole

criterion is allowed for MAID, then the number of physicians willing to provide the service may reduce significantly. Especially when an individual's death is not reasonably foreseeable, it has been studied that "the resulting ethical, emotional, and psychological burden might result in fewer physician and nurse practitioners being willing to assess for and provide MAID," as they feel this goes beyond the requirements of their profession (Pesut et al., 2021, p. 3). Expanding the role of physicians would create an added layer of stress to their jobs that they might be ill-prepared to face. Those who oppose mental illness as a sole criterion for medical assistance in dying also feel this applies to psychiatrists in the country. There is a collection of Canadian psychiatrists who fear that once the legislation is extended to allow a mental illness as a sole condition for accessing MAID, then "distinguishing eligible patients would be challenging, if not impossible" (Komrad, 2021). Should the eligibility requirements change, then physicians and psychiatrists would be obligated to make rather difficult prognoses about whether an individual's mental illness is severe enough to qualify them for MAID. Barbara Sibbald (2016, p. 243) makes a note of how Canada's removal of the reasonably foreseeable natural death requirement can have serious repercussions on doctors because should they misdiagnose someone because they can be held criminally responsible for aiding in the death of an individual who does not qualify for MAID.

Irremediableness

Opponents have also had their reservations about both the removal of irremediable medical condition requirements and defining irremediableness. These opponents argue that removing this requirement will allow a significant amount of individuals to access MAID when their mental illness could be improved. These opponents "fear that those with a mental illness may be told that their condition is irremediable and can never improve, although that is difficult,

if not impossible to predict,” and thus determining the irremediableness of a mental illness is a challenging task (Collins, 2024, p. 30). Bill C-14’s eligibility requirements ensured that an individual’s medical condition was both grievous and irremediable. The grievous and irremediable requirements guarantee that the medical condition “causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition” (Department of Justice, 2017, p. 1). Opponents of MAID, where mental illness is the sole underlying condition, argue that determining the irremediableness of an individual’s mental condition is considerably challenging. Those who oppose this extension state that “the capacity to make [life-altering] decisions may be compromised by the cognitive or emotional state of people with mental health disorders,” and as such, these opponents argue that medical assistance in dying eligibility should not extend to allow mental illness as the sole condition (Buote et al., 2021, p. 130). Studies conducted on establishing irremediability in the context of MAID for patients with a psychiatric disorder demonstrate the challenges that physicians have when trying to diagnose an individual who only suffers from a mental illness and wishes to request MAID. The study conducted by van Veen et al. (2021, p. 7) attests to how “establishing irremediability for [somatic suffering] is more certain due to the clear biological substrate of the disease and also because patients will often die from these diseases unassisted.” The difficulty of determining the seriousness of an individual’s mental illness is at the crux of the opponent’s arguments against the extension of MAID.

Within the Report of the Special Joint Committee on Medical Assistance in Dying, opponents contend that irremediableness in individuals with a psychiatric condition can significantly impact whether or not an individual will qualify under the eligibility requirements outlined in the current MAID regime. The Special Joint Committee outlines how “many

practitioners remain concerned, particularly regarding the challenges of assessing irremediability, distinguishing requests for MAID [mental disorder is the sole underlying medical condition] from suicidality, and protecting the most vulnerable in our society” (Parliament of Canada, 2024, p. 4). Assessing irremediableness in individuals whose sole underlying condition is a psychiatric condition goes hand in hand with protecting vulnerable people in society. Additionally, the Special Joint Committee on MAID reported on witness testimonies to determine irremediableness in individuals solely suffering from a mental illness.

“The committee heard that it is difficult, if not impossible, to accurately predict the long-term prognosis of a person with a mental disorder. Some witnesses took this to mean that irremediability cannot be assessed with certainty, thereby indicating a lack of readiness for MAID MD-SUMC. In addition, some witnesses opined that adequate criteria have not been established for determining irremediability. According to Dr. Gaiand, there is evidence that clinicians’ predictions are wrong over half the time” (Parliament of Canada, 2024, p. 12).

Quoting the difficulty of providing accurate long-term prognoses highlights how opponents would rather not risk a physician or psychiatrist providing a wrong diagnosis of an individual’s mental state and condition. Opponents of allowing mental illness as a sole condition for medical assistance in dying are purposefully demonstrating how troubling it is to accurately pinpoint the severity of an individual’s mental illness on a case-by-case basis. Different psychiatric conditions can be tougher to truly diagnose how irremediable and painful the condition is within an individual. Opponents of this extension are aware of the precarious position that physicians and psychiatrists are in when determining the irremediableness of a mental illness when an individual requests MAID.

Slippery Slope

From the beginning of the medical assistance in dying debate, opponents have feared that allowing this medical procedure to occur will inevitably lead to a slippery slope. Discussions leading up to the creation of Canada's MAID regime were concerned about how easy it would be for an individual to end their life with the help of a physician. In the context of the MAID debate, the slippery slope argument is highlighted by Tom Koch. The study on the slippery slope argument found that "an expanding class of persons eligible for MAID has resulted in an exponential increase in the number of reported cases," which demonstrates how this fear is evident in society (Koch, 2021, p. 670). Presently, opponents worry that the discussions surrounding mental illness as a sole underlying condition will be the start of this slippery slope. John Ivison (2022) worries that Canada is moving dangerously away from a balance between protecting vulnerable individuals and moving toward easier access for anyone who wants to access MAID. Additionally, opponents who fear the slippery slope acknowledge that extending medical assistance in dying legislation would mean that "it is considered a solution by people who would not otherwise have thought about ending their own life" (Ivison, 2022). Opponents of MAID extending to allow mental illness as an eligible sole criterion are uncertain of where the law will stop and where legislators will draw the line on where to stop the access to medical assistance in dying. Even the current leader of the Conservative Party of Canada, Pierre Poilievre, observes that he and the "Conservatives believe that we should provide mental health care to people to improve their quality of life, help heal the psychological wounds that are afflicting them rather than giving up" (Rocca, 2022). Conservatives fear that allowing mental illness as a sole condition for MAID would lead to these vulnerable individuals feeling unsupported and thus feel that they have no option except to end their lives via assisted death. As

such, these opponents would rather ensure that the legislation does not extend so that these individuals do not have the option to end their lives in a dignified manner through MAID.

Proponents

The opposing views outlined above, although valid concerns, are unsubstantiated in the countries that have physician-assisted death and allow psychiatric conditions as a sole condition (the Netherlands, Belgium, and Luxembourg). Advocates for MAID, where mental illness is the sole underlying condition, are vocal in their efforts to get the legislation altered to incorporate this extension. Proponents of this extension acknowledge the concerns voiced by the opponents, however, the advocates provide compelling arguments to be seriously considered by legislators so that they make the necessary alterations to Canada's medical assistance in dying regime. Notable proponents have been writing in support of allowing mental illness as a sole condition for MAID since Bill C-14 was passed into law in 2016. Out of the 20 witnesses who spoke before the Special Joint Committee for Medical Assistance in Dying, 13 of them stated that Canada is prepared and capable of handling mental illness as a sole condition for medical assistance in dying (Parliament of Canada, 2024, pp. 26-27). Among those who agree that Canada's medical system is prepared for this extension are experts who have done extensive work advocating for this legislative change through their publications and participation in different review boards and expert panels on the subject matter. Of all the advocates, Dr. Jocelyn Downie has been the most vocal. In her statement to the Special Joint Committee, she stated "that 'robust statutory, monitoring, regulatory, and clinical preparedness has been demonstrated' and reminded members that political preparedness is not a justification for limiting the Charter rights of those intolerably suffering from a mental disorder" (Parliament of Canada, 2024, p. 27). Not only do proponents feel strongly about allowing a mental illness to be an acceptable sole

underlying condition for MAID, but they also counter the claims of the opponents through their arguments.

Opponents of MAID MI-SUMC tend to treat everyone with a disability as a monolith. By treating both physical and mental disabilities as the same, opponents have a habit of implicitly suggesting that every person with a disability is vulnerable and does not have the proper autonomy to make life-altering decisions. Eric Mathison (2022) articulates what healthcare policies, especially in the context of MAID, should encompass:

“We should select the policy that best promotes the values of patients. This is the core of patient-centred care, which is a broadly recognized goal of medicine. For MAID, this means that we should let people with decision-making capacity decide for themselves what constitutes intolerable suffering and when their lives are no longer worth living. We can’t determine whether someone’s suffering is intolerable to them, so we must leave it up to them. Further, neither a patient’s healthcare team nor the government can determine how to weigh one form of treatment versus another for a patient. This is true throughout health care. Some patients want aggressive treatment to the end; others want comfort care early on. There’s no fact of the matter that’s best for everyone all the time. It depends on what they value.

Some disabilities cause suffering, and, for some people, there aren’t sufficient means to address their suffering. Another person with the same condition experiencing the same amount of pain can decide that it’s tolerable and that continued life is worthwhile. People should be able to make this decision for themselves, and it’s an unjustified form of paternalism to try to overrule them. So it isn’t the government or the healthcare system that is making any claims about the value of different lives.

Instead, people are given the option to decide for themselves, and some people with disabilities decide that their disabilities make life no longer worth living.”

Ensuring that healthcare policies are patient-centred is needed, especially for MAID MI-SUMC. This would ensure that individuals with disabilities are not treated as a monolith that should have the personal autonomy to make a life-altering decision such as MAID.

A notable critic of MAID, Christopher Lyon, has made an empirical claim that there is no other occupation in the world which kills people as frequently as a MAID provider. However, Mathison addresses this argument and ultimately argues that this cannot be true. Mathison (2024) maintains that “disconnecting life-sustaining treatment is killing, and since physicians routinely disconnect life-sustaining treatment...some physicians have killed far more people than the record number of MAID provisions, even if they aren’t involved in MAID.” Providing this rebuttal demonstrates how there have been, and continue to be, cases of physicians who are essentially ending the lives of patients when they disconnect life-sustaining treatment. Although MAID MI-SUMC would be a new form of ending a patient’s life, at their request and should they meet the criteria of Canada’s MAID regime, this does not mean it would be problematic.

Mental Capacity

Whereas opponents state that it is exceedingly difficult to determine the mental capacity of an individual who suffers from a mental illness and wants to request medical assistance in dying, proponents have conducted studies that come to different conclusions. In a study done that used “the most well-validated standardised capacity assessment tool, the McArthur Competence Assessment Tool for Treatment..., established that 70% to 80% of involuntarily hospitalised patients with mental illness are capable with respect to treatment decisions” (Dembo, Schuklenk, & Reggler, 2018, p. 453). The results of this study demonstrate that individuals who solely suffer

from a mental illness and wish to request MAID can provide the necessary consent to go through with this end-of-life service. Each individual is different, and capacity needs to be assessed on an individual level, as one individual may be more mentally capable of making this life-ending decision than another. By claiming that individuals who suffer from a psychiatric condition are mentally incapable of requesting MAID, then opponents who do so are falsely implying “that everyone in that category lacks capacity” (Dembo, Schuklenk, & Reggler, 2018, p. 453).

Proponents make a considerable effort to promote the value of the lives of these individuals who suffer from mental illness and wish to request MAID. Guaranteeing that this group of individuals is not discriminated against is an important part of the advocates’ campaign to change the legislation. It is imperative that Canadian legislators are aware that individuals who suffer from a mental illness can have the mental capacity to make life-altering decisions, such as requesting medical assistance in dying, and that it is possible to identify those who have and those who do not have, capacity.

This view is supported by the experience of other countries, as examined above. Studies conducted in Belgium refute the fears of opponents who state mental capacity within individuals who suffer from psychiatric conditions is difficult to predict. This Belgian study concludes that the mental capacity of these individuals who wish to request MAID but whose only condition is a psychiatric condition can ultimately be assessed in a reliable manner (Dierickx, 2017, p. 6). Other findings further support this claim. It is recognized that “despite capacity being a complex, value-laden, multidimensional construct, this finding suggests that it can be assessed with greater reliability than cardiologists interpreting mammograms or haematologists reading peripheral blood films” (Okai et al., 2007, p. 295). By making the claim that individuals who solely suffer from a mental illness and wish to request medical assistance in dying could lack the mental

capacity to make this decision, opponents drastically diminish the value of the lives of these individuals. In addition to these first two studies, a third study used the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) to further investigate mental capacity's reliability in psychiatric patients. Once again, the findings of this last study concur that utilizing this tool can help "to produce extremely reliable binary judgements of capacity," which would be beneficial should an individual's mental capacity be called into question as they request MAID as a result of their mental illness alone (Cairns et al., 2005, p. 376). In addition to these studies, the jurisdictions explored above provide further evidence and safeguards. Should an individual's mental capacity be called into question, then the Netherlands, Belgium, and Luxembourg all have it within their respective regimes that a second physician is required to determine if this individual's mental capacity is reliable.

Protecting the Vulnerable

Individuals who solely suffer from a mental illness are considered by everyone as being the most vulnerable in society, ensuring that these people are protected from ending their lives when they, in fact, did not want to request medical assistance in dying. Notable advocates for allowing mental illness as an acceptable sole condition for MAID recognize that the government's attempt at protecting the vulnerable overstepped by severely restricting access under Bill C-7. Jocelyn Downie and Daphne Gilbert (2019) write that the government "imposed a restriction on access to MAID limiting the rights of competent adults experiencing enduring and intolerable suffering, but the government could not demonstrate the restriction was needed to protect 'vulnerable persons...from being induced, in moments of weakness, to end their lives.'" Even though one of the pillars of the opposing argument is that Canada's MAID regime needs to protect the vulnerable, the government has yet to outline how significantly limiting eligibility

safeguards this group of Canadians who wish to request medical assistance in dying. Whereas opponents favour a more restrictive MAID regime, to the point that Canada should not allow people the option to request MAID for physical ailments, the Supreme Court of Canada ultimately disagreed with this sentiment. The Supreme Court determined that opponents labelling all patients as vulnerable devalues their right to choose and make autonomous decisions (Dembo, Schuklenk, & Reggler, 2018, p. 454). Other proponents for extending MAID contend that vulnerability does not differentiate for those who request medical assistance in dying for a physical condition or a psychiatric condition. These proponents affirm that “many other proffered determinants of vulnerability (such as abuse, fraud, and poverty) do not seem to be more applicable to psychiatric patients than patients with terminal physical illnesses” (Rooney, Schuklenk, & van de Vathorst, 2018, p. 333). Although opponents are keen on protecting the vulnerable, these assertions that extending MAID to allow a mental illness as an acceptable sole condition will lead to vulnerable people being easily coerced into requesting this service are once again unsupported. While it is a valid concern from opponents; however, the ‘Benelux’ countries (Belgium, the Netherlands, and Luxembourg) once again demonstrate how the vulnerable populations there are not taken advantage of when accessing physician-assisted death.

All three Benelux countries have review committees to ensure that physicians who assist in an individual’s death follow the respective steps of each country’s PAD regime. As mentioned earlier, these review committees guarantee that physicians fulfill assisted-death requests with due care. Canada should look to incorporate these review committees as they are another useful safeguard that would protect the vulnerable, without having to continue on the rights of individuals who solely suffer from a mental illness and wish to request MAID. The function of this review committee is to certify that no vulnerable individual is or was coerced into making

this decision to end their life as a result of someone else. The last annual report that is available from the regional euthanasia committee shows how psychiatric disorders alone accounted for less than 1.5% of the total PAD cases that happened in 2022 (Regional Euthanasia Review Committees, 2023, p.10). Further, the trial judge who rendered the *Truchon* decision acknowledged how effective the safeguards in the Benelux countries have been at protecting the vulnerable. Justice Lynn Smith concluded in *Carter* “that the safeguards in place in permissive jurisdictions were sufficiently effective in protecting vulnerable populations from being induced or coerced into assisted death and in preventing legalized euthanasia from being abused” (Chan & Somerville, 2016, p. 146). Evidently, what is in place elsewhere is efficient at safeguarding the most vulnerable in society from making a rash decision to request MAID. The findings from the other countries highlight once again how the concerns expressed by the opponents are unsupported elsewhere and, thus, would not be an issue here in Canada when mental illness becomes an acceptable sole criterion for accessing medical assistance in dying.

Role of Physicians

Whereas opponents fear that the number of physicians will diminish considerably should Canada allow mental illness as a sole underlying condition to access MAID, proponents are more focused on altering their role to mimic that of the Benelux countries. Most notably, in the Netherlands, physicians support individuals and their value-based reasons for wanting to request and ultimately go through with the euthanasia process. It is observed in qualitative studies that Dutch physicians and psychiatrists have “emphasized the value-based reasons for supportive attitudes towards euthanasia, e.g. the value of self-determination, compassion, fairness, and suicide prevention, versus the value-based reasons for not supporting euthanasia, e.g. the mission of medicine of hope and healing” (Verhofstadt et al., 2024, p. 2). These physicians are deciding if

they want to help and assist in ending another individual's life who is suffering and who qualifies to access this end-of-life service. In the Benelux countries, the physician's role goes beyond the scope of simply hearing a patient's request, ruling if they qualify for MAID or not, and then following through with the process of assisted death. A study conducted by Brian Mishara and Ad Kerkhof (2018, p. 728) found that Dutch physicians are required to have their patients try every treatment option, "but if the patient refuses and the doctor is convinced that viable alternatives to MAID that could be tried exist, the doctor can refuse access to MAID on these grounds." Presently, Canadian physicians "do not have a determining role in requiring that viable alternative interventions be tried," it should be seriously considered that the role of physicians changes so that they can have a greater say in improving the quality of life of their patients who request MAID (Mishara & Kerkhof, 2018, p. 728). Other suggestions focus on protecting those physicians who object to providing MAID. This recommendation follows the same lines as what is evidenced in the Benelux countries as Dian Kelsall (2018, p. 181) proposes that "physicians who are unwilling to provide a direct referral for MAID should be prepared to provide patients and their caregivers with information about options that include such coordination services – but not required to provide a direct referral." This would ensure that any physician who conscientiously objects to assisting in the death of another individual would be removed from this service as they would only be providing the necessary information of other physicians who are open to providing MAID.

Irremediableness

Opponents claim that it is difficult for a physician to predict the irremediableness of an individual's mental illness who wishes to access medical assistance in dying. A study conducted by William Rooney, Udo Schuklenk, and Suzanne van de Vathorst (2018, p. 328) used Treatment

Resistant Depression (TRD) as their starting point for determining whether a psychiatric condition can be irremediable. Although the study did not conclude that every case of TRD should be understood as irremediable, Rooney, Schuklenk, and van de Vathorst ultimately note how a considerable amount of these cases can and should be labelled as irremediable cases of a psychiatric condition. Within this same study, the authors outline what it truly means when a physician is assessing irremediableness:

“Assessing irremediableness is to perform a cost-benefit analysis of given treatments on a case-by-case basis, making medical decisions based on the statistically likely outcome. Indeed, concern for patient welfare is one value organizations like the Dutch Psychiatric Association have in mind when they define irremediableness as they do; namely, that ‘there must be reasonable balance between the expected treatment results and the burden of treatment’ as well as a ‘real prospect of improvement’ within a ‘reasonable period of time’” (Rooney, Schuklenk, & van de Vathorst, 2018, p. 330)

Understanding how the Dutch regime defines irremediableness can be useful for Canada’s regime in the coming years. This definition of irremediableness demonstrates that there is more to consider than solely if an individual’s psychiatric condition is impossible to cure. Ultimately, through studying other regimes, proponents made it evident that “neither concerns about the assessment of irremediableness nor about incompetence are sufficiently well supported to justify restricting access to MAID such that only terminally ill patients may access it” (Rooney, Schuklenk, & van de Vathorst, 2018, p. 341). It is further advanced through the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group) that irremediableness should be determined on a case-by-case basis as every individual’s pain and

psychiatric condition differs. This “Advisory Group recommends a broad reading of the ‘grievous and irremediable’ condition to include any condition that cannot be alleviated by means ‘acceptable to the patient’ and reject any legislative or regulatory attempts to limit the scope of these terms” (Chan & Somerville, 2016, p. 173). Proponents are vocal about giving individuals who solely suffer from a mental illness and want to access medical assistance in dying the capacity to determine the irremediableness of their respective psychiatric conditions. Irremediableness can be assessed by physicians and psychiatrists alike. Once more, like the other notable claims of opponents, the fear of assessing the irremediableness of a psychiatric condition is ultimately unsupported in the Benelux countries.

Slippery Slope

Consistently among the fears of the opponents, the slippery slope argument remains the most cited concern. Opposing views state that should Canada allow mental illness as a sole condition for accessing medical assistance in dying, then the entire MAID regime would ultimately undermine “human dignity and the sanctity of life” (Parliament of Canada, 2024, p. 46). As explored in the previous sections, the experiences of the Benelux countries demonstrates that the slippery slope argument is again unsubstantiated. In *Truchon*, Quebec’s Superior Court acknowledged how “neither the national data in Canada or Quebec nor the foreign data indicate any abuse, slippery slope, or even highlighted risks for vulnerable people when imminent end of life is not an eligibility criterion for medical assistance in dying” (Parliament of Canada, 2024, pp. 38-39). Other proponents of allowing mental illness as a sole condition for MAID effectively diminish the three main slippery slope arguments that came about following the removal of the reasonably foreseeable natural death requirement. Slippery slopes in permissive jurisdictions, that is, the jurisdictions that allow psychiatric conditions as a sole condition for assisted death,

are unproven. Justice Smith, who rendered the *Carter* decision, noted upon the removal of the reasonably foreseeable natural death requirement that “the evidence does not support the conclusion that, since the legalization of physician-assisted death, there has been a disproportionate impact, in either Oregon or the Netherlands, on socially vulnerable groups such as the elderly or persons with disabilities” (Downie & Schuklenk, 2021, p. 667). Acknowledging that even in the Netherlands there has not been any evidence of a slippery slope is significant. Since Oregon does not allow mental illness as a sole condition for MAID, but the Netherlands does allow it, the fact that neither has evidence of a slippery slope is important to note. Downie and Schuklenk’s (2021, p. 667) work demonstrates the weakness of the slippery slope claim. Although Canada’s present legislative debate centres on claims that a slippery slope exists, the lack of evidence from other jurisdictions worldwide ultimately puts this fear into sharp perspective.

The second major slippery slope claim addressed by Downie and Schuklenk focuses on removing natural death as a reasonably foreseeable requirement. While opponents fear that Canada’s MAID regime became too permissive from Bill C-14 to Bill C-7, these proponents correctly argue that this is a shift back to where the Supreme Court had initially set up Canada’s regime to be following *Carter*. Downie and Schuklenk agree that

“yes, the change from C-14 to C-7 moves Canada in a more permissive direction.

However, that ignores where Canada was before. The change from *Carter* to C-14 moved Canada in a more restrictive direction. The entire scene is that Canada has not become more permissive as between the Supreme Court of Canada decision in *Carter* and Bill C-7. Rather, there was a period during which Canada had an

unconstitutional tightening of the eligibility criteria. Canada is simply back where the Supreme Court of Canada put it through *Carter*” (2021, p. 668).

The entirety of the slippery slope argument is centred around opponents’ fear of the unknown (Reggler, 2017, p. 471). Opponents of allowing mental illness as a sole condition for medical assistance in dying use this fear of the unknown to attempt to strengthen their unsubstantiated claim. As evidenced by both the *Carter* and *Truchon* decisions and the statements made by the judges from these cases, the permissive jurisdictions worldwide do not provide any evidence whatsoever supporting this slippery slope concern. As such, this fear that Canada would slip further down a slippery slope should it allow mental illness as a sole condition for accessing MAID is unsupported elsewhere and thus there is no basis for thinking it applicable to the Canadian context.

Section 15 Equality Rights

The plaintiffs in *Carter v. Canada (Attorney General)* argued that the blanket prohibitions that outlawed medical assistance in dying violated numerous rights under the Charter. This case focused on the section 7 rights infringement, but the plaintiffs had also argued “the right to equal protection and equal benefit of the law without discrimination” under section 15 of the Charter (Downie & Schuklenk, 2021, p. 663). It was “concluded that the prohibition on physician-assisted dying violates s. 7, it is unnecessary to consider whether it deprives adults who are physically disabled of their right to equal treatment under s. 15 of the Charter” (*Carter v. Canada*, 2015). Section 15 rights were similarly not considered in *Truchon*. However, the Court in *Truchon* found that the reasonably foreseeable natural death requirement infringed upon section 15 and is not justified under section 1, similar to what happened in *Carter* (2012). Legislators continued to oversee this fact and ultimately created Bill C-7 in a restrictive manner once again.

It is important to examine the section 15 claims found in *Carter* as the government needed to provide a rationale for why they imposed on the rights of these individuals who wished to access medical assistance in dying. Suzy Flader (2020, p. 48) recognizes that through recent cases, “the legal definition of equality under section 15 has focused on substantive equality. This conception of equality focuses on ensuring that laws or policies do not subordinate groups who already face social, political, or economic disadvantages in Canada.” Understanding how the Court has, as of late, defined and applied section 15 to cases dealing with equality is important to note as it relates significantly to how there is a clear rights violation as individuals whose sole underlying medical condition is a mental illness are explicitly prohibited from accessing MAID.

The equality rights section of the Charter, section 15, “prohibits discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability” (Smith, 2020, p. 610). These are known as the enumerated grounds. Unfortunately, the judiciary does not often hear claimants arguing that their section 15 rights have been infringed upon. Some notable cases have successfully argued this; however, Flader (2020, p. 48) notes that “given judicial reluctance to grant claimants section 15 rights, it is worth considering how marginalized claimants could benefit if judges relied on revamped substantive equality analyses.” Successful claimants of a section 15 Charter challenge do not necessarily advance the issue of securing substantive equality for all. Ensuring that the concept of substantive equality is promoted, especially in the context of medical assistance in dying, where mental illness is the sole underlying condition, is imperative to warrant an extension of who is eligible for this end-of-life service. Judicial reluctance and its impact on achieving substantive equality are drawn out by Suzy Flader (2020, p. 49):

“The trend of courts hesitating to uphold equality rights under section 15 implies judicial confusion surrounding the concept of equality that must be avoided in the context of section 7. The primary reason for this confusion, which has been consistently revealed through section 15’s evolutions, is that courts focus too heavily on comparators and fail to undertake truly contextual analyses of equality rights. The limited number of protected enumerated grounds under section 15 does not help matters. These grounds help ensure a further uphill battle for claimants who face discrimination due to analogous or intersecting grounds. It follows that the human dignity of section 15 claimants is not assessed equally under the current substantive equality approach.”

Even though the enumerated grounds are intended to promote equality for those individuals who need it the most in society, the judiciary ultimately does not assess these section 15 claims substantively equally. This disappointing realization is not promising for individuals who solely suffer from a mental illness and wish to access MAID. The arguments surrounding section 15 were addressed at the trial level in *Carter*. Mary Shariff (2023, p. 170) acknowledges “that while the trial court found Ms. Taylor’s Section 15 right to equality was engaged as well as the Section 7 rights to ‘life, liberty and security’ of Ms. Taylor *and* those who would assist, the Supreme Court of Canada...confined its decision to the Section 7 rights of those ‘who seek assistance in dying’.”

It is important to examine what occurred at the trial level of *Carter* since the trial judge acknowledged that the equality rights of the plaintiffs in this case were engaged and not saved under section 1 of the Charter. The trial court in *Carter* (2012) had conducted the two-step test developed from *Withler v Canada (Attorney General)* to determine whether

section 15 had been infringed. Within the first step of this test, the court acknowledged that prohibiting assisted suicide creates a significant distinction as it burdens individuals with a physical disability who are incapable of ending their lives, which is not present for able-bodied persons (Centre for Constitutional Studies, 2012). The second step of the section 15 test seeks to find if this prohibition creates a disadvantage by perpetuating prejudice or stereotyping. Rather quickly, “the Court concluded that Ms. Taylor had proven an infringement of her right to equality under section 15 of the Charter,” meaning that the government’s only response was to justify its infringement with section 1 of the Charter (Centre for Constitutional Studies, 2012). Ultimately, the government failed its section 1 test. This led to Justice Lynn Smith ruling that the complete prohibition on MAID is an unjustifiable section 15 rights infringement.

A lower court found a section 15 rights infringement is present with a complete prohibition on medical assistance in dying. However, the Supreme Court of Canada did not consider the section 15 rights infringement that occurred through the MAID prohibition. Due to “the violations of sec. 7, the Supreme Court found it unnecessary to determine whether any of the prohibitions of discrimination in sec. 15 of the Charter were violated by the prohibition on assisted suicide” (Chan & Somerville, 2016, pp. 149-150). It is unclear how different Canada’s MAID regime would have looked had section 15 been examined by the SCC. There was potential for MAID MI-SUMC to be part of Bill C-14 from the very beginning. Although opponents would argue that Canada was not ready in 2015 for mental illness to be an acceptable sole underlying condition for MAID, the Supreme Court could have prevented such a restrictive regime from being implemented in Canada. Reading into section 15 during *Carter (2015)* would have led both the judiciary and

legislators to recognize that other groups in society would be negatively impacted because of the significant restrictions that were ultimately implemented in Bill C-14. Since this did not occur, this is only speculative. Without addressing the equality rights infringement, Canada's MAID regime was thus restrictive and provided unequal access to individuals whose sole underlying medical condition is a mental illness.

It is evident that from the beginning of Canada's medical assistance in dying regime to Bill C-7, the prohibition for individuals whose sole condition is a mental illness engages with a rights infringement under section 15. Bill C-7's Charter Statement acknowledges how this prohibition "engages section 15 because the exclusion from eligibility for MAID would apply to individuals who suffer from a mental illness," which is a protected enumerated ground (Government of Canada, 2020). Apart from this, Bill C-7's Charter Statement fails to acknowledge the inequality present in Canada's MAID regime, as individuals who solely suffer from a mental illness are explicitly prohibited from requesting this service. Beyond this, the continued invoking of the sunset clause to extend the period of this MAID prohibition continues to be a serious infringement under section 15 of the Charter. The extension of the sunset clause that now ends in March of 2027 is acknowledged by the Justice Minister has the potential to engage not only section 7 of the Charter but also section 15 "because the exclusion applies only to individuals who suffer from a mental illness" (Parliament of Canada, 2024, p. 37). Going back to the enumerated ground of section 15, discrimination based on mental or physical disability qualifies as an unjust infringement of an individual's equality rights. From the Special Joint Committee report, Senator Dalphond's dissenting report contends that not only is the extension of the existing policy on MAID MI-SUMC until 2027 overbroad and excessive under section 7 of the Charter but also that "this group exclusion contravenes section 15 by disallowing access

that must rest in all other cases on individualized assessment of compliance with all requirements of the *Criminal Code*” (Parliament of Canada, 2024, p. 40). The decision of the government to push the decision about whether to extend MAID eligibility until 2027 sends a considerably negative message to these individuals who are ineligible to access MAID because their sole condition is a mental illness. The equality rights of individuals suffering solely from a mental illness and who wish to access MAID are significantly infringed upon and, thus considerable changes to the legislation need to occur.

One of the most relevant cases where section 15 plays a considerable role is *Eldridge v. British Columbia (Attorney General)*. This case “involved whether deaf hospital patients suffered from adverse discrimination due to the failure of the province’s Medical Services Commission to provide sign language interpretation,” as a lack of sign language services provided these individuals with inequitable access to medical services (Macfarlane, 2018, p. 162). Ultimately, the Court unanimously ruled that deaf hospital patients had their Section 15 Charter rights infringed upon as they had unequal access to this medical service that everyone else in society accesses. From this *Eldridge* decision, Just LaForest stated that “the adverse effects suffered by deaf persons stem not from the imposition of a burden not faced by the mainstream population, but rather from a failure to ensure that they benefit equally from a service offered to everyone” (Macfarlane, 2018, p.162). Since the eligibility requirements of MAID require a physical medical condition that causes intolerable suffering, this service is not offered entirely to everyone. Bill C-7 explicitly states that individuals who solely suffer from a mental illness are ineligible to access medical assistance in dying. This is a clear violation of the equality rights as outlined by section 15. It is of significance to note how the *Eldridge* decision can be applied to this substantive equality issue. Taken altogether, *Eldridge* highlights how equality rights under

section 15 of the Charter can and should be applied to those groups who need equal treatment for different services so that they are not discriminated against, especially in the case of MAID, where mental illness is the sole underlying medical condition.

Although *Eldridge* is focused on the equality rights of deaf patients not having equal access to sign language interpretation while in the hospital, it is imperative to note how section 15 of the Charter was applied in this case and not in *Carter*. Macfarlane (2018, p. 164) outlines how the Court in *Carter* failed “to address the s. 15(1) argument” and that “the Court’s reasoning fails to provide meaningful guidance to governments about their equality rights obligations, including implementation to ensure access at the provincial level.” This article was published before *Truchon* and ultimately before Bill C-7 was enacted. However, Macfarlane’s sentiment remains the same. Failing to provide medical assistance in dying to individuals whose sole underlying medical condition is a mental illness is discriminatory. Individuals who suffer from a mental illness are protected under section 15’s enumerated grounds, and thus, they deserve equal access to MAID as outlined by the Charter. Continuing to prohibit mental illness as a sole condition is a rights infringement under the Charter, and it is up to Canada’s legislators to make the necessary adjustments to Canada’s MAID regime so that substantive equality under section 15 can be achieved.

Chapter 7: Discussion

As it currently stands, Canada's medical assistance in dying regime is too restrictive. It infringes upon the rights of individuals who wish to access this service but do not qualify as their sole underlying medical condition is a mental illness. Continuing to prohibit MAID MI-SUMC only causes further harm and suffering to this group of individuals. Following *Truchon*, with the reasonably foreseeable natural death requirement removed from Canada's MAID regime, individuals whose sole condition is a mental illness would surely have qualified for this service. However, as noted throughout the Thesis, Bill C-7 explicitly prohibited this legislative outcome. Excluding mental illness as a sole condition "was made subject to a sunset clause. The sunset clause provided that the exclusion would be repealed two years following the coming into force of former Bill C-7, on March 17, 2023" (Government of Canada, 2024). With Bill C-7 coming into force in 2020, it would take three years before legislators would even consider amending the law to allow mental illness as a sole condition for MAID. Individuals who suffer solely from a mental illness were hoping that they would qualify after the sunset clause expired; however, the government passed Bill C-39, which extended the exclusion for an additional year until March 17, 2024 (Government of Canada, 2024). As this day approached, the government rushed Bill C-62 to receive Royal Assent, claiming that the exclusion would continue "until the government is satisfied, based on recommendations from their respective departments and in consultation with their provincial and territorial departments and with Indigenous Peoples, that it can be safely and adequately provided" (Major, 2024). It is imperative to note that Bill C-62, once again, pushed the deadline for extending MAID MI-SUMC for three years, meaning that the government would not consider allowing mental illness as a sole condition until March 17, 2027.

This context is important as it highlights how the government has handled MAID MI-SUMC in the years following *Truchon*. By pushing the extension date multiple times and continuing to prohibit MAID MI-SUMC, the government continues to infringe upon the rights of these individuals who wish to access this end-of-life service but do not qualify. Making false claims that the country is ill-prepared to handle the MAID MI-SUMC cases that will occur once the legislation is altered demonstrates how hesitant the government is regarding this significant issue. The government proved its unwillingness to allow mental illness as a sole condition for MAID through the report of the Special Joint Committee. The dissenting opinion within the report recognized that this committee failed to address its mandate. This committee “invited 23 individuals who represented themselves or organizations,” where 15 witnesses “had extensive knowledge of the preparedness criteria and preparedness activities” (Parliament of Canada, 2024, p. 25). Additionally, of the 21 witnesses on the committee, those with relevant experience regarding Canada’s preparedness for MAID MI-SUMC spoke favourably about this extension. However, five witnesses on this committee who did not have any pertinent experience commented against MAID MI-SUMC, and it is the account of these five members that is part of the reason why the government decided not to allow MAID MI-SUMC (Parliament of Canada, 2024, p. 25). Since the government did not heed the spoken testimonies of individuals who are extensively involved with MAID MI-SUMC, it is clear that the government would rather continue infringing on individuals’ rights than change its medical assistance in dying regime. The government cites that the medical system is unprepared and that a considerably slippery slope would occur once mental illness becomes an acceptable sole condition for MAID. However, as evidenced elsewhere, these claims are unsubstantiated.

The assertions made by both the government and opponents to this extension are not evidenced in any other jurisdiction that permits mental illness as a sole condition for medical assistance in dying. Adversaries' main fear is the slippery slope that they claim will occur once Canada allows mental illness as an acceptable sole condition for MAID. After examining the Benelux countries, this slippery slope is nothing more than an attempt by the government and opponents to continue to justify this problematic infringement. Jonathan Reggler (2017, p. 471) draws attention to how Madam Justice Lynn Smith, in *Carter (2012)*, ruled in the Supreme Court of British Columbia, stating that "the evidence from other jurisdictions shows that the risks inherent in legally permitted assisted death have not materialized in the manner that may have been predicted...This evidence serves to allay fears of a practical slippery slope." From here, the Supreme Court of Canada, in *Carter (2015)*, specified that "the trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide" (Downie & Schuklenk, 2021, p. 6). An overwhelming lack of evidence from the permissive jurisdictions reveals no increased risk of falling down a slippery slope with a more lenient MAID regime. Over the twenty years in which both the Netherlands and Belgium have had their respective physician-assisted death regimes, there is no indication of these regimes experiencing an exponential increase in the number of assisted death cases they experience annually. Downie and Schuklenk (2021, p. 6) note that the "criticisms of the current legislation have merely claimed that a slippery slope exists, but evidence from other jurisdictions fails to demonstrate that it exists in reality." As a result of a significant lack of evidence, the slippery slope argument against MAID MI-SUMC is thus unsupported and ultimately not a strong enough reason to continue this illegal prohibition.

As noted earlier in the Thesis, opponents and Canadian legislators continue to push the narrative that Canada's MAID regime, above all else, needs to protect vulnerable populations. The government's attempt at protecting the vulnerable resulted in a significant rights infringement. From Bill C-14 to Bill C-7, the government created a separate set of procedural safeguards. This separate set is intended "for individuals whose natural death is not reasonably foreseeable," additionally, this legislative change also made "some amendments to the safeguards that apply in the case of individuals whose natural death is reasonably foreseeable" (Nicol & Tiedemann, 2020, p. 1). One of the more notable changes is the new waiting period when an individual's death is not reasonably foreseeable. Bill C-7 "introduces a 90-day waiting period between when the first assessment is made and the provision of MAID, unless both of the physicians...are of the opinion that the person's loss of capacity is imminent" (Nicol & Tiedemann, 2020, p. 7). Whereas when natural death is reasonably foreseeable, this waiting period is only 10 days. Furthermore, another safeguard focuses on the capacity of an individual before going through with MAID. Nicol and Tiedemann (2020, p. 14) outline how Dr. Thomas McMorrow "has raised concerns that there is no limit to how long in advance a person can arrange in writing for MAID to be provided if they lose capacity," prior to an individual signing the final consent waiver for accessing medical assistance in dying. Ensuring that an individual has the capacity to provide consent to the two physicians has been pushed forward by opponents of MAID MI-SUMC. The safeguard for ensuring mental capacity at the time of, and just prior to accessing MAID restricts MI-SUMC. An individual whose sole underlying condition is a mental illness could be deemed as mentally incapable of making this decision by their physician based solely on the nature of the mental illness. This, in turn, raises the concern that these individuals

are further seen as mentally inept to make the potentially life-ending decision of requesting MAID.

Drastically restricting the eligibility requirements, in turn, takes away the personal autonomy of a person who solely suffers from a mental illness and wants to request MAID. Although they claim they are protecting those who may be vulnerable and easily coerced into requesting medical assistance in dying, the government of Canada does not provide any context into how they plan on achieving this protection. The government states that it “is committed to ensuring our laws reflect Canadians’ needs, protect those who may be vulnerable, and support autonomy and freedom of choice,” however, its restrictive MAID regime devalues the autonomy and freedom of choice of individuals that solely suffer from a mental illness (Government of Canada, 2024). Individuals who wish to request MAID MI-SUMC and consciously decide to access this end-of-life service have made a personal decision that the government prohibits. It is made clear that the Supreme Court of Canada feels that labelling these individuals as vulnerable and significantly restricting MAID eligibility can, in turn, devalue the lives of this group of people.

The government have used the guise of protecting vulnerable groups because they have made claims that individuals who wish to access MAID MI-SUMC will be increasingly at risk of being coerced into this decision. Attempts at shielding this group of individuals from ‘harm’ are actually considerably harmful. Once again, the Benelux countries prove that ‘vulnerable individuals will be exponentially harmed’ claims are anecdotal. Each of the Benelux countries, as noted earlier, has regional euthanasia review committees to ensure that no individual who would be deemed as vulnerable is being taken advantage of and forced into ending their life with the help of a physician. Results from annual reports in the Benelux countries indicate that vulnerable

individuals are not at risk of being harmed. Rather, psychiatric disorders alone were the least frequent condition for assisted death when compared to the other conditions that accessed this end-of-life service in the Benelux countries. With mental illness being a considerably small percentage of MAID cases, the idea of this extension being a slippery slope is disproven as a result of the records found in these other jurisdictions. Anees Bahji and Nicholas Delva (2021, p. 931) emphasize how “imposing an outright ban on an entire group of patients to protect them from coercion is ironically coercive and may further their vulnerability.” A considerable lack of evidence of coercion in the Benelux countries does not support the claims that vulnerable groups are more likely to be harmed when compared to other groups in society who wish to request medical assistance in dying. Penny Lewis and Isra Black (2013, p. 895) reviewed the legal criteria in the Netherlands, Belgium, Oregon and Switzerland, and found “that the legal criteria that apply to an individual’s request for assisted dying are well respected: individuals who receive assisted dying do so on the basis of valid requests; third parties who assist individuals to die do not act unlawfully.” This evidence from these countries proves that although third parties do involve themselves in the process of another individual’s assisted death, it has not been coercive in nature, as those who are requesting MAID MI-SUMC are doing so under their own free will.

When Canada considers allowing mental illness as an acceptable sole condition for MAID, legislators should take the lessons of the regional review committees and adopt this system in Canada. The regional review committees act as a secondary safeguard, which would not be a grievous infringement on the rights of individuals who wish for MAID MI-SUMC. Excluding mental illness as a sole underlying condition for MAID is not a safeguard; rather, it is a serious infringement on the equality rights of this group of people. Incorporating the regional

euthanasia review committees in Canada would ensure that each provincial MAID regime adheres to and ultimately protects vulnerable groups of individuals. As has been witnessed in the Benelux countries, the regional euthanasia review committees have effectively reduced any concerns that vulnerable populations would be taken advantage of when a psychiatric condition is an acceptable criterion for assisted dying. Canada could easily incorporate this type of committee in each province and territory since they would control their respective MAID policies. Incorporating the regional euthanasia oversight committee in Canada would help ease the country into accepting mental illness as an acceptable sole underlying medical condition for medical assistance in dying. The overview provided by the Dutch euthanasia act offers Canada a concrete foundation to examine and potentially even mimic when legislators consider how they are going to protect Canadians when they amend the legislation to allow MAID MI-SUMC.

The most notable part of continuing to have restrictive medical assistance in dying regimes is the serious infringement on the equality rights of individuals who do not qualify under the present MAID criterion. Section 15 of the Charter ensures that individuals have equal access to the law and benefit from the law without discrimination, particularly when an individual has a mental or physical disability (Government of Canada, 1982). Canada's current medical assistance in dying eligibility allows for a physical condition, yet a clear violation of section 15 is present as mental illness does not qualify for this service, as previously noted. Following the notable cases that shaped and created Canada's MAID system, the Charter Statements of Bill C-14 and C-7 acknowledge how the legislation engages with Section 15 rights. A continued prohibition of MAID MI-SUMC is a serious rights issue that Canadian legislators can no longer ignore. In a world where substantive equality is becoming more prominent, guaranteeing that mental illness can be an acceptable sole criterion for MAID is needed. The clear rights violation

should be at the forefront of this decisive argument. Violating the rights of individuals who solely suffer from a mental illness and want to request MAID is unjustified by the government. Although *Carter* and *Truchon* used section 7 for their Charter analyses, both monumental cases addressed section 15. Before it created Bill C-14, “the Supreme Court of British Columbia minutely analyzed the prohibition against [MAID] under section 15 of the Charter and concluded that the *Criminal Code* provision violated that provision and was not justified under section 1” (*Truchon c. Procureur Général du Canada*, 2019, Para 649). The *Truchon* decision follows a similar vein as the conclusion in *Carter*. As stated earlier, the *Truchon* “Court concludes that the reasonably foreseeable natural death requirement set out in s. 241.2(2)(d) [of the Criminal Code] does not meet the standard of minimal impairment and proportionality of effects. It therefore infringes section 15 of the *Charter* and is not justified under section 1” (*Truchon c. Procureur Général du Canada*, 2019, Para 690).

Asserting that Canada’s restrictive medical assistance in dying is unjustified and therefore not saved by section 1 of the Charter, strengthens the claims made throughout the Thesis. A significant change is needed to this legislation to promote equality so that mental illness can be an acceptable sole criterion for MAID. From a purely rights-based approach, with the Courts in *Carter* and *Truchon* acknowledging that the infringement of section 15 is not saved by section 1, it emphasizes the need for the legislation to be amended to allow MAID MI-SUMC. Whereas the judicial branch interpreted this as a clear violation of section 15 equality rights, the legislative and executive branches do not consider this important enough to warrant a change in the MAID eligibility. The hesitancy of the government to allow mental illness as a sole condition for MAID is unconstitutional, and so is pushing the date of extension for three years. Each claim put forward by those who oppose this extension has been disproven. Whether they were invalidated

through the comparative analysis, or through the Charter analyses from both the *Carter* and *Truchon* courts', these reservations of opponents are unsupported and thus should no longer be considered as fears for allowing MAID MI-SUMC.

Although opponents may believe that it is impossible to predict what Canada's medical assistance in dying regime would look like should it allow mental illness as an acceptable sole underlying medical condition, examining the permissive Benelux countries gives Canadian legislators an insightful look at what Canada could expect soon. It is apparent that any of the fears that opponents of this extension have are nothing more than speculative in nature. The lack of evidence from permissive jurisdictions reveals that Canada can allow mental illness as a sole condition and not fear a slippery slope or an exponential increase in the number of assisted suicide cases. Continuing to enforce this prohibition violates the Charter rights of these individuals who solely suffer from a mental illness. The overwhelming lack of evidence and overall support from the permissive jurisdictions are enough to warrant a crucial change in Canada's medical assistance in dying legislation. A fear of the unknown will only continue this unjust infringement of rights. Canadian legislators need to be prepared to amend the MAID legislation as it stands. The disproven fears from the comparative analysis and the severe rights infringement under section 15 that is not saved by section 1 are more than enough evidence to support the claims that Canada can create a metaphorical bridge over the muddied waters of the medical assistance in dying and mental illness as a sole underlying condition debate.

Deciding to exclude mental illness as an acceptable sole criterion for medical assistance in dying does not inevitably result in this being classified as a dialogic response under the dialogue theory discussed earlier. The courts have not addressed continuing to prohibit MAID MI-SUMC. *Truchon* demonstrates this lack of dialogue theory, especially during the creation of

Bill C-7. It was the legislators who addressed excluding mental illness as a sole condition for MAID within Bill C-7. This highlights how the legislative branch went beyond the prescription of the judiciary to put it in writing that MAID MI-SUMC remains illegal under Canada's regime. Canada's institutional relationships are apparent in how the government deals with MAID MI-SUMC. The government has not been proactive in dealing with this issue. Continuously delaying a decision on including mental illness as an acceptable sole condition exhibits the government's attempt to avoid blame for this controversial issue. The Liberal government does not want to be associated with allowing MAID MI-SUMC, so they have aggressively pushed to extend this decision until 2027. Leaving this major decision up to the courts, rather than through dialogue theory or coordinate constitutional interpretation, highlights judicialization by the government. Christopher Manfredi (1997, p. 320) found that "the amount of rights-based constitutional litigation dealt with by a nation's highest court provides a reasonable measure of changes in the absolute level of the judicialization of political disputes." This judicialization would have the Court make the necessary judicial decisions to recognize the severe rights infringement that occurs with the continued prohibition of MAID MI-SUMC. Since the government is not proactive enough and ultimately leaves this controversial issue to the courts, it is apparent that this decision to prohibit MAID MI-SUMC is not necessarily dialogic.

Chapter 8: Conclusion

Medical assistance in dying is a controversial issue on its own. But allowing mental illness as an acceptable sole underlying medical condition is another heavily debated matter that seems to have no straight answer from the legislative, judicial or executive branches. With Canada's MAID regime officially beginning in 2015 under Bill C-14, this system is relatively new compared to those studied throughout the Thesis, with the exception of Australia and New Zealand, as these were created after Canada's. A lot has changed in Canada's MAID system from 2015 until now. The focus of this Thesis examined whether mental illness can be an acceptable sole underlying medical condition for medical assistance in dying. Examining both the countries that do not allow mental illness as a sole condition for MAID (Australia, New Zealand and the United States) and the countries that allow mental illness as a sole condition for MAID (the Netherlands, Belgium and Luxembourg) helped outline why each of these countries have formed their respective views on physician-assisted dying. Both sides of this debate were displayed through this analysis. Valid concerns and fears were expressed by the countries that oppose mental illness as an acceptable sole criterion. The fears found in the countries that oppose allowing MAID MI-SUMC were also evidenced in Canada by both opponents and legislators alike. However, the evidence discovered in the Benelux countries disproved each of these worries. Examining the Netherlands, Belgium and Luxembourg facilitated the overall argument of the Thesis. It has become evident through analyzing the Benelux countries that MAID MI-SUMC can be implemented safely in Canada as there is a significant lack of evidence that supports the claims and fears of the opponents of this legislation.

The discussion on dialogue theory and coordinated constitutional interpretation highlighted the inter-institutional relationships within Canada. Determining which branch has the

final say when it comes to interpreting the Constitution is often difficult between the legislative, judicial, and executive branches of government. Examining both *Carter* and *Truchon*, the dynamic of this relationship is demonstrated when dealing with medical assistance in dying. Following *Carter*, a dialogic response was evident. The legislative branch of government had altered what was prescribed by the judiciary to create Bill C-14. What followed in *Truchon*, was not necessarily dialogic in nature. Deciding to explicitly exclude mental illness as an acceptable sole underlying criterion for MAID does not replicate dialogue. The executive branch of the government engaged itself following *Truchon*, which further provided significant opposition to MAID MI-SUMC. Since each branch of the government has its obligation to interpret the Constitution, no one branch is supreme over the others. Parliament is not proactive enough in that its decision to delay the inclusion of mental illness as an acceptable sole condition demonstrates its leaving this significantly important decision up to the courts to avoid blame. Constitutional interpretation following both *Carter* and *Truchon* has caused Canada's MAID regime to become very restrictive as it infringes on the Charter rights of individuals who wish to access MAID MI-SUMC.

Canada's continued prohibition on MAID MI-SUMC is, ultimately, a serious rights infringement. Whereas *Carter (2015)* ruled that section 7 Charter rights were infringed upon, the government proceeded to disregard the section 15 equality rights claim, which the trial judge in *Carter (2012)* identified as a complete prohibition on all types of MAID violates section 15 of the Charter. This rights issue is not saved under section 1 of the Charter, and thus, outlawing mental illness as an acceptable sole condition for MAID runs counter to the Charter of Rights and Freedoms. What has been highlighted throughout this Thesis is that the fears of the opponents of MAID MI-SUMC are unsupported in other jurisdictions. Canada's MAID regime

cannot continue to be this restrictive. The eligibility criterion needs to be altered to accommodate those who solely suffer from a mental illness and wish to access medical assistance in dying. The muddled waters of this debate are easily resolved after examining the Benelux countries and seeing the parts of their respective PAD systems that protect the vulnerable, while also allowing mental illness as a sole condition for assisted death. Canada's MAID regime can handle what would occur once MAID MI-SUMC is allowed. Delaying the decision to include MAID MI-SUMC exacerbates these individuals as they cannot qualify for this end-of-life service for a minimum of three more years. The government's prohibition on MAID MI-SUMC effectively shows these individuals that their personal autonomy is less than those who request MAID for a medical condition. Canadian legislators do not have to fear anything that the opponents claim will happen, as these claims are disproven. Canada's MAID regime needs to allow mental illness as an acceptable sole underlying medical condition as the equality rights of these individuals are drastically infringed upon with this continued prohibition.

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