
Submitted to the Standing Senate Committee on Legal and Constitutional Affairs

By:

Jonas-Sébastien Beaudry, DPhil*

November 2020

* Jonas-Sébastien Beaudry is an Assistant Professor of Law at McGill University.

As data (from Canada and other jurisdictions) consistently show, people most often choose to request medical aid in dying (MAID) because of existential suffering connected with the loss of autonomy and the difficulty in enjoying activities that they used to enjoy. Sometimes, no amount of financial or social support can attenuate this existential suffering. However, in some circumstances, patients may change their mind. They may have suicidal ideations that could be attenuated through proper social and medical attention, care, and support. For example, people suffering their recently acquired dependency, disability, or inability to fulfill social roles important to their personal integrity may come to terms with their struggles, and, through therapy, (disability and social) networks, and enjoying other goods and endorsing other roles, they may find that life can be valuable even when facing disability, illness, or dependency on a caretaker. Through autonomy-enhancing support, they might find their dependency on caretakers more agreeable. Proper social support may help them to overcome loneliness, or to not feel that their lives are burdensome on their families or on an aging partner. Such changes would heighten their autonomy more significantly than merely rendering them eligible for MAID. It would be tragic and unfair if patients contemplating medical aid in dying decided to die because of social factors that could have been attenuated.

I have therefore argued elsewhere that governments ought to ensure that such patients are given adequate resources so that they do not choose to die due to a sudden bout of hopelessness that could have been mitigated if their social circumstances had been different. The historical reality is that people who are older, disabled, and sick have long endured prejudices, including social marginalization. Often, these prejudices have been internalized. Certain legal and social contexts may, indeed, facilitate or invite this internalized prejudice. Bill C-7—An Act to amend the Criminal Code (medical assistance in dying)—is one such legal mechanism. Briefly, the bill paves a wider path for MAID by establishing procedural safeguards for individuals seeking assisted dying whose death is not reasonably foreseeable.

Legalizing assistance in dying for people who are not terminally ill implies that some lives are not worth living. This is a position that some bioethicists are comfortable taking: they argue that suicide is sometimes reasonable, most notably when a certain quality of life is so appalling that one would be better off dead. On the other hand, other bioethicists and disability theorists worry that such an assessment allows for ableist, ageist and diseasist views to surface and acquire increasing social legitimacy. The more formal recognition that our state gives to the notion that some lives are not worth living, the more likely it is for the state to subtly or directly impinge on the constitutional rights of all Canadians (whether sick, disabled, old, or not) to life and equality.

By limiting medical aid in dying to patients whose death is due to occur soon (i.e. the current law), the state could in principle avoid making or condoning these problematic quality of life judgements. This is because medical aid in dying could be considered, not as a kind of suicide, but as a modality of

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1 J.S. Beaudry, “The Way Forward for Medical Aid in Dying: Protecting Deliberative Autonomy is Not Enough”, Supreme Court Law Review, Second Series, Vol. 85: 335-385; also published as a chapter in Derek B.M. Ross (ed) Assisted Death: Legal, Social and Ethical Issues after Carter (Toronto: Lexis Nexis, 2018); “What’s missing from the conversation about assisted death”, Policy Options (16 October 2019); “MAID Monitoring and the Carter Compromise”, part of the “Monitoring Matters” Blog published online by the Vulnerable Persons Standard, March 2018; “Carter and the Politics of Certainty”, Impact Ethics (Online forum managed by the Novel Tech Ethics research team in the Faculty of Medicine at Dalhousie University), February 2015.

death/dying. Death being inevitable, MAID patients would be perceived as choosing the modality of their
death (active, passive, etc.) rather than as choosing to die outright. By contrast, by opening the door to euthanizing people whose death is not reasonably foreseeable, Bill C-7 effectively invites quality of life judgements and infers a formal condonation by the state of the position that some lives are not worth living and are better off not existing.

The problem is not so much that this is an untenable position. (Some bioethicists think that some very grave and rare conditions, such as certain cases of epidermolysis bullosa, amongst others, make a life not worth living). The problem is a normative one: Bill C-7 effectively opens a normative space in which various social actors (including medical experts) and the state itself can discuss the topic of “lives not worth living”. This legal-medical space will facilitate the cultural emergence of categories of human beings whose lives can be legally and morally disposed of. Since our society and our courts are barely aware of how ageist and ableist our culture is, this is a dangerous door to open—and, indeed, one that does not need to be opened, since palliative care is almost always sufficient in dealing with physical and immediate pain.

A concern is that, when Bill C-7 becomes law, an indefinite number of Canadians living with challenging medical conditions will now have to identify and reorient themselves with the knowledge that many people in their situations have chosen to legally end their lives. Our governments issued MAID bills in response to the Carter case, amongst other cases which challenged criminal laws against assisted suicide. The court in Carter ruled that the criminal laws prohibiting physician-assisted death unjustifiably infringe section 7 of the Charter, which protects the right to life, liberty, and security of the person. One would have hoped that simultaneous constitutional challenges to provincial and federal laws would have used the constitutional right to life to suggest that patients need social support to overcome suffering that could potentially pass. Instead, our courts and governments have legalized euthanasia as a solution for all kinds of suffering connected to serious medical conditions, including the ones that could be socially addressed.

Time will tell how much cultural harm will come from legalizing euthanasia of people who are not terminally ill. We are likely, as a society, to not see, measure, analyze, and counter this harm, due to widespread ableist and ageist prejudices. Claims of “lives not worth living” presented as sound medical judgments risk being de-politicized and taken as biological facts rather than value-laden judgements. More concretely, current reporting measures do not include extensive descriptions of why people choose to die. If, at the very least, provincial and federal guidelines were to mandate reports of why people choose to die, such as, ideally, thorough interviews that include the social and psychological causes of suicidal ideations of patients asking for MAID, scholars and policymakers could then begin to create an accurate picture of the social causes of medically-assisted suicides that could be attended to through social measures. If we do not collect this data, no social initiative to help those most vulnerable who choose to die can be put in place.

Even though I personally am not in favour of Bill C-7 for the reasons laid out above, I must at least welcome the two following provisions of the law:

“(g) ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care;

(h) ensure that they and the medical practitioner or nurse practitioner referred to in paragraph (e) have discussed with the person the reasonable and available means to relieve the person’s suffering and they and the medical practitioner or nurse practitioner referred to in paragraph (e) agree with the person that the person has given serious consideration to those means”
Some may nonetheless fear that these social safeguards will not suffice for the following reasons:

Regarding paragraph (g), the text uses the word “inform”. Merely informing the patients that alternative means of dealing with their suffering exist does not guarantee that the patient will seriously consider those alternatives. The requirement of “informing” the patient may become an empty formality (e.g. some quick words or sharing a list of support resources with the patient, who may quickly dismiss them).

A more robust safeguard could have been, for instance, one or more mandatory session(s) with a psychiatrist specialized specifically in the area of suicide, hopelessness, depression, etc. as regards to grave medical conditions. Of course, this implies coordination with provincial authorities, since provinces are in charge of medical care, but the importance of securing the safety and life can be conceptualized as a federal/criminal matter.

Paragraph (h) is an important addition. Currently people who ask for MAID can do so on subjective grounds, once their grave condition has been medically confirmed. They can decide which alternative treatments are acceptable to them, and what sort of suffering is intolerable to them. There is no objective measurement or confirmation of the patient’s personal assessment beyond the initial diagnosis. For people who have many years of life ahead of them, it seems essential to require them to seriously consider alternatives to suicide.

A more robust safeguard could have required such an assessment to be carried out by a relevant expert. Suicidal ideations in situations of grave medical conditions are part of a psychiatric expertise that goes beyond the usual expertise of nurses and doctors.

Summary of Recommendations:

• Ideally, not legalizing MAID for patients whose death is not reasonably foreseeable.

Alternatively, developing a coordinated provincial and federal responses to the risks and problems mentioned above by:

• Making one or more therapy session(s) with a psychiatrist specialized in the area of suicide (especially in the context of old age, diseases and disabilities) mandatory.
• Requiring this psychiatrist, rather than a nurse or doctor, to confirm that the patient has given serious consideration to alternatives.
• Mandating the collection of data (perhaps in collaboration with the aforementioned psychiatrist or through an independent interview) focused on determining social factors that could reduce suicidality in future patients.
• Developing coordinated provincial and federal responses to ensure access to basic resources enabling a tolerable life for people contemplating suicide, when such resources could indeed attenuate suicidality.

Such steps are not foreign to the approach deployed in curtailing suicidal trends among subgroups of the population that show growing numbers of suicides or suicide attempts.

These goals may be accomplished by amending paragraphs (g) and (h) accordingly and by mandating provincial and federal coordination to reach this result.

Conclusion
Bill C-7 is no less problematic than the 2016 *Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* in that it continues to legalize medical aid in dying *without* setting up structures that truly enhance autonomy, socially understood, and truly protect vulnerable populations. However, unlike the 2016 amendment that restricted the risk of ableist oppression to dying patients, the bill now extends it to a much wider population of people with disabilities. It does so in the name of compassion, of course, but we should remember that oppression has a habit of being packaged as a benefit for the oppressed.

Medical aid in dying, in many ways, is a distraction from what is really at stake: creating a more welcoming world for people who are old, sick, or disabled. Debating for decades about whether and how society should kill them to help them is a sinister way to go about doing this hard work. We need to develop, alongside an ethics and law of “medical assistance in dying”, and ethics and law of “social assistance in living”. Such a debate would focus on social rights; on revealing how ableism and ageism infiltrate the agency of many people—“sick” and “healthy” alike, “productive” and “dependent” alike—and how our laws and legal frameworks contribute to harmful messaging. I believe that, until our policymakers pay attention to these social problems, broadening access to MAID is ultimately dangerous for vulnerable populations.

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