RESEARCH PAPER

Medical Assistance in Dying (MAiD) in Canada: A Critical Analysis of the Exclusion of Vulnerable Populations

Aide médicale à mourir (AMM) au Canada : analyse critique de l'exclusion des populations vulnérables

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Abstract

Canadian medical assistance in dying (MAiD) legislation was introduced in 2016. Although Bill C-14 attempted to balance patient autonomy and the protection of the vulnerable, recent court challenges suggest that an ideal balance has not been achieved. Numerous advocacy initiatives as well as a parliamentary review currently focus on three specific populations: mature minors, patients requesting MAiD via an advance directive and patients with a mental illness as the sole underlying condition.

This article approaches these issues from an ethical and legal lens. We first outline a policy review on existing MAiD legislation in 11 jurisdictions. We then use the Oakes test (a critical assessment tool in the *Carter v Canada* case) to determine whether the restrictions on the three above-mentioned groups are consistent with the *Canadian Charter of Rights and Freedoms*. Finally, we consult our literature review to propose reasonable solutions that would be more consistent with the *Charter*.

Résumé

La loi canadienne sur l'aide médicale à mourir (AMM) a été adoptée en 2016. Même si le projet de loi C-14 tentait d'assurer un équilibre entre autonomie du patient et protection des vulnérables, les récentes contestations judicaires portent à croire que l'idéal en matière d'équilibre n'a pas été atteint. Plusieurs initiatives de défense des droits, ainsi qu'une revue parlementaire, portent sur trois groupes de la population : les mineurs matures, les patients qui veulent pouvoir faire une demande anticipée d'AMM et les patients dont la maladie mentale est la seule condition sous-jacente.

L'article aborde ces enjeux du point de vue éthique et juridique. En premier lieu, nous décrivons les politiques d'AMM en place dans 11 autorités sanitaires. Ensuite, nous employons les critères de l'arrêt Oakes (outil d'évaluation critique dans le dossier *Carter c. Canada*) pour déterminer si les restrictions touchant les trois groupes mentionnés ci-dessus sont conformes à la *Charte canadienne des droits et libertés*. Pour terminer, nous avons consulté notre revue de la littérature pour avancer des solutions raisonnables qui sont plus conformes à la *Charte*.

Introduction

Canadian legislation on medical assistance in dying (MAiD) was introduced in June 2016, a year after *Carter v Canada* concluded that the provisions in the *Criminal Code of Canada* criminalizing the assistance in another's suicide violated the *Canadian Charter of Rights and Freedoms* (*Carter v Canada* 2015). The resultant Bill C-14 attempted to balance the individual autonomy rights of eligible patients and the protection of persons who may be vulnerable, that is, people who could be subtly coerced into ending their lives.

The first Supreme Court of Canada case on MAiD was filed by Sue Rodriguez in 1993. Rodriguez, suffering from amyotrophic lateral sclerosis, argued that section 14 (criminalizing the consent to have death inflicted upon oneself) and section 24.1 (b) (criminalizing assistance in another's suicide) of the *Criminal Code* jointly violated three *Charter* rights (*Rodriguez v British Columbia* 1993), most notably Section 7 ("the right to life, liberty and security of the person") (*Canadian Charter of Rights and Freedoms* 1982). The court concluded that section 7 was infringed; however, it was saved by section 1 of the *Charter*, which allows rights to be limited if "demonstrably justified in a free and democratic society" (*Canadian Charter of Rights and Freedoms* 1982). In Canada, the test for determining if a limitation is demonstrably justified is the Oakes test, which requires that:

1. the goal of the *Charter* restriction be pressing and substantial;
2. the restriction be rationally connected to the law's purpose;
3. the restriction minimally impair the violated *Charter* right; and
4. the restriction's benefits outweigh the costs (proportionality) (*R v Oakes* 1986).

In *Rodriguez*, the court ruled that a universal prohibition on MAiD was demonstrably justifiable as it served to protect the vulnerable (*Rodriguez v. British Columbia* 1993). Rodriguez lost with a five-to-four ruling, and the sections of the *Criminal Code* remained unchallenged until the joint case of Lee Carter and Gloria Taylor was heard by the Supreme Court of Canada in 2015. Carter and Taylor sued for legally accessible MAiD, drawing on many elements of Rodriguez's case. This time, the section 7 infringement did *not* pass the Oakes test because of the reality that multiple other countries had implemented MAiD legislation since Rodriguez's case. The restriction therefore no longer satisfied the minimal impairment requirement (*Carter v. Canada* 2015), thereby closely linking the concept of minimal impairment to the presence of pertinent legislation in other jurisdictions.

In the time between the *Carter* ruling and the proclamation of Bill C-14, MAiD was decriminalized but unregulated in Canada. When Bill C-14 was finally enacted in 2016, the following eligibility criteria were specified:

(a) they [patients] are eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada;
(b) they are at least 18 years of age and capable of making decisions with respect to their health;
(c) they have a grievous and irremediable medical condition;
(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care" (Bill C-14 2016).

Furthermore, the bill deliberately deemed three important groups ineligible for MAiD: mature minors, patients wishing to access MAiD at the direction of an advance medical directive and patients with a mental illness as the sole underlying medical condition (Bill C-14 2016).

The objective of this paper is to determine whether the *a priori* exclusion of these three populations meets the relevant ethical standard. In the words of Aristotle, it is not enough to do only the right thing; one has to do "the right thing at the right time, in the right way, and for the right reason" (Cahn and Markie 2002: 130). We do not think that the absolute exclusion of these patient populations without considering the relevant details of their particular circumstances is the best way of achieving the goal of protecting the vulnerable. We further want to clarify that, although the legislation explicitly states that the three groups are vulnerable, vulnerability is not actually defined anywhere in the bill. The object of this paper is not

to define this concept as this would be up to the courts. Instead, the object is to accept it as a framework. In addition to not meeting the relevant ethical standard, we do not think that the exclusion of these groups will withstand a *Charter* challenge. To demonstrate this, we will apply the Oakes test.

Methods

First, we summarize a literature review on international MAiD legislation. Countries are excluded if their MAiD laws had been overturned, if only passive means of dying (e.g., withholding life-sustaining treatment) are currently legal or if MAiD is not explicitly legislated. Second, we discuss each restriction in light of the minimal impairment requirement (Condition 3) of the Oakes test. If our analysis reveals that a restriction on a given population does not pass the Oakes test (i.e., the restriction is not demonstrably justifiable), we propose reasonable solutions based on practices in other jurisdictions.

We use the term "MAiD" to refer to the act (by a medical doctor or nurse practitioner) of performing either assisted suicide (prescribing a lethal medication to be self-administered) or active euthanasia (directly administering a lethal injection). The withholding or withdrawing of life-sustaining treatment (passive euthanasia) is a separate issue and will not be discussed.

Legislation in other jurisdictions

MAiD laws from 11 jurisdictions were included in the analysis. Table 1 provides a summary of each, grouped by country/continent and then subgrouped by date to demonstrate regional and temporal trends. For each country, a specifier is added for whether the legislation permits active euthanasia (aiding a person in taking their life, e.g., by lethal injection), assisted suicide (e.g., prescribing a medication for the patient to take on their own) or both. Belgium, the Netherlands and Luxembourg are the only jurisdictions to have adopted MAiD legislation for minors, via advance directive and in the situation where mental illness is the sole diagnosis.

Results

The exclusion of mature minors

Bill C-14 explicitly excludes minors from eligibility under the supposition that minors constitute a vulnerable population and need to be protected by the government (Bill C-14 2016). The motivation for excluding minors is pressing, substantial and rationally connected to the goal of protecting the vulnerable (thereby satisfying Conditions 1 and 2 of the Oakes test). However, a blanket exclusion of all minors regardless of their circumstances is not a minimally impairing restriction. For example, Belgium and the Netherlands have successfully determined how to provide the procedure to minors while simultaneously protecting the

TABLE 1. Main stipulations of MAiD laws included in the analysis

Jurisdiction	Year	Assisted suicide, active euthanasia or both?	Competency necessary on day of death?	Advance directives permitted?	Waiting period	Mental illness included?	Mature minors (<18) included?
Canada (Bill C-14 2016)	2016	Both	Yes	No	10 days	No	No
Quebec (Bill 52 2013)	2013	Active euthanasia	Yes	No	None	No	No
Oregon (*Oregon Death with Dignity Act* 2017)	1994	Assisted suicide	Yes	No	15 days	No	No
Washington (*Washington Death with Dignity Act* 2017)	2008	Assisted suicide	Yes	No	15 days	No	No
Vermont (*Act 39* 2013)	2013	Assisted suicide	Yes	No	15 days	No	No
California (*End of Life Option Act* 2016)	2015	Assisted suicide	Yes	No	15 days	No	No
Colorado (*End of Life Options Act* 2016)	2016	Assisted suicide	Yes	No	15 days	No	No
Washington, DC (*Act 21-577* 2015)	2016	Assisted suicide	Yes	No	15 days	No	No
The Netherlands (*Termination of Life on Request and Assisted Suicide [Review Procedures] Act* 2001)	2002	Both	Not with advance directive	Yes	None	Yes	Yes – starting at age 12, with separate protocol for infants
Belgium (*Wet betreffende de euthanasie* 2002)	2002	Both	Not with advance directive	Yes	One month if death is not imminent	Yes	2002 – emancipated minors 2014 – mature minors
Luxembourg (*Loi sur l'euthanasie et l'assistance au suicide* 2009)	2009	Both	Not with advance directive	Yes	None	Yes	No

vulnerable. In Belgium, legislation for minors differs from that for adults. The minor must first be deemed mature and then be shown to endure constant physical suffering that will lead to death in the short term (note that, in Belgium, minors have to be terminal, whereas adults do not). In addition, a child psychiatrist or psychologist must examine the patient, and the patient's guardian(s) must explicitly consent (*Wet betreffende de euthanasie* 2002).

In the Netherlands, patients aged 16–18 who are deemed mature may access MAiD as long as the guardians have been consulted, but guardians do not *have* to consent. If the patients are aged 12–16, MAiD is an option if the guardians agree with the decision (*Termination of Life on Request and Assisted Suicide [Review Procedures] Act* 2001). MAiD is also possible for infants via the Groningen protocol (Verhagen and Sauer 2005) under extremely stringent safeguards: the disease must be clearly diagnosed, the infant must be

suffering unbearably and there must be no reasonable chance of improvement. Both parents, as well as one other physician, must give their approval. After the procedure, all information along with the coroner's findings must be forwarded to the prosecuting authority, and each case is evaluated to ensure that proper procedure was followed (Verhagen and Sauer 2005).

The illegality of advance directives

Bill C-14 requires that immediately before MAiD is performed, the patient be given the opportunity to withdraw their consent. Should they not change their mind, they must provide express consent to receive the procedure (Bill C-14 2016). The intention is to give patients many opportunities to change their mind, thereby limiting their vulnerability. This necessitates that the patient be mentally competent and legally capable at the time of the procedure, which precludes the administration of MAiD solely at the direction of advance directives.

An advance directive is a legal document that outlines a patient's explicit wishes regarding the management of their healthcare. For example, patients may choose to specify in their medical directive that, should they become severely ill and lose competency to express their wishes directly, no extraordinary measures be taken to keep them alive. Most Canadian provinces have a legislation that regulates how these documents are drafted and accessed, but there currently exists no possibility for prespecifying wishes for MAiD via advance directive in Canada. A country that has taken this measure is Belgium, giving specific instructions as to how a directive should be written and stored, as well as a time frame for validity (five years) (*Wet betreffende de euthanasie* 2002).

We generally agree with the sentiment that an advance directive for MAiD with a time frame spanning many years would be inappropriate in the Canadian context. A practice of this sort would open up various possibilities for "false positives," risking the administration of a lethal procedure to potentially non-consenting patients. Therefore, a universal prohibition on MAiD via an advance directive spanning multiple years satisfies the minimal impairment requirement of the Oakes test as this is the only currently reliable means of protecting vulnerable patients in this setting. The fact that other countries (Belgium, Luxembourg and the Netherlands) have enacted legislation for MAiD via advance directives is insufficient to fail this criterion as thorough analysis of these laws fails to show sufficient safeguards to prevent false positives. Using the example of Belgium, we do not think that a five-year time frame of validity for an advance directive is sufficiently protective for potentially vulnerable patients. This lack of applicability may be explained in part by cultural differences. As a result of the arguments made in the *Carter* ruling, there is an explicit focus in Canada on the protection of vulnerable populations. As a result, these protections must be explicitly accounted for so that legislation can be deemed appropriate for the Canadian context. In other countries, this same focus is not as explicit in the legislation, leading to a potential lack of applicability of some stipulations that deal with especially vulnerable groups. This,

however, begs the question of whether some form of directive could be tailored to allow patients to request MAiD in the short term when they fear loss of competency.

Consider, for example, the case of a patient who wants the control of specifying a point in time within the next month to receive MAiD but fears losing their competency due to the large doses of pain medication necessary to keep them comfortable. It could be argued that having the ability to wait longer than the prespecified 10-day waiting period (Bill C-14 2016) implies that the patient's condition is not "intolerable" as prescribed by legislation, thereby excluding them from eligibility. However, we remain unconvinced of this argument as data to date show that a substantial number of patients undergo the initial eligibility assessment to have the option for MAiD without ever actually specifying a date and going through with it (Li et al. 2017). This suggests that the lack of control over their illness, not necessarily the illness itself, is central to some patients' subjective interpretation of intolerable suffering.

What further complicates this issue is that, as it stands, the illegality of advance directives still violates patients' right to life. By not allowing patients to specify a point in their illness at which they anticipate their quality of life to be sufficiently intolerable to end their lives, the law may drive patients to end their lives earlier than desired. This violates their right to life and exposes the law to the same arguments that were rendered unconstitutional in the *Carter* decision. We therefore need to seek a middle ground to balance the individual autonomy rights of patients and the adequate protection of the vulnerable, and the most logical solution would be that of a short-term advance directive under highly controlled circumstances.

To achieve this, we must ask ourselves what the eligibility criteria in Bill C-14 aim to achieve. There are generally two aims: to ensure that a patient is not vulnerable and to ensure that the patient is an appropriate candidate (i.e., that they meet the eligibility criteria outlined in Bill C-14). At the time of the request, the assessment of these two conditions is crucial; if the patient is determined to be vulnerable or not an appropriate candidate, they should be excluded from eligibility. However, if the patient is not vulnerable and is deemed an appropriate candidate, the fact that they may undergo a cognitive decline in the short term and may be unable to provide express consent at the time of the procedure does not make them suddenly vulnerable or inappropriate candidates. Therefore, competency at the time of the procedure should be considered of secondary importance unless new information emerges that changes one of these parameters. Naturally, a time frame for validity would need to be specified for directives of this sort. Foreign legislation provides little guidance with regard to this; however, we can likely agree on a minimum duration of validity, namely, 10 days (laid out by Bill C-14 as the mandatory waiting time between filing the request and receiving the procedure) (Bill C-14 2016).

The exclusion of persons with mental illness

Finally, Bill C-14 (2016) excludes *a priori* those who request MAiD based solely on a mental illness with the presumption that, by definition, these are vulnerable patients who need to be protected. The case of EF, a 58-year-old Alberta woman, demonstrates that there is a need for MAiD among this population. She applied for MAiD during the interval between the *Carter* ruling and the proclamation of Bill C-14. At that time, the terms "grievous" and "irremediable," which were hallmarks of the *Carter* ruling, had not yet been defined; therefore, it was up to the court to determine whether mental illness was a condition that satisfied these terms. The court ruled that it was, and permission for MAiD was granted (*Canada [Attorney General] v. E.F.* 2016).

The topic of extending MAiD to patients with mental illnesses raises important questions. For example, Appelbaum (2017) asks whether it is possible to determine an individual's ability to consent when their wish to die is an intrinsic property of their illness instead of a consequence. This is an important distinction because Bill C-14 defines vulnerability as subtle coercion by third parties. However, in this patient population, an added vulnerability (in addition to previously discussed extrinsic vulnerabilities, such as the potential for coercion and exploitation) is potentially a property of their disease. In their current form, the eligibility criteria of Bill C-14 do not appreciate this distinction.

An example of how vulnerability manifests in this patient population is that patients with mental illnesses may change their minds more often. Some Belgian data show that patients who request MAiD based solely on mental illnesses are more likely to rescind their requests than patients who file based on "physical" illnesses (Thienpont et al. 2015). If patients with mental illnesses tend to withdraw their requests more often, the universal exclusion of this population may be warranted to protect those who may change their minds. Other countries do not appear to have solved this problem. In jurisdictions where MAiD is permitted for mental illnesses, no explicit safeguards are added for this population. For example, the Belgian law simply mandates a waiting period of one month for all patients who are not terminal, which essentially *includes* those with mental illnesses (*Wet betreffende de euthanasie* 2002). Because no specific safeguards have been developed for this population, their exclusion fulfills the minimal impairment condition.

In comparison with the previous discussions, the exclusion of patients with mental illnesses is much more multifaceted. The complete exclusion of this population likely satisfies the minimal impairment condition because legislation in other countries does not safeguard the unique vulnerabilities of this population. This does not mean that no such solution exists, and we are not convinced that a blanket prohibition would satisfy the proportionality criterion (Condition 4) of the Oakes test. Furthermore, when placing this issue in the Canadian context, we can see that there is a legitimate demand for MAiD among these patients. Examples are provided by EF and by Adam Maier-Clayton, a 27-year-old man who died by unassisted suicide after a year of publicly advocating for the extension of MAiD to

persons with mental illnesses (Maier-Clayton 2016). In addition, 12–20% of depression cases may be treatment resistant (Mrazek et al. 2014), which would qualify some mental illnesses as both "grievous" and "irremediable." Other countries also demonstrate that citizens tend to take advantage of this possibility when it is offered: in the Netherlands, mental illnesses made up 1% of MAiD requests in 2015 (Boztas 2016), and in Belgium, this number was 3.9% in 2013 (Dierickx et al. 2016). Granted, as there are no established safeguards, some of those patients might have been vulnerable, but others might not have been. Further research is required to help distinguish between these two patient categories.

In the absence of evidence-based guidance for the distinction between these two patient categories, we can derive some guidance from the case of *EF v. Alberta*. Here, the motions judge noted that "[…] persons with a psychiatric disorder are not deprived of exercising their rights, provided they can establish that they are both competent and clearly consent" (*Canada [Attorney General] v. E.F.* 2016). These two criteria therefore form the basis of our vulnerability assessment. To evaluate these criteria, the court deemed the professional judgment of physicians sufficient, concluding that, given due care and attention, physicians had the tools to adequately evaluate and comment on a patient's decisional capacity (*Canada [Attorney General] v. E.F.* 2016). This case specifically focused on the judgment of what appeared to be EF's general practitioner (GP) and an independent psychiatrist, deeming their impressions to be accurate testimonies to her capacity and the irremediability of her disease.

Discussion

The exclusion of mature minors

From an ethical and legal perspective, the objective of protecting vulnerable minors is appropriate; however, their universal exclusion is not minimally impairing; hence, there are other ways of meeting this objective while still respecting the rights of those for whom this procedure would be appropriate. The Dutch Groningen protocol combined with the law for minors suggests a useful strategy for Canadian legislation: safeguards should become increasingly strict with decreasing age (i.e., with increasing degree of vulnerability).

The illegality of advance directives

Within the context of MAiD, long-term advance directives are generally inappropriate; however, there will almost certainly be a need for short-term advance directives to allow for adequate pain control, unforeseen losses of competency and other factors that may potentially limit the competency of otherwise eligible patients in the short term. We therefore propose the implementation of a short-term advance directive (with a minimum validity of 10 days and a maximum validity to be determined by the courts). These directives should be an option for patients who meet the conditions of the initial assessment, thereby ensuring that they are not vulnerable and that they are appropriate candidates. These patients would

thereby constitute a unique subpopulation in which competency at the time of the procedure is not a necessary condition.

The exclusion of persons with mental illness

Ultimately, given the example of EF in 2016, it is very likely that there will be patients who request MAiD with mental illness as the sole criterion. It should be appreciated that vulnerability in patients with mental illnesses can be a result of internal factors and not just external coercion. Based on the reasoning provided by the judicial review of EF, we think that a mandatory consultation by either a psychiatrist or a GP with a long-standing relationship with the patient should be part of the assessment at the time of the initial request to assess the patient for decisional capacity and any other potential source of vulnerability. Although this is not a perfect solution, given that a significant proportion of persons with mental illness may not have a long-standing relationship with a GP, it does bring the legislation one step closer to diminishing false negatives by including those whose vulnerability can be adequately assessed.

Conclusion

Using the Oakes test as our framework, we conclude that the restrictions on minors and patients accessing MAiD solely at the direction of a short-term advance directive fail the condition of minimal impairment. We suggest adapting current legislation to extend MAiD rights to minors based on an age-tiered system (as modelled by the Netherlands) and to include the possibility of a *short-term* advance directive for patients who meet eligibility criteria and are deemed not vulnerable. We further conclude that the exclusion of patients with a mental illness as their sole underlying condition likely fulfills the criterion of minimal impairment, as other jurisdictions have not developed legislation that sufficiently protects this population. However, given the push for the inclusion of this population in the Canadian context, the restriction may not meet the proportionality requirement. There is potential for Canada to lead the way in legislating this population in a way that sufficiently protects the vulnerable, such as accounting for the different sources of vulnerability in this population and assessing their decisional capacity by mandating formal assessments by either a psychiatrist or a GP at the time of the initial request.

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