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Two Views of Vulnerability in the Evolution of Canada's Medical Assistance in Dying Law

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Abstract

Canada is six years into a new era of legalized medical assistance in dying (MAiD). The law continues to evolve, following a pattern in which Canadian courts rule that legal restrictions on eligibility for MAiD are unconstitutional and Parliament responds by gradually expanding eligibility for MAiD. The central tension underlying this dialogue between courts and government has focused on two conceptions of how to best promote and protect the interests of people who are vulnerable by virtue of intolerable and irremediable suffering due to an illness, disease, or disability. Do we, as a society, have a duty to protect vulnerable people from seeking certain medical procedures that are contrary to their interests, as those are perceived by others? Or do we have a duty to uphold their rights to autonomy, including the right to make choices within a range that may be constrained by many factors, some of which may be socially unjust? This is a recurrent problem in bioethics and medical law, which we explore through the lens of how Canadian courts and Parliament have grappled with defining eligibility for MAiD.

Keywords: MAiD; medical assistance in dying; physician assisted suicide; law; vulnerability; autonomy

Introduction

Canada is six years into a new era of legalized medical assistance in dying (MAiD). Prior to 2016, the provision of MAiD was prohibited regardless of a patient's particular circumstances—a prohibition that was upheld by the Supreme Court of Canada in a 1993 challenge before being ultimately overturned by that same Court in a new challenge in 2015. The federal government's response came in 2016 with the decriminalization of MAiD in certain circumstances. In the years since, the law surrounding MAiD has continued to evolve, following a pattern of dialogue between the courts and the federal Parliament: Canadian courts have heard and accepted arguments that legislated restrictions on eligibility for MAiD are unconstitutional because they constitute unjustified infringements of rights and freedoms protected under the Canadian *Charter of Rights and Freedoms*.¹ Parliament has responded by amending the law to gradually expand eligibility for MAiD. As we write, this evolution continues to play out.

The central tension underlying this dialogue has focused on two conceptions of how to best promote and protect the interests of people who are vulnerable by virtue of intolerable and irremediable suffering due to an illness, disease, or disability. One view prioritizes autonomy and seeks to ensure the availability of the option to die with assistance, rather than have people turn to solitary and dangerous means of ending their own lives (if they are still physically capable of doing so). Another view prioritizes the protection of people who are vulnerable not just to the direct influence or coercion of others, but also because their suffering is driven—at least in part—by social factors such as stigma, neglect, isolation, or other similar influences that a good and equitable society should seek to remedy.

Both Parliament and the courts have taken up questions of *who* is vulnerable as well as *how* the law should respond to that vulnerability. This second question—whether access to a particular form of controversial treatment should be protected or limited in the face of patient vulnerability—is a central problem in bioethics and medical law. Certain treatments, open to capable people in Canada, are effectively prohibited for incapable people because substitute consent is not permitted. These include contraceptive sterilization² or psychosurgery.³ Living organ donation is another medical procedure in which first person capable consent is required.⁴ Other prohibitions apply to capable people as well, such as the ban on compensation for living donation of organs, gametes, and blood, or for gestational surrogacy.⁵

Together, these examples provoke numerous questions: Do we, as a society, have a duty to protect vulnerable people from seeking certain medical procedures that are contrary to their interests, as perceived by others? Or do we have a duty to uphold their rights to autonomy, including the right to make choices within a range that may be constrained by many factors, some of which may be socially unjust? Our objective in this article is to explore this recurrent problem through the lens of how Canadian courts and Parliament have grappled with defining eligibility for MAiD.

The Tension Between Vulnerability in Medical Ethics and Law

Vulnerability is frequently cited as a concern in relation to decisionmaking in medicine and medical research but is not always clearly defined. Wendy Rogers, Catriona Mackenzie, and Susan Dodds define vulnerability as “being at increased risk of harm, and/or having a decreased capacity to protect oneself from harm.”⁶ This may include physical, emotional, or cognitive vulnerability, each influencing the decisionmaking process and sometimes the capacity of a patient.⁷ In the MAiD context, the most frequently expressed concern is that certain patient populations may be more inclined to seek to end their lives due to social factors, depression, or a lack of adequate alternatives. These same patients are also said to be vulnerable to having their autonomy undermined by restricting their access to MAiD.

When significant concerns regarding vulnerability arise in the healthcare context, the law sometimes responds by disallowing a type of medical intervention altogether. For example, payment for organ donation⁸ and gestational surrogacy⁹ is prohibited under Canadian law, due to the concern that certain people would be at a heightened risk of exploitation (e.g., those with less socioeconomic means and, in the case of surrogacy, young and/or poor women).¹⁰ In other cases, substitute consent is prohibited for people who are incapable of consenting to a treatment, which effectively means that the treatment is disallowed for that population. This is the case with psychosurgery¹¹ and contraceptive sterilization.¹² Other interventions, like living organ donation, are available only to those above a specified age.¹³ These various prohibitions are a means of protecting vulnerable people from invasive treatments that might be applied for the benefit of others¹⁴ rather than that of the patient. At the same time, this approach to protection means that although vulnerable patients are protected from potential harm or exploitation, they are ultimately prevented from accessing treatments that all other patients may obtain.¹⁵

Thus arises the trade-off between autonomy and self-determination (including the ability to make suboptimal decisions, or decisions that society feels certain people should not make) and protecting vulnerable patient populations from making these suboptimal decisions. One can be vulnerable to poor healthcare decisions but also to loss of autonomy,¹⁶ through restricted decisionmaking authority or withholding of options available to others. As Rogers, Mackenzie, and Dodds have argued:

If human persons are both vulnerable and capable of autonomy, then we need an account of autonomy that is premised on recognition of human vulnerability, and we need an analysis of vulnerability that explains why we have obligations not only to protect vulnerable persons from harm, but to do so in a way that promotes, whenever possible, their capacities for autonomy.¹⁷

Relational theorists further view agency and (at least some degree of) autonomy as central to a flourishing life—as such, “a relational approach is committed to the view that the obligations arising from vulnerability extend beyond protection from harm to the provision of the social support necessary to promote the autonomy of persons who are more than ordinarily vulnerable.”¹⁸ Given that a loss of autonomy and control, as well as an increased dependence on others, are contributing factors to mental suffering¹⁹—denying MAiD to decisionally capable patients could increase their suffering. In the remainder of this article, we illustrate how this tension in how to conceptualize and respond to vulnerability constitutes a continuous thread in the evolution of the Canadian MAiD law.

Brief Overview of the MAiD Law in Canada

A good starting point in the evolution of the Canadian approach to MAiD is the 1993 case of *Rodriguez v. British Columbia (Attorney General)*.²⁰ Sue Rodriguez, a 42-year-old woman with amyotrophic lateral sclerosis (ALS), challenged the Canadian *Criminal Code* provisions that criminalized assisting suicide, arguing the prohibition infringed on her constitutionally protected right to life, liberty, and security of the person.²¹ Her challenge was dismissed by a 5:4 split decision of the Supreme Court of Canada. At this time, no other jurisdiction in the world had legalized MAiD.²² Indeed, the majority noted that not only did this case represent a potential expansion of legally assisted suicide “beyond that of any country in the western world,” but that it also failed to provide the safeguards that were required (or were at least considered) elsewhere.²³

The Supreme Court of Canada reversed its position in the 2015 case of *Carter v. Canada*, accepting a challenge to the same *Criminal Code* provisions in the case of capable adults who had a “grievous and irremediable medical condition” causing intolerable suffering.²⁴ Although the *Carter* case was working its way through the courts, the Government of Quebec launched a study of end-of-life care including physician-assisted dying.²⁵ This process culminated in the 2014 *Act Respecting End-of-Life Care*, which allowed for MAiD for those at the end of life.²⁶ This legislation came into effect in December 2015, and applied only in the province of Quebec. As for the *Carter* ruling, which concerned criminal legislation applicable throughout the country, the Supreme Court suspended the operation of its ruling for 12 months to allow Parliament to amend the *Criminal Code*.

The Parliamentary response came in 2016 with the passage of Bill C-14.²⁷ The preamble of this Bill noted that it was an attempt to strike “the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other.”²⁸ Parliament defined the eligibility criterion of “grievous and irremediable medical condition” to include the requirement that a person’s natural death be reasonably foreseeable—a criterion not mentioned in the *Carter* decision. In so doing, they sought “to create a statutory framework for medical assistance in dying that considers the perspectives of those who may wish to access it; those who are concerned about its consequences, including vulnerable persons who could be put at risk by the legalization of this practice; and those who may be asked to provide the assistance.”²⁹ The criterion that natural death must become reasonably foreseeable was challenging to interpret precisely, and appeared to restrict access to MAiD to include those with terminal or life-threatening conditions, excluding those with chronic—but nonterminal—conditions.³⁰ This was quite controversial,³¹ as some viewed this as narrowing eligibility in a manner inconsistent with the Supreme Court’s ruling in *Carter*.³² To add to the confusion, court cases taking place between the *Carter* decision and Parliament’s response in Bill C-14 had already interpreted *Carter* as recognizing that people with nonterminal “grievous and irremediable medical conditions” were included in the right to access MAiD.³³

Indeed, the criterion “reasonably foreseeable natural death” in the federal law—and the analogous “be at the end of life” requirement in Quebec’s law—were both challenged as unconstitutional in the 2019 case of *Truchon and Gladu v. Attorneys General of Canada and Quebec*.³⁴ This case involved two claimants, both of whom had a nonterminal physical disability. The Quebec Superior Court ruled the legislative provisions represented unjustified violations of the *Charter* and were of “no force or effect.”³⁵

It was then the turn of the federal and Quebec governments to respond, and neither appealed the trial court’s decision. Once again, the federal Parliament proposed an amended law—Bill C-7—which came into force in March 2021. Bill C-7 removed the requirement that “natural death be reasonably foreseeable,” but put in place additional safeguards for those instances where this was not the case.³⁶ One key issue that arose during the drafting of Bill C-7 was whether MAiD should be available in cases where mental illness was the sole underlying medical condition. Bill C-7 excluded these cases for 24 months (i.e., until March 2023), to give time to consider these cases further. This “sunset clause” was proposed by Senator Kutcher, a psychiatrist who argued that the exclusion is not only unconstitutional, but also “stigmatizes people with mental illnesses, suggesting that they 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.”³⁷ The 24-month period was intended to provide time to engage in further research and debate on what safeguards are most appropriate in striking the right balance between autonomy and protecting the vulnerable. An independent expert panel is currently examining the issue of MAiD in cases where mental illness is the sole underlying condition, and its recommendations regarding protocols, guidance, and safeguards are expected by March 2022.³⁸

As it currently stands, Canadian law allows MAiD for people who are 18 years or older, are capable, have a grievous and irremediable medical condition, make a voluntary request, and give informed consent. Additional clauses include various procedural safeguards with respect to the signing, dating, and witnessing of the request; the number and independence of eligibility assessments; and re-confirmation of the request immediately prior to providing MAiD.³⁹ The law allows this final consent to be waived in certain cases where a person loses capacity.⁴⁰

Additional safeguards apply in cases where natural death is not reasonably foreseeable. These further requirements include: ensuring assessors have expertise in the condition causing the suffering (or have consulted with a practitioner who has that expertise)⁴¹; ensuring that the person has been informed of all available means to relieve suffering (including counseling, mental health and disability support, community services, and palliative care) and has been offered consultations with relevant professionals⁴²; ensuring that these available means to relieve suffering have been discussed and given serious consideration by the person⁴³; and a 90-day waiting period has elapsed.⁴⁴

The Concept and Response to Vulnerability in the Evolution of Canadian MAiD Law

Throughout this legal evolution, vulnerability has been—and continues to be—invoked in two different ways. One interpretation centers on the vulnerability of severely suffering people who, if assistance in dying were denied, would have to endure intolerable suffering or take their own lives in a solitary and potentially risky manner.⁴⁵ According to this view, the option of MAiD would reduce vulnerability to harm and would increase autonomy by allowing people the option of dying with dignity. The second interpretation focuses on the vulnerability of people who live with illness or disability and are affected by psychosocial factors like isolation, hopelessness, and the stigmatization of disability, or who lack access to adequate care or support. The concern expressed through this view is that people facing these challenges would be vulnerable to choosing MAiD if it were available, and that access might be granted when instead, society ought to furnish better support for vulnerable populations.⁴⁶

Herein lies the tension: on one hand, if expanded eligibility for and accessibility of MAiD poses a risk of death for vulnerable people, perhaps it should not be available to those populations (or portions thereof) to protect people from making that choice. Some might also regard the legalization of MAiD as allowing society to avoid spending on expanded community services, medical services, or social

supports. These concerns are valid, but it is not certain whether expanded supports would be forthcoming if MAiD were prohibited, or whether those expanded supports would actually alleviate the suffering of all of those who might seek MAiD. On the other hand, the refusal to permit MAiD would deny options to vulnerable persons that are available to others—potentially infringing their constitutional rights to liberty and security of the person and to equal treatment under the *Charter of Rights and Freedoms*. This concern is also valid, although some would say that the vulnerabilities of some groups may compromise the capacity to make a sufficiently autonomous decision in choosing MAiD.⁴⁷

In what follows, we track this tension as the policymaking focus shifts from one form of vulnerability to the other, or attempts to hold the two in view while balancing the risks associated with both. We organize the path chronologically as the discussion moved back and forth between the Courts and Parliament—a process that is still ongoing with the current discussions of safeguards appropriate to permitting MAiD in cases where the sole underlying condition is a mental illness.

Rodriguez (1993)

Sue Rodriguez framed her argument on the basis of her interests in liberty and security of the person. She claimed (1) the right to live her remaining life with the inherent dignity of a human person, (2) the right to control what happens to her body while she is living, and (3) the right to be free from governmental interference in making fundamental personal decisions concerning the terminal stages of her life.⁴⁸ The majority of the Supreme Court accepted the validity and importance of these interests, writing in vivid terms:

The effect of the prohibition in s. 241(b) is to prevent the appellant from having assistance to commit suicide when she is no longer able to do so on her own. She fears that she will be required to live until the deterioration from her disease is such that she will die as a result of choking, suffocation or pneumonia caused by aspiration of food or secretions. She will be totally dependent upon machines to perform her bodily functions and completely dependent upon others. Throughout this time, she will remain mentally competent and able to appreciate all that is happening to her. Although palliative care may be available to ease the pain and other physical discomforts which she will experience, the appellant fears the sedating effects of such drugs and argues, in any event, that they will not prevent the psychological and emotional distress which will result from being in a situation of utter dependence and loss of dignity. [...] In my view, these considerations lead to the conclusion that the prohibition in s. 241(b) deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person.⁴⁹

However, the majority of the Supreme Court recognized competing values, namely the “sanctity of life” and the protection of vulnerable persons “who might be induced in moments of weakness to commit suicide.”⁵⁰ It noted that terminally ill patients “are particularly vulnerable as to their life and will to live and great concern has been expressed as to their adequate protection.”⁵¹

How then should the law balance the valid liberty and dignity-based interests of the claimant against the objectives of the state, characterized by the Court as valid and desirable goals of preserving life and protecting the vulnerable? The Court recognized that a balance had to be struck, and that “[t]he principles of fundamental justice are concerned not only with the interest of the person who claims his liberty has been limited, but also with the protection of society. Fundamental justice requires that a fair balance be struck between these interests, both substantively and procedurally.”⁵² Reviewing the history of the law on suicide, the rules on withdrawal of treatment, and the similar legal prohibition of assisted suicide in other countries, the majority concluded that the consensus favored the protection of life and vulnerable persons over the liberty of those who wanted assisted suicide.⁵³ In addition, a complete prohibition was a proportionate response to the risks that legalized assisted suicide would pose to vulnerable persons:

[T]his protection is grounded on a substantial consensus among western countries, medical organizations and our own Law Reform Commission that in order to effectively protect life and those who are vulnerable in society, a prohibition without exception on the giving of assistance to commit suicide is the best approach. Attempts to fine tune this approach by creating exceptions have been unsatisfactory and have tended to support the theory of the "slippery slope." The formulation of safeguards to prevent excesses has been unsatisfactory and has failed to allay fears that a relaxation of the clear standard set by the law will undermine the protection of life and will lead to abuses of the exception.⁵⁴

Carter (2015)

The Supreme Court's judgment in *Carter* begins with the tension between autonomy and vulnerability:

This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protecting the vulnerable.⁵⁵

As it did in *Rodriguez*, the Supreme Court clearly acknowledged that those unable to access MAiD faced not just diminished autonomy and dignity, but also the risk of physical and mental suffering. The introduction to the judgment notes:

It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.⁵⁶

One can see from the above that the position of people unable to access MAiD is not framed by the Court in terms of vulnerability, even though the risk of various harms is clearly acknowledged. Echoing *Rodriguez*, the Court in *Carter* emphasized that the objective of Canadian MAiD law "is to protect vulnerable persons from being induced to commit suicide at a moment of weakness."⁵⁷ It is not clear from this statement what precisely is the source of the vulnerability of concern—whether diminished capacity, impulsivity, pressure by others, exposure to social factors that aggravate suffering, or lack of access to measures that might alleviate suffering (or potentially all of these)—but it is clear that vulnerability is understood as a risk of death by MAiD in circumstances where it is felt to be inappropriate.

In fact, the Court never clearly defines vulnerability in the *Carter* judgment, although it notes that "not every person who wishes to commit suicide is vulnerable, and ... there may be people with disabilities who have a considered, rational and persistent wish to end their own lives."⁵⁸

Having accepted that there is a class of vulnerable persons who should not be eligible for MAiD, the Court's judgment focuses on whether it is possible to craft an approach that could distinguish between those who should have access and vulnerable persons who should not. If it is not possible to do so, then a second question would need to be addressed: whether the individual rights of those seeking MAiD could justifiably be infringed by a complete prohibition in order to protect vulnerable people.

On the first point, the respondent—Canada—argued that "it is difficult to conclusively identify the 'vulnerable,'" and "everyone is potentially vulnerable," so a complete prohibition was justifiable.⁵⁹ However, the Court disagreed. It found that the complete prohibition is overly broad because it captures some people who are not vulnerable, and it reiterated the trial judge's conclusion "that vulnerability can

be assessed on an individual basis using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decisionmaking more generally.”⁶⁰ Having decided that a permissive regime could be safely designed to protect vulnerable people from abuse and error, it was not necessary to address the second question.

Bill C-14 (2016)

The conceptual framework of a contest between autonomy and vulnerability is further demonstrated throughout Bill C-14. Although both terms are used several times in the preamble, neither is defined in the Bill. The preamble states that “vulnerable persons must be protected from being induced, in moments of weakness, to end their lives” and that “it is important to affirm the inherent and equal value of every person’s life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled.”⁶¹ At the same time, it starts with a recognition of “the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering.”⁶²

The preamble stresses the need to balance these values and objectives, and the language of “balance” was also evident throughout Parliamentary debates on the proposed Bill—per the Leader of the Opposition:

I believe that we need to strike a measured and careful balance between the rights of vulnerable people and the rights of people who are suffering. At the same time, we need to ensure that people who are asking for medical assistance in dying are doing so within a very clear and structured protective mechanism that leaves no room for vagueness or uncertainty.⁶³

Some Parliamentarians stressed one set of interests over the other. The Hon. Denise Batters argued that Parliament’s “responsibility must primarily be to protect the vulnerable ... the vast majority of Canadians agree with this, that requiring terminal illness in this bill would best meet that objective. The risks otherwise are simply too high.”⁶⁴ Conversely, the Hon. Victor Oh emphasized the need for patients—including those with chronic or progressive illnesses (that are not terminal in nature)—to have autonomy over their own important medical decisions:

Who are we to determine what an acceptable quality of life is for another person? One cannot decide what the right choice is for someone else. For this reason, I want to emphasize the importance of respecting a patient’s right to choose. The decision to end one’s life is a personal one. We must avoid taking a patronizing approach.⁶⁵

Ultimately, the Bill introduced the restriction of MAiD to those whose deaths are reasonably foreseeable as a way to strike the balance between these goals and values:

[P]ermitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable strikes the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other.⁶⁶

Truchon & Gladu (2019)

The Government’s restriction of MAiD to those whose deaths were reasonably foreseeable was meant to protect people with chronic but non-fatal physical or mental conditions, who it was felt should not be helped to die or indirectly encouraged to die by being provided access to MAiD. As the then-Minister of Justice had articulated in earlier debates over this restriction:

[I]f eligibility is drastically expanded to all Canadians who are suffering unbearably, regardless of whether or not their death is reasonably foreseeable ... there are more risks of different types that are much harder to detect. These risks include the very real possibility that individuals may be motivated to request medical assistance in dying for a whole host of reasons, psychosocial, emotional, or systemic, which are separate from their medical condition but that exacerbate their suffering. People may die unnecessarily or prematurely, when other options for improving their quality of life are available. ... The result [would be] that any serious medical condition, whether it be a soldier with post-traumatic stress disorder, a young person who suffered a spinal cord injury in an accident, or a survivor whose mind is haunted by memories of sexual abuse, could result in eligibility for medical assistance in dying. I raise these examples from other jurisdictions not to be sensational, but to highlight the real risks at play.⁶⁷

Although some national organizations representing Canadians with disabilities felt that the foreseeable death requirement struck an appropriate balance,⁶⁸ the autonomy and dignity-based challenge came swiftly from individual Canadians with chronic disabilities.

In her judgment in *Truchon & Gladu*, Justice Baudouin noted that the concept of the vulnerable person was central to the case, but was not defined in the legislation.⁶⁹ She heard extensive expert testimony on the meaning of vulnerability in the context of MAiD and offered a lengthy discussion of the issue.⁷⁰ Importantly, her judgment distinguishes between individual and collective concepts of vulnerability.⁷¹ The government evidence tended to invoke a collective concept that assigned vulnerability to groups of vulnerable people defined by age, disability, mental illness, or membership in groups with higher rates of suicide. The applicants argued for an individual concept:

They maintain that a person may very well find himself or herself in a position of vulnerability but still be capable of making personal decisions in his or her best interests. Consequently, an individualized approach to vulnerability that takes into account characteristics that are specific to the person, rather than labelling someone as a “vulnerable person” on the basis of their membership in a group, would be more appropriate.⁷²

Justice Baudouin endorsed this view, noting that “like any other capable and well-informed person, disabled persons may have a rational and legitimate desire to end their lives because of their condition, but also, and especially, because of the enduring and intolerable suffering they are experiencing.”⁷³

Ultimately, this individualized approach is more consistent with the judicial approach to the interpretation of the *Charter of Rights and Freedoms*. In addressing other situations in which individuals with disabilities have complained about the application of blanket conditions to the group of people with disabilities, the Supreme Court has emphasized the need to take an individualized approach wherever possible. For example, in a case dealing with a provincial workers’ injury compensation scheme that provided more limited benefits for workers with chronic pain conditions than to other injured workers, the Supreme Court accepted that early return to work for people with these conditions—which was one of the governmental justifications of the limited benefits coverage—may well be the most promising approach for some people with chronic pain, but it would not work for all.⁷⁴ The provincial law’s “indefensible assumption that their needs are identical” meant the law was discriminatory, and what was needed was an individualized approach based on the actual “needs, capacities or circumstances” of each worker.⁷⁵

It is thus unsurprising that Justice Baudouin rejected the arguments based on assertions of group-based vulnerability:

The Court cannot accept the concept of collective vulnerability suggested by the Attorney General because the broad protection that results therefrom is too general an application of a precautionary principle. Vulnerability should not be understood or assessed on the basis of a person’s belonging to a defined group, but rather on a case-by-case basis, at least for the purposes of an analysis under

section 7 of the *Charter*. In other words, it is not the person's identification with a group characterized as vulnerable – such as persons with disabilities, Indigenous persons or veterans – that should bring about the need to protect a person who requests medical assistance in dying but, rather, that person's individual capacity to understand and consent in a free and informed manner to such a procedure, based on his or her specific characteristics.⁷⁶

The structure of the reasoning under the Canadian *Charter of Rights and Freedoms* involves two steps. A judge must first determine whether a law infringes on one of the *Charter* rights. If this is the case, the government may still defend the infringement as a reasonable and proportionate measure in light of pressing governmental objectives. Having found that the claimants' rights were infringed by being excluded from eligibility by the reasonably foreseeable death requirement, Justice Baudouin moved on to determine whether this was justifiable. She accepted that the objective of protecting vulnerable people was an important objective, but held that physicians were able to detect problems with capacity, ambivalence, coercion or abuse, as well as “social, economic or other type of vulnerability [that] motivates ... requests for medical assistance in dying.”⁷⁷ As a result, a complete prohibition for those whose death was not reasonably foreseeable was an unreasonable infringement of the autonomy and dignity-based interests of people like the claimants, Truchon and Gladu.

Bill C-7 (2021)

The governments of Canada and Quebec chose not to appeal the decision in *Truchon & Gladu*. Instead, Parliament attempted once again to enact legislation that balanced the objectives of recognizing “the autonomy of individuals choosing MAiD as a means of relieving intolerable suffering regardless of the foreseeability of their natural death, while at the same time protecting vulnerable persons and affirming the inherent and equal value of every person's life.”⁷⁸

Bill C-7 removed the eligibility requirement that death be reasonably foreseeable, and put in place additional safeguards for cases where it was not. The exclusion of people whose sole underlying condition is a mental illness was controversial, and a compromise position was adopted—a 24-month “sunset” exclusion during which time, the need for additional safeguards would be examined.⁷⁹ A review of the Parliamentary debates shows that the concerns over vulnerability continue to be acute. For example, the Hon. Yonah Martin expressed that “[d]isability rights groups have condemned the bill, arguing that it devalues the lives of people with disabilities who may be pressured, either directly or indirectly, through societal attitudes and a lack of support services, into ending their lives prematurely.”⁸⁰ Similarly, the Hon. Jane Cordy warned that:

As we protect those most vulnerable in our society, our challenge is to ensure that MAiD is not a fallback position, nor a default decision, because individuals do not have equitable and timely access to adequate supports to address suffering. We need to ensure that poverty, homelessness, systemic racism or a lack of disability or health care supports do not lead individuals to believe that MAiD is their only option.⁸¹

The additional safeguards put in place differ from what might be called “protection by exclusion” from MAiD when it comes to people whose death is not reasonably foreseeable. Instead, they seek to ensure robust assessment by ensuring assessors are either experts or have access to expertise in the condition at issue, to ensure that access to various support services and treatments has been offered and seriously considered, and to ensure some measure of stability through a 90-day delay between assessment and MAiD. Whether these safeguards will be adequate to protect people who are vulnerable will no doubt continue to be much debated.

Conclusion

In less than a decade, Canada has changed its legislated approach to MAiD twice over, provoked by judicial declarations that prohibitions against MAiD unconstitutionally limit the autonomy and dignity interests of people seeking MAiD, and that it is possible to craft eligibility criteria that adequately and safely strike a balance between autonomy interests and the protection of vulnerable persons. The turbulent evolution of MAiD is not finished. The rapidly approaching March 2023 deadline for the removal of the mental illness exclusion may well provoke further changes to MAiD law or medical practice in Canada.

The evolution of MAiD law in Canada reflects a legislative and judicial struggle with a recurrent bioethics conundrum: If a potentially vulnerable patient is seeking MAiD, does society have a duty to protect them from harm by refusing them MAiD, or to protect their autonomy of choice? And if the decision of that patient is influenced by factors such as poverty, should we simply prohibit MAiD to vulnerable populations, or should we attempt to improve socioeconomic supports while simultaneously making MAiD available to those who wish to have it?

In our view, a key problem with the debate has been the lack of detailed information about the consequences of expanding MAiD access. This is unsurprising given the novelty of these changes for Canada. Many potential harms and risks of expanding eligibility have been raised throughout the debate, and it will be critical to ensure that detailed information is collected and carefully and transparently reviewed. Canada's MAiD law, and regulations passed under the law, impose a data collection requirement, and this should be updated if new concerns suggest a need for additional information.⁸² At the same time, there is another risk—following from the idea that vulnerability may flow not just from access to MAiD, but also from difficulties in accessing MAiD—that cumbersome procedures and safeguards may make MAiD difficult to access for people experiencing grievous and irremediable suffering. Data on the accessibility of MAiD should also be collected. There is not a simple formula to resolve the challenge of balancing autonomy and vulnerability, but a complex and empathetic conception would recognize both that people who are vulnerable still have an interest in making choices within their constrained circumstances even if it makes others uncomfortable, and that a good society will try to maximize the room for voluntary choice available to its most vulnerable members by addressing the social, economic, or other factors that may exacerbate suffering.

Conflicts of Interest. Sarah J. Lazin declares no conflicts of interest. Jennifer A. Chandler is a member of the Independent Expert Panel appointed by the Government of Canada in 2021 to make recommendations related to safeguards and policies relevant to MAiD in the context of mental illness. Jennifer A. Chandler was also a member of the 2018 Canadian Council of Academies Independent Review Panel appointed by the Government of Canada to consider the evidence applicable to MAiD in the context of mental illness. This article reflects the views of the two authors and does not purport to reflect the views of any Expert Panel or the Government of Canada.

Notes

1. Namely, the rights to life, liberty, and the security of the person guaranteed by section 7 and to equality in section 15: *The Constitution Act*, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11.
2. *E. (Mrs.) v. Eve*, [1986] 2 SCR 388 [*Eve*].
3. *Mental Health Act*, RSO 1990, c M.7, s. 49(1).
4. *Gift of Life Act*, RSO 1990, c H.20, s 3(1).
5. *Human Tissue and Organ Donation Act*, SA 2006, c H-14.5, s. 3(2); *Assisted Human Reproduction Act*, SC 2004, c. 2, s 6(1).
6. Wendy R, Catriona M, Susan D. Why bioethics needs a concept of vulnerability. *International Journal of Feminist Approaches to Bioethics* 2012;5(2):11–38, at 12 [“Vulnerability”].
7. See, for example, Joachim B. The concept of vulnerability in medical ethics and philosophy. *Philosophy, Ethics, and Humanities in Medicine* 2019;14(1):6, at 3.

8. *Human Tissue and Organ Donation Act*, SA 2006, c H-14.5, s. 3(2).
9. *Assisted Human Reproduction Act*, S.C. 2004, c. 2, s. 6(1).
10. Similarly, in order “to reduce the chances that young women are taken advantage of, it is a crime in Canada to advise or persuade in any way a woman to become a surrogate mother” if she is under 21 years of age. See “Prohibitions Related to Surrogacy”; available at *Government of Canada*; available at canada.ca/en/health-canada/services/drugs-health-products/biologics-radiopharmaceuticals-genetic-therapies/legislation-guidelines/assisted-human-reproduction/prohibitions-related-surrogacy.html (last accessed 3 Dec 2021).
11. *Mental Health Act*, RSO 1990, c M.7, s. 49(1). This prohibition prevents surrogate decisionmakers from consenting to psychosurgery.
12. See note 2, *Eve* 1986.
13. *Gift of Life Act*, RSO 1990, c H.20, s 3(1).
14. See note 2, *Eve* 1986. In this case, a mother sought permission to have her mentally incapable adult daughter sterilized, so as to prevent her daughter from accidentally becoming pregnant and forcing the mother to take on childcare duties in her old age. The Supreme Court held not only that the physical harm and intrusion of rights outweighed the advantages of the sterilization, but also that under the *parens patriae* jurisdiction, invasive procedures should not be authorized for nontherapeutic purposes.
15. See Jennifer A Chandler, “Regulating ‘Psychosurgery’ in the 21st Century”; 2015 November 16; online: Centre for Law, Technology and Society; available at techlaw.uottawa.ca/news/regulating-psychosurgery-21st-century-0. (last accessed 3 Dec 2021). See also Chandler J et al. International legal approaches to neurosurgery for psychiatric disorders. *Frontiers in Human Neuroscience* 2021;14:1.
16. See note 6, Wendy et al. 2012, at 12.
17. See note 16, at 23.
18. See note 16, at 24.
19. *Truchon and Gladu v Attorneys General of Canada and Quebec*, 2019 QCCS 3792 at para 210 [*Truchon & Gladu*].
20. [1993] 3 SCR 519 [*Rodriguez*].
21. See note 20, at 583–84. Ms. Rodriguez argued that “prohibiting anyone from assisting her to end her life when her illness has rendered her incapable of terminating her life without such assistance ... deprives her of both her liberty and security of the person,” See note 20.
22. “First Annual Report on Medical Assistance in Dying in Canada”; 2019, 1 at 10, online (pdf): *Health Canada*; available at canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf [“First Annual Report”].
23. See note 20, *Rodriguez*, at 582. At this point, there was nowhere in the world where “assisted suicide [was] expressly permitted, and most countries [had] provisions expressly dealing with assisted suicide which [were] at least as restrictive as our s. 241 ... In the Netherlands, although assisted suicide and voluntary active euthanasia [were] officially illegal, prosecutions [were not] laid so long as there [was] compliance with medically established guidelines.”. See note 22, at 602–03.
24. 2015 SCC 5 [*Carter*]. The appellants in this case included a woman who had ALS, together with the daughter and son-in-law of a woman who had traveled to Switzerland to obtain assisted death.
25. See note 22, First Annual Report 2019, at 11.
26. *An Act respecting end-of-life-care*, CQLR c S-32.0001.
27. *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, SC 2016, c3 [Bill C-14].
28. See note 27, at preamble.
29. Canada, Parliament, *House of Commons Debates*, 42nd Parl, 1st sess, Vol 148, No 062 (31 May 2016) at 1010 (Hon. Jody Wilson-Raybould).
30. See note 29, at 1115 (Mr. Murray Rankin).
31. See Jocelyn D, Kate S. Foreseeably unclear: The meaning of the ‘reasonably foreseeable’ criterion for access to medical assistance in dying in Canada. *Dal LJ* 2018; 41(1):23 at 25.

32. Canada, Parliament, *House of Commons Debates*, 42nd Parl, 1st sess, Vol 148, No 062 (31 May 2016) at 1115 (Mr. Murray Rankin). See also Downie J, Chandler, JA. Interpreting Canada's medical assistance in dying legislation; 2018;1:5–6, online (pdf): Institute for Research on Public Policy; available at irpp.org/wp-content/uploads/2018/03/Interpreting-Canadas-Medical-Assistance-in-Dying-Legislation-MAiD.pdf.
33. Eleni N, Matthew H. Carter conflicts: The supreme court of Canada's impact on medical assistance in dying policy. In: Emmett M, ed. *Policy Change, Courts, and the Canadian Constitution* (Toronto: University of Toronto Press, 2018), at 320.
34. See note 19, *Truchon & Gladu*.
35. See note 34, at paras 763–70: Both the federal and provincial provisions were found to violate section 15 of the *Charter* (right to equal treatment), and the federal *Criminal Code* provision was also found to violate section 7 of the *Charter* (right to life, liberty, and security of the person).
36. *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021, c 2, s 1(3.1) [Bill C-7].
37. Joan B. Senators amend MAID bill to put 18-month time limit on mental illness exclusion. *CTV News*; 9 February 2021, Online; available at ctvnews.ca/politics/senators-amend-maid-bill-to-put-18-month-time-limit-on-mental-illness-exclusion-1.5302151 (last accessed 3 Dec 2021).
38. Canada's new medical assistance in dying (MAID) law; 2021, Online: *Government of Canada*; available at justice.gc.ca/eng/cj-jp/ad-am/bk-di.html (last accessed 3 Dec 2021).
39. *Criminal Code*, RSC 1985, c C-46, s 241.2(3).
40. See note 39, ss 241.2(3.2)–(3.5).
41. See note 39, s 241.2(3.1)(e.1).
42. See note, 39, s241.2(3.1)(g).
43. See note 39, s 241.2(3.1)(h).
44. See note 39, s 241.2(3.1)(i).
45. For example, the judgment in *Carter* began: “It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.” See supra note 24, *Carter* at para 1.
46. Precarious living situations, especially when coupled with the stigma and discrimination that often surround mental illness, “can be very significant in how people judge the value of their life or whether they feel valued and have a place in the wider community ... It would be tragic if societal inadequacies increase people's sense of hopelessness so that they seek death by MAiD.” See Simpson AIF. Medical assistance in dying and mental health: A legal, ethical, and clinical analysis. *Canadian Journal of Psychiatry* 2018;63(2):80, at 82.
47. See Louis CC, Trudo L, Kyoko W. Decision-making capacity to consent to medical assistance in dying for persons with mental disorders *Journal of Ethics in Mental Health* 2016;1:8.
48. See note 20, *Rodriguez* at 583.
49. See note 20, *Rodriguez* at 588–89.
50. See note 20, *Rodriguez* at 595.
51. See note 20, *Rodriguez* at 585–86.
52. See note 20, *Rodriguez* at 593–94, citing *Cunningham v. Canada* [1993] 2 SCR 14.
53. See note 20, *Rodriguez* at 616.
54. See note 20, *Rodriguez* at 613.
55. See note 24, *Carter* at para 2.
56. See note 24, *Carter* at para 1.
57. See note 24, *Carter* at para 86.
58. See not 24, *Carter*.
59. See note 24, *Carter* at para 87.
60. See note 24, *Carter* at para 115.
61. See note 27, *Bill C-14* at preamble.

62. See note 27.
63. Canada, Parliament, *Debates of the Senate*, 42nd Parl, 1st sess, Vol 150, No 042 (2 June 2016) at 2120 (Hon. Claude Carignan).
64. See note 63, at 2030 (Hon. Denise Batters).
65. See note 63, at 2220 (Hon. Victor Oh).
66. See note 63.
67. Canada, Parliament, *House of Commons Debates*, 42nd Parl, 1st sess, Vol 148, No 074 (16 June 2016) at 1045 (Hon. Jody Wilson-Raybould).
68. See note 19, *Truchon & Gladu* at paras 295–6, reporting the views presented by the Canadian Association for Community Living in the parliamentary discussion on Bill C-14.
69. See note 19, at para 240: “The concept of vulnerable person invoked by the defendants as the cornerstone of their positions is not defined in the legislation. This “person,” however is at the heart of the current debate, because the impugned provision is, according to the Attorney General, essentially intended to ensure his or her protection by prohibiting medical assistance in dying for all persons who are not close to death.”
70. See note 19, at paras 230–422. For example, psychiatrist Dr. Justine Dembo warned that “[l]abelling entire groups as ‘vulnerable’ does not account for individual differences within those groups. It also perpetuates medical paternalism, in that the medical profession to makes decisions for entire groups of people, rather than letting each capable patient exercise his autonomy from within his/her unique circumstances.” See note 19, at note 264.
71. See note 19, *Truchon & Gladu* at para 241.
72. See note 19, *Truchon & Gladu* at para 246.
73. See note 19, *Truchon & Gladu* at para 305.
74. *Nova Scotia (WCB) v Martin*, 2003 SCC 54.
75. See note 74, at para 99: “[T]he treatment of injured workers suffering from chronic pain under the Act is not based on an evaluation of their individual situations, but rather on the indefensible assumption that their needs are identical. In effect, the Act stamps them all with the “chronic pain” label, deprives them of a personalized evaluation of their needs and circumstances, and restricts the benefits they can receive to a uniform and strictly limited program.”
76. See note 19, *Truchon & Gladu* at para 252.
77. See note 19, *Truchon & Gladu* at paras 466, 689.
78. Canada, Parliament, *House of Commons Debates*, 43rd Parl, 2nd sess, Vol 150, No 064 (23 February 2021) at 1030 (Hon. David Lametti, Minister of Justice).
79. See note 78.
80. Canada, Parliament, *Debates of the Senate*, 43rd Parl, 2nd sess, Vol 152, No 032 (17 March 2021) at 1510 (Hon. Yonah Martin).
81. Canada, Parliament, *House of Commons Debates*, 43rd Parl, 2nd sess, Vol 150, No 060 (17 February 2021), at 1640 (Hon. Jane Cordy).
82. Bill C-7, *supra* note 36, at preamble; *Criminal Code*, *supra* note 39, at ss 241.31(1), 241.31(2) and 241.31(3).