"WL11"

EXPERT REPORT
JOCELYN DOWNIE, CM, FRSC, FCAHS, SJD
JANUARY 9, 2025

I. Summary of my qualifications

1. I am Professor Emeritus in the Faculties of Law and Medicine at Dalhousie University in Halifax, Nova Scotia, Canada. I have Bachelor's and master's degrees in philosophy from Queen's University, Kingston, Canada, a Master's in Philosophy from the University of Cambridge, England, a Bachelor's in Law from the University of Toronto, Canada, and a Master's and Doctorate in Law from the University of Michigan at Ann Arbor, Michigan, USA. I am a Fellow of both the Royal Society of Canada and the Canadian Academy of Health Sciences. I was named a member of the Order of Canada in part in recognition of my work advocating for high-quality, end-of-life care.

2. My work on end-of-life law and policy includes: author of *Dying Justice: A Case for the Decriminalizing Euthanasia and Assisted Suicide in Canada*; author of many peer-reviewed articles and book chapters; invited plenary speaker at conferences across Canada and the world; and member of the Royal Society of Canada Expert Panel on End-of-Life Decision-Making, the plaintiffs' legal team in *Carter v. Canada (Attorney General)*, the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, the Canadian Council of Academies Expert Panel on Medical Assistance in Dying, and the federal MAID Practice Standards Task Group.

3. I have attached my cv to provide more detail.

PICI

II. Answers to questions posed[1]

1. **What is the legal status of assisted dying in Canada? Please address:**

a. ***How and when did medical assistance in dying become legal in Canada? In other words, please explain the history of the legalisation of assisted dying in Canada, including both the judicial and legislative developments that have taken place.***

4. Medical assistance in dying (MAiD) became legal in Canada through an iterative process between the courts and the federal Parliament.

5. *Carter v Canada (AG)* [2] – a *Charter* challenge to the existing *Criminal Code* prohibition on assisted dying. The Supreme Court of Canada found that the prohibition breached the right to life, liberty, and security of the person of the Canadian *Charter of Rights and Freedoms* of capable adults with "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', it should be added, does not require the patient to undertake treatments that are not acceptable to the individual."[3] The Court found that the limits on the rights were not saved by s.1 (the government had failed to demonstrate that the limits on the rights were demonstrably justified in a free and democratic society). The SCC issued a declaration of invalidity but suspended it for one year (later extended for 4 months) to give the federal government time to amend the *Criminal Code* should it wish to do so.

6. Bill C-14[4] – the federal Parliament amended the *Criminal Code* in response to the *Carter* decision, removing the absolute prohibition on MAiD by creating exemptions to the offences of aiding suicide, homicide, administration of a noxious substance. It also introduced a robust

---

[1] Québec has its own MAiD legislation, Act respecting end-of-life care CQLR c S-32.0001. In this report, I answer the questions posed about the legal status of MAiD only in relation to the federal legislation. I include data on Québec as that is gathered as part of the federal monitoring system. For responses to question #1 in relation to Québec, see Eliana Close and Jocelyn Downie, "Medical assistance in dying in Canada" in Ben P. White (ed), Research Handbook on Voluntary Assisted Dying Law, Regulation and Practice, Edward Elgar, forthcoming 2025.

[2] *Carter v Canada (AG),* 2015 SCC 5 (*"Carter"*).

[3] *Carter* at para 127.

[4] Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying*), 1st Sess, 42nd Parl, 2016 (assented to 17 June 2016), SC 2016, c 3. ("Bill C-14")

PKI

regulatory framework for MAiD. It included a set of eligibility criteria beyond *Carter* (e.g., eligible for government funded health care) and a set of procedural safeguards (e.g., two independent clinicians must find the person eligible, two independent witnesses, minimum ten-day period between request and provision, etc.). It also mandated the introduction of regulations to govern reporting of MAiD cases to the federal government, initiation of an independent review of the issues of mature minors, advance requests, and requests for MAiD where mental illness is the sole underlying condition, and at the start of the fifth year after royal assent to refer to a committee of the House, the Senate, or both the task of reviewing the provisions of the act and the state of palliative care in Canada.

7. Notably, in terms of understanding the chronology that followed, Bill C-14 narrowed the SCC eligibility criteria, most significantly, defining "grievous and irremediable medical condition" as including the requirement that a person's natural death had to have become "reasonably foreseeable".

8. *Truchon c. Procureur général du Canada (Truchon)*[5] – a *Charter* challenge to the "natural death has become reasonably foreseeable" eligibility criterion. Justice Baudouin of the Québec Superior Court found that the criterion breached *Charter* rights of Canadians (the right to life, liberty, and security of the person as well as the right to equal protection and equal benefit of the law without discrimination based on physical disability) and found that the limits on the rights were not saved by s.1. She issued a declaration of invalidity but gave the government six months (subsequently and ultimately extended to February 26, 2021) to amend the *Criminal Code* should it wish to do so.

9. Bill C-7[6] – the federal Parliament amended the *Criminal Code* in response to the *Truchon* decision, removing the criterion of "natural death has become reasonably foreseeable." It also created two tracks for procedural safeguards: Track One for persons whose natural death had become reasonably foreseeable, and Track Two for persons whose natural death had

---

[5] *Truchon c. Procureur général du Canada,* 2019 QCCS 3792 (*"Truchon"*).
[6] Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), 2nd Sess, 43rd Parl, 2020 (assented to 17 March 2021), SC 2021, c 2. ("Bill C-7")

not. For Track One, it removed the mandatory minimum ten-day period between request and provision, reduced the witness requirement from two to one, and introduced the "final consent waiver" (a mechanism through which a person who already meets all of the eligibility criteria for MAiD could make arrangements with their provider for MAiD to be provided should they lose decision-making capacity). For Track Two, Bill C-7 introduced numerous additional safeguards including, e.g., a minimum 90-day period between the day the first assessment begins and provision, requirements re: informing the patient about means available to relieve their suffering, and requirements re: consulting with a clinician with expertise in the condition causing the person's suffering (full details provided below).

10. Notably, Bill C-7 also added a temporary exclusion of MAiD where mental illness is the sole underlying medical condition (MAiD MI-SUMC) (to be automatically repealed in March 2023, later extended to March 2024, and again to March 2027).[7]

b. ***What forms of medical assistance in dying is permitted in Canada? Put differently, how is "medical assistance in dying" defined in Canada and in what circumstances can patients access it?***

11. Under the Canadian *Criminal Code*, medical assistance in dying (MAiD) means: "the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death ["provider-administered MAiD"]; or the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. ["self-administered MAiD"]."[8]

12. The circumstances in which individuals can access MAiD are set out below in responses to questions 1 d) and e).

---

[7] Bill C-39, An Act to amend An Act to amend the Criminal Code (medical assistance in dying), 1st Sess, 44th Parl, 2023 (assented to March 9, 2023). Bill C-62, An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No.2, 1st Sess, 44th Parl, 2024 (assented to February 29, 2024).
[8] *Criminal Code*, RSC 1985, c C-46, s.241.1 (*"Criminal Code"*).

PKI

c. ***How does medical assistance in dying operate under the Criminal Code, as amended? In particular: Who can provide medical assistance in dying?***

13. Physicians and nurse practitioners are legally permitted to provide MAiD (current distribution is 94.5% physicians, 5.5% nurse practitioners[9]).

14. The provision of MAiD is not restricted to any particular specialties. However, the majority come from family medicine, palliative medicine, and anesthesiology.[10]

	Track One	**Track Two**
Family Medicine	64%	69.5%
Palliative Medicine	12.6%	8.2%
Anesthesiology	11.6%	6.8%
Internal Medicine	3.1%	2.0%
Critical Care and emergency medicine	2.5%	4.3%
Oncology	1.2%	X
Other	0.7%	X
Surgery	4.3%	7.3%

d. ***Who is eligible for medical assistance in dying and what are the eligibility criteria?***

15. The eligibility criteria for MAiD are set out in the *Criminal Code* as follows:

- Eligible for government-funded health services
- At least 18 years of age
- Capable of making decisions with respect to health
- Made a voluntary request for MAiD not made as a result of external pressure
- Gave informed consent to receive MAiD after having been informed of means available to relieve their suffering, including palliative care

---

[9] Fifth Annual Report on Medical Assistance in Dying 2022 ("Fifth Annual Report") at page 53. Available online: https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#a4.1

[10] Fifth Annual Report at page 80.

- Have a grievous and irremediable medical condition defined as:
    - Serious and incurable illness, disease or disability (until March 2027, "mental illness" is not considered to be an illness, disease or disability. On March 17, 2027, that exclusion will be automatically repealed[11])
    - Advanced state of irreversible decline in capability
    - Illness, disease or disability or state of decline causes enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.[12]

e. ***What are the procedural safeguards that must be met before medical assistance in dying can be provided?***

16. There are two tracks for procedural safeguards.[13] A patient is on Track One if their natural death has become reasonably foreseeable. They are on Track Two if it is not. "Natural death has become reasonably foreseeable" is not defined in the legislation nor has there been an authoritative interpretation from the courts. It is my opinion that it means that there is sufficient temporal proximity to death (e.g., 12 months) and/or the person is on a predictable trajectory toward death (e.g., on diagnosis with ALS).[14]

17. The procedural safeguards for both Tracks One and Two are:

- Two medical or nurse practitioners (NPs) must be of the opinion that the person meets the eligibility criteria
- The request must be signed and dated before one independent witness

---

[11] Bill C-62 An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No.2, SC 2024, c1.
[12] Eligibility criteria are set out in *Criminal Code* ss.241.2(1)-(2.1).
[13] Procedural safeguards are set out in *Criminal Code* ss. 241.2(3)-(3.1).
[14] The basis and justification for this opinion is set out in Jocelyn Downie and Kate Scallion, "Foreseeably Unclear: The Meaning of the 'Reasonably Foreseeable' Criterion for Access to Medical Assistance in Dying in Canada" (2018) 41:1 Dal LJ 23. See also Jocelyn Downie & Jennifer Chandler, Interpreting Canada's Medical Assistance in Dying Legislation (Montreal: Institute for Research on Public Policy, 2018). See also Canadian Association of MAiD Assessors and Providers, "The Interpretation and Role of 'Reasonably Foreseeable' in MAiD Practice" (2022) Available online: https://camapcanada.ca/wp-content/uploads/2022/03/The-Interpretation-and-Role-of-22Reasonably-Foreseeable22-in-MAiD-Practice-Feb-2022.pdf

DKT

- Person must give informed consent to receive MAiD after having been informed of the means that are available to relieve their suffering, including palliative care
- Immediately before providing MAiD, the person is given an opportunity to withdraw their request and physician/NP ensures person gives express consent to MAiD (exceptions: "advance consent" and "final consent waiver")

18. There are additional procedural safeguards for Track Two:

- If neither the first or second physician or NP has expertise in the condition causing the person's suffering, 1st or 2nd practitioner must consult with a physician or NP with that expertise and share results of consultation with the other practitioner.
- 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.
- The person has been offered consultations with relevant professionals who provide such available counselling services, mental health and disability support services, community services, and palliative care.
- Both of the physicians/NPs have discussed with the person the reasonable and available means to relieve the person's suffering and agree with the person that the person has given serious consideration to those means.
- 90 clear days between day on which first assessment begins, and the day MAiD is provided unless the assessments have been completed and both physicians/NPs are of opinion that loss of capacity is imminent, in which case any shorter period the provider considers appropriate.

19. There are two exceptions to the procedural safeguard that immediately before providing MAiD, the person must be given an opportunity to withdraw their request, and the physician/NP must ensure that the person gives express consent to MAiD: final consent waiver;[15] and advance consent – self-administration.[16]

---

[15] *Criminal Code* ss. 241.2(3.2)-(3.4).
[16] *Criminal Code* ss. 241.2(3.5).

PKI

20. The final consent waiver is available only to patients on Track One. If a patient's natural death has become reasonably foreseeable, they meet all the eligibility criteria for MAiD, and they are at risk of losing capacity to consent to MAiD, then they can enter into a written arrangement with their provider agreeing to the provision of MAiD on or before a specified date if they lose capacity prior to that date. MAiD can then be provided after loss of capacity so long as they do not demonstrate resistance or refusal (involuntary words, sounds, gestures made in response to contact do not constitute refusal or resistance).

21. Advance consent – self-administration is available to patients on both Tracks One and Two. If a patient meets all the eligibility criteria for MAiD, then they can enter into a written arrangement that the provider will be present at the time the person self-administers and will administer medications to cause the person's death if, after self-administering, the person loses the capacity to consent to receiving MAiD and does not die within a specified period.

f. ***What is the position in relation to oversight, monitoring and reporting?***

22. All intentional/explicit requests for MAiD received by health care professionals must be **reported** to the federal government.[17] Clinicians in some provinces/territories report directly to the federal government and others to the federal government through a designated provincial/territorial body.[18] This allows for annual reporting on, e.g., the number of MAiD requests and deaths as well as the underlying conditions; gender, age, race, Indigenous

---

[17] Regulations for the Monitoring of Medical Assistance in Dying SOR/2018-166) and Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying SOR/2022-222. For details, see "Guidance Document: Reporting requirements under the Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying" available online: https://www.canada.ca/en/health-canada/services/publications/health-system-services/guidance-document-reporting-requirements-under-regulations-amending-regulations-monitoring-medical-assistance-dying.html

[18] "1. Directly to Health Canada via a secure web-based collection portal: Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Ontario (requests not resulting in provision of MAID, as well as reports from pharmacists/pharmacy technicians), Manitoba, and Yukon.
2. Through a designated provincial or territorial body which in turn submits the data quarterly to Health Canada: Québec, Ontario (requests resulting in provision of MAID), Saskatchewan, Alberta, British Columbia, Northwest Territories, and Nunavut." Fifth Annual Report at page 63.

DKI

identity, and disability; the nature of the suffering; access to palliative care and disability support services; locations of MAiD; specialties of MAiD practitioners; reasons for finding individuals ineligible; and withdrawal of requests. The federal Minister of Health is required to report annually on the results of this data collection (understood to fulfil the **monitoring** function).[19]

23. Oversight of clinical practice falls within provincial/territorial jurisdiction in Canada's division of powers. Some provinces/territories have additional **oversight** systems. The Office of the Chief Coroner for Ontario,[20] Office of the Chief Medical Examiner for Alberta,[21] British Columbia's MAiD Oversight Unit,[22] and the Québec Commission on end-of-life care[23] review all MAiD cases for compliance. This represents 91.1% of all MAiD provisions in Canada.[24] Furthermore, all of the regular mechanisms for oversight of clinical practice (*Criminal Code*, civil law, professional regulatory bodies) also provide oversight for MAiD (as they do for all clinical practice).

g. ***How is conscientious objection handled?***

24. Conscientious objection may take many forms. It may be an objection to: assessing/providing, providing information in response to questions, providing information even when not asked, participating/assisting in provisions, and allowing provisions within a facility.

---

[19] See, for example, Fifth Annual Report.
[20] Medical Assistance in Dying Memorandum, Office of the Chief Coroner of Ontario available online: https://www.ontario.ca/page/medical-assistance-dying-memorandum#section-0
[21] Advice to the Profession, Medical Assistance in Dying (MAID), College of Physicians and Surgeons of Alberta available online: https://cpsa.ca/wp-content/uploads/2020/06/AP_Medical-Assistance-in-Dying.pdf
[22] Oversight of Medical Assistance in Dying. Available online at https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying
[23] Rapport annuel d'activités: Commission sur les soins de fin de vie 2023 available online at https://numerique.banq.qc.ca/patrimoine/details/52327/2718720
[24] Fifth Annual Report at pages 15 and 17.

PKI

25. All clinicians in Canada have freedom of religion and conscience protected under the *Canadian Charter of Rights and Freedoms*.[25]

26. There is no duty for any individual clinicians to **assess or provide** MAiD anywhere in Canada. Clinicians are free to choose not to assess or provide at all, or not to assess or provide in any specific case for any reason and without any need for justification.

27. The Supreme Court of Canada addressed individual conscientious objection in *Carter*:

> "[132] In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note — as did Beetz J. in addressing the topic of physician participation in abortion in *Morgentaler* — that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled."[26]

28. The federal Parliament addressed it in the Preamble to Bill C-14: "Whereas everyone has freedom of conscience and religion under section 2 of the Canadian Charter of Rights and Freedoms; Whereas nothing in this Act affects the guarantee of freedom of conscience and religion."[27] The *Criminal Code* expressly states "nothing in this section [the MAiD section] compels an individual to provide or assist in providing MAiD."[28]

29. In most provinces and territories, there is a duty to **refer** or make an **effective transfer of care** under provincial/territorial professional regulatory practice standards.[29]

---

[25] *Charter of Rights and Freedoms*, Part I of the *Constitution Act 1982*, being Schedule B to the *Canada Act 1982* (UK), c 11, s 2(a).
[26] *Carter* at para 132.
[27] Bill C-14
[28] *Criminal Code* s. 241.2(9)
[29] For example, Ontario has a duty to refer (College of Physicians and Surgeons of Ontario, Human Rights in the Provision of Health Services (September 2023) https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Human-Rights-in-the-Provision-of-Health-Services) and Nova Scotia has a duty of effective transfer of care (College of Physicians and Surgeons of Nova Scotia, Professional Standard Regarding Medical Assistance in Dying (May 2021) https://cpsns.ns.ca/resource/medical-assistance-in-dying/. The duty of effective

DCI

30. In all provinces and territories, there is a duty to **provide information** (there is variation as to whether this must be met directly or may be met by referring the patient to someone who is available and willing to provide information or to a resource that provides accurate information about MAiD) if a patient asks about MAiD.[30]

31. There is uncertainty across the country with respect to whether there is a duty to **inform** some patients about MAiD if they do not ask about it. This is sometimes referred to as "bringing up MAiD." The concern about having a duty to inform is that it could be experienced as coercive. The concern about not having a duty to inform is that some individuals do not know that MAiD is legal (or potentially an option in their case) and would not know to ask about it but would want it if they knew. The legal foundation for this duty for those who say there is a duty is the established legal position that clinicians have a duty to inform patients about all alternatives in the context of informed consent processes. As MAiD can be a legal alternative, they reason, there can be a duty to inform about MAiD in some circumstances.[31]

32. Some regulatory bodies and employers (e.g., hospitals) also address the duty to **participate/assist**. This is especially relevant for nurses (as they would potentially be involved in inserting IVs in preparation for MAiD provision and in providing non-MAiD related care to patients preparing for and receiving MAiD) and pharmacists (as they would potentially be involved in dispensing the medications). Typically, allied health professionals are not obligated to to participate/assist but they must assure the patient they will not be

---

referral has been upheld as *Charter* compliant by the Ontario Court of Appeal in *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393.

[30] For example, College of Physicians and Surgeons of British Columbia, "Medical Assistance in Dying Practice Standard" (February 26, 2024) Available online: https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf), College of Physicians and Surgeons of Manitoba, "Medical Assistance in Dying (MAiD) Standard of Practice" (March 2024) Available online: https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Medical%20Assistance%20in%20Dying%20(MAiD).pdf).

[31] The Canadian Association of MAiD Assessors and Providers has a guidance document on this topic. See CAMAP, "Bringing up Medical Assistance in Dying (MAiD) as a clinical care option." Available online: https://camapcanada.ca/wp-content/uploads/2022/02/Bringing-up-MAiD.pdf

WM PCI

abandoned, continue to provide care that is not associated with MAiD, and notify their employer about their conscientious objection to participation/assistance so that alternative arrangements can be made. For example, nurses in Alberta are advised: "Reassure the client that they will not be abandoned. No personal moral judgments about the beliefs, lifestyle, identity or characteristics of the client should be expressed by the nurse. Until a replacement caregiver is found, a nurse must continue to provide nursing care, as per a client's care plan, that is not related to activities associated with medical assistance in dying." [32]

33. It is an unsettled question whether publicly funded healthcare **institutions** (palliative care programs, faith-based hospitals, hospices) are legally permitted to refuse to allow MAiD to be provided within their walls.[33] This does not happen in some provinces (as the facilities are all owned and operated by government), it is prohibited in some provinces, expressly permitted in others, and still other provinces are silent but take no action against it.[34]

h. ***What <u>mechanisms</u> are in place to prevent abuse and what <u>mechanisms</u> are in place to prevent non-compliance with the safeguards? Please address both proactive and reactive mechanisms.***

<u>Reactive</u>

---

[32] For example, College & Association of Registered Nurses of Alberta, "Guidance related to the new Medical Assistance in Dying legislation for Alberta's nurses has not been released by the Tri-Nursing Group (CRNPA, CARNA, CLPNA)" (December 2016) "Reassure the client that they will not be abandoned. No personal moral judgments about the beliefs, lifestyle, identity or characteristics of the client should be expressed by the nurse. Until a replacement caregiver is found, a nurse must continue to provide nursing care, as per a client's care plan, that is not related to activities associated with medical assistance in dying."
https://www.crpna.ab.ca/CRPNAMember/CRPNA_Member/Medical_Assistance_and_Dying.aspx#:~:text=Nurses%20are%20not%20required%20to,of%20medical%20assistance%20in%20dying.
https://www.crpna.ab.ca/CRPNAMember/CRPNA_Member/Medical_Assistance_and_Dying.aspx#:~:text=Nurses%20are%20not%20required%20to,of%20medical%20assistance%20in%20dying

[33] This issue is currently being litigated in British Columbia and Québec. *O'Neill, Jayaraman, and Dying With Dignity Canada v. British Columbia (Minister of Health), Vancouver Coastal Health Authority, Providence Health Care Society* (June 17, 2024) and Jacob Serebrin, "Quebec judge won't exempt church-supported palliative care home from MAID law" (March 7, 2024) Available online: https://www.cbc.ca/news/canada/montreal/exempt-church-palliative-care-1.7137469

[34] Close E, Jeanneret R, Downie J, Willmott L, White BP, "A qualitative study of experiences of institutional objection to medical assistance in dying in Canada: ongoing challenges and catalysts for change" BMC Medical Ethics 24:71 (2023).

DKI

34. MAiD is governed by the federal Criminal Code. The MAiD provisions create exceptions to the existing offences that MAiD would otherwise be (i.e., homicide,35 aiding suicide,36 and administering a noxious substance37). If the MAiD provisions are followed, there will be no offence. If they are not followed, there may be and anybody who believes there has been non-compliance with Canada's MAiD law can report this to the police who will investigate and, if warranted, charges will be laid and the accused prosecuted. Non-compliance can be punishable by imprisonment ranging from up to two years for failure to comply with reporting obligations, five years for failing to comply with the procedural safeguards, fourteen years for failing to meet the terms of the exemption for the offence of aiding suicide, and life for failing to meet the terms of the exemption for the offence of homicide.

35. MAiD is also regulated at the provincial/territorial level. Some provinces/territories have legislation that addresses MAiD,[38] others have MAiD policies at the provincial/territorial or health authority levels,[39] others leave the regulation entirely to the regulatory colleges.

36. MAiD can only be provided by physicians or nurse practitioners. Physicians and nurse practitioners are self-regulated professions in Canada. Physician conduct is regulated by the provincial/territorial Colleges of Physicians and Surgeons and nurse practitioner conduct is regulated by the provincial/territorial Colleges of Nurses. The Colleges have a mandate to act in the public interest. For example, to "(a) serve and protect the public interest in the practice of medicine; and (b) subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine."[40]

---

[35] Criminal Code s.227(1)
[36] Criminal Code s.241(2)
[37] Criminal Code s.245(2)
[38] E.g., Quebec's *Act respecting end-of-life care*, S-32.0001
[39] E.g., British Columbia's Ministry of Health Policy Communiqué, "Medical Assistance in Dying: Access and Care Coordination" (March 4, 2022).
[40] E.g., Nova Scotia's *Medical Act*, SNS 2011, c38, s.5.

DCI

37. Colleges have practice standards, policies, and guidance documents to guide clinician conduct. MAiD is regulated through standards etc. that are specific to MAiD[41] but also standards etc. of more general application (e.g., consent to treatment).[42] Colleges have the responsibility and authority to investigate potential non-compliance and to discipline where non-compliance is made out. Discipline can range from giving advice or guidance to suspension to permanent loss of the license to practice.

38. Anybody who believes there has been non-compliance with College standards or policies in the context of MAiD can report this to the College who will follow their complaints process. Clinicians who are aware of another clinician's incompetence or professional misconduct (whether in relation to MAiD-specific standards/policies or general ones that nonetheless apply to MAiD) have a professional duty to report this to their College.[43]

39. Oversight, monitoring, and reporting in relation to these laws, standards, and policies is described above in response to question #1(f).

Proactive

40. Prevention of abuse and non-compliance is also dealt with proactively through education.

41. Funded by Health Canada, the Canadian Association of MAiD Assessors and Providers (CAMAP) has developed:

> "the first nationally accredited, comprehensive, bilingual program to support the practice of MAiD in Canada. The training is delivered through a combination of online and in-person formats.

---

[41] For example, College of Physicians and Surgeons of Ontario Medical Assistance in Dying Policy https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying. For review of nursing colleges, see Pesut B, Thorne S, Stager ML, Schiller CJ, Penney C, Hoffman C, Greig M, Roussel J. Medical Assistance in Dying: A Review of Canadian Nursing Regulatory Documents. Policy Polit Nurs Pract. 2019 Aug;20(3):113-130. doi: 10.1177/1527154419845407. Epub 2019 May 6. PMID: 31060478; PMCID: PMC6827351.

[42] For example, College of Physicians and Surgeons of Nova Scotia Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment https://cpsns.ns.ca/wp-content/uploads/2018/06/Informed-Patient-Consent-to-Treatment-Standard-and-Guidelines.pdf

[43] For example, the College of Physicians and Surgeons of Nova Scotia https://cpsns.ns.ca/resource/duty-to-report-health-professionals/#:~:text=Physicians%20must%20immediately%20notify%20the,%2C%20including%20sexual%20misconduct%2C%20incapacity%2C.

DKI

The curriculum offers a comprehensive total of 81 credits for the CFPC [College of Family Physicians of Canada], 27 hours of self-assessment for the RCPSC [Royal College of Physicians and Surgeons of Canada]. There are 13 online self-study hours and 14 hours for facilitated sessions. The curriculum is free for clinicians (licensed physicians and nurse practitioners) until March 2026. Health Canada is funding clinician learners to take the curriculum in the first two years, and all topics in this curriculum are accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC)."[44]

42. CAMAP also hosts several online fora where clinicians can share experiences and discuss complex or controversial issues. It hosts an annual national conference at which practice issues and research are explored and develops guidance documents to aid assessors and providers.[45]

43. MAiD is also covered in some residency programs[46] as well as continuing education programs for all clinicians.[47]

2. **What has been the position in practice in Canada since assisted dying was legalised? Please address:**

a. ***Who has been accessing medical assistance in dying?***[48]

---

[44] https://camapcanada.ca/curriculum/

[45] https://camapcanada.ca/for_clinicians/publications/

[46] For example, knowledge in re: MAiD is a required competency for the Adult Palliative Medicine specialty in the Royal College of Physicians and Surgeons of Canada. https://www.royalcollege.ca/en/standards-and-accreditation/information-by-discipline?specialty=&subspecialty=royal-college%3Aibd%2Fsubspecialty%2Fpalliative-medicine&special-program=&afc-diploma= and in neurology chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/file:///Users/jocelyndownie/Downloads/neurology-competencies-e.pdf. See also, for example, LeBlanc, S., MacDonald, S., Martin, M. *et al.* Development of learning objectives for a medical assistance in dying curriculum for Family Medicine Residency. *BMC Med Educ* **22**, 167 (2022). https://doi.org/10.1186/s12909-022-03204-1.

[47] For example, "Medical Assistance in Dying (MAID) and Mental Disorders", November 28, 2024 9-12:30, New Brunswick, Horizon Health Network and Vitalité Health Network, accredited by College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. See also MAiD2025 – Weathering Change accredited for CME from the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. https://uottawacpd.eventsair.com/QuickEventWebsitePortal/maid2025/info.

[48] Unless otherwise noted, the data provided in response to Question 2 are taken from the Fifth Annual Report available online at https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#a4.1.

DKI MAC

44. There were 15,343 MAiD deaths in 2023 (for a total of 60,031 MAiD deaths since legalization in 2016). This represents 4.7% of all Canadians who died in 2023. 95.9% of MAiD deaths were Track 1 (4.5% of all deaths). 4.1% of MAiD deaths were Track 2 (0.19% of all deaths).

45. There was a 15.8% increase from 2022 (compared to a 32.6% increases 2020-2021 and 31.2% increase 2021-2022).

46. Slightly more men than women received MAiD (51.6%/48.4%). Track 1 was 51.6% men and 48.4% women. Track 2 was 58.5% women and 41.5% men.

47. The median age of MAiD recipients was 77.6 years (77.7 for Track 1 and 75 for Track 2). 59.7% of MAiD recipients on Track 1 were over 75. 50.2% of recipients on Track 2 were over 75.

48. The most common underlying condition for recipients on Track 1 was cancer at 64% followed by "other" at 26.6% and cardiovascular at 16.4 %.[49] The most common underlying condition for recipients on Track 2 was neurological 56.1% and then "other" at 55.1%. ("The conditions provided for the "other" conditions category include diabetes, frailty, autoimmune conditions, chronic pain and mental disorders, but practitioners sometimes listed other conditions such as joint bone and muscle issues, hearing and visual issues and various internal diseases in the write-in fields." These may be co-morbidities).

49. Provider-administered MAiD is by far the preferred method with fewer than five cases of self-administered MAiD in 2023 (of 15,343 cases).

b. ***What are the most common reasons given by patients for why they are requesting medical assistance in dying?***

50. The most common nature of suffering underlying requests for MAiD are:

- loss of ability to engage in meaningful activities (Track 1 95.5% Track 2 96.3%)

[49] Note: can be >100% as providers can select more than one condition.

PCI

- loss of ability to perform activities of daily living (Track 1 87.3% Track 2 83.1%)
- loss of dignity (Track 1 64.9% Track 2 70.4%)
- inadequate pain control or concern about controlling pain (Track 1 54.4% Track 2 58.5%)
- loss of independence ((Track 1 52.8% Track 2 39.1%)

51. More than one cause of suffering can be reported. "In almost every instance, practitioners reported more than one source of suffering related to the person's medical condition. Practitioners most commonly reported five sources of suffering."[50]

c. ***What are the barriers to accessing medical assistance in dying?***

52. In 2023, 3,195 individuals made requests for MAiD, were not found to be ineligible, but died of another cause. The reasons for this that could signal a barrier (rather than patient choice) include:[51]

- Person was found eligible but died before scheduled MAID provision (864)
- Person died before both assessments were completed (503)
- Person was referred or requested MAID too late (i.e. referral time was too short) (319)
- Other (145)
- Loss of capacity to consent without a waiver of final consent being completed (84)
- Operational issues (i.e., could not be moved to a facility that allowed MAID, medication shortages, bed shortages, health care personnel unavailable) (24)
- No assessor/provider available/willing (19)
- Lack of pharmacy willing to provide MAID medications X [suppressed for confidentiality]

53. Patients may encounter barriers to access MAiD when the institution they are in does not permit MAiD within its walls (this can drive many of the reasons listed above). There are

[50] Fifth Annual Report at p. 32.
[51] More than one reason can be provided by the clinician.

PKJ

patients who have no choice as to which facility they are admitted to. There are patients who are not stable enough to be transferred to an institution that has not opted out. There are patients for whom a transfer is excruciatingly painful. Some patients could be transferred without pain, but this may impose the burden of social dislocation (being removed from an institution that they consider to be home and separated from long term caregivers). A significant percentage of health services in several provinces are controlled by publicly funded faith-based institutions, there are whole regions with only publicly funded faith-influenced hospitals, and there are regions where the largest palliative care facility/only complex palliative care facility in region is operated by publicly funded faith-based institution.[52]

54. The Fifth Annual Report contains information about forced transfers:

	Provisions that involved transfer (% [of MAiD deaths])	Transfers due to institutional policies (% [of transfers])
Newfoundland and Labrador	13.9	X
Prince Edward Island	X	X
Nova Scotia	3.3	X
New Brunswick	10.7	28.1
Québec	2.6	9.0
Ontario	8.0	42.9
Manitoba	13.2	70.0
Saskatchewan	9.6	45.5
Alberta	9.3	85.7
British Columbia	5.6	34.2

X indicates suppressed to maintain confidentiality

55. This means that in just one year there were 345 MAiD deaths that involved a transfer due to institutional policy. This does not reflect all those who would have wanted a MAiD death but could not get one because of institutional policies.

[52] Close E, Jeanneret R, Downie J, Willmott L, White BP, "A qualitative study of experiences of institutional objection to medical assistance in dying in Canada: ongoing challenges and catalysts for change" BMC Medical Ethics 24:71 (2023).

DKI

56. Additional available data on the prevalence of transfers due to institutional policies is gathered in "A qualitative study of experiences of institutional objection to medical assistance in dying in Canada: ongoing challenges and catalysts for change."[53]

d. ***What is the relationship between medical assistance in dying and palliative care in Canada? Please address, in particular but not limited to, the effect of the legalisation of assisted dying on palliative care.***

57. Many palliative care providers and facilities are supportive of, and directly involved with, MAiD.

58. It has been suggested that MAiD is inconsistent with the values of palliative care. However, this is belied by the fact that some palliative care units and hospices now provide/allow provision of MAiD – 21.8% of MAiD deaths are in a palliative care facility. Some palliative care clinicians are MAiD assessors and providers – 12.6% of providers in Track 1 cases are in palliative medicine with 8.2% for Track 2 (of 2197 unique providers total in 2023 compared with 9.1% of 1271 unique providers in 2019).

59. MAiD and palliative care are also not inconsistent in practice. Indeed, 75% of MAiD recipients required and accessed palliative care. 2.8% of MAiD recipients required but did not receive palliative care - in only 6 cases was palliative care needed but not accessible.

60. Legalization of MAiD has not harmed the development of palliative care. According to the Canadian Institute for Health Information, "[m]ore people are receiving some form of palliative care compared with 5 years ago."[54]

---

[53] Close, E., Jeanneret, R., Downie, J. *et al.* A qualitative study of experiences of institutional objection to medical assistance in dying in Canada: ongoing challenges and catalysts for change. *BMC Med Ethics* **24**, 71 (2023). https://doi.org/10.1186/s12910-023-00950-9

[54] Canadian Institute for Health Information, "Access to Palliative Care in Canada" (2023) online: <https://www.cihi.ca/en/access-to-palliative-care-in-canada#:~:text=Key%20findings,live%20or%20their%20disease%20diagnosis>.

DCI

61. According to the 2023 Health Canada report "The Framework on Palliative Care in Canada—Five Years Later: A Report on the State of Palliative Care in Canada":

> "Federal investments of $24 million from 2019 to 2021 supported implementation of the Action Plan [on Palliative Care]. Budget 2021 provided an additional $29.8 million over a six-year period (starting in 2021–2022) for Health Canada to continue to implement the Action Plan. This funding extends beyond the timeline of this report, allowing for a longer-term focus on the Framework's collective vision for palliative care."[55]

62. Comparing 2016-2017 to 2021-2022, more people died at home with palliative care, and residential hospices increased from 88 to 142. Other improvements in palliative care after the legalization of MAiD are described in the Health Canada report.

63. Provinces/territories as well are expanding access to palliative care. For example, according to the Government of Ontario:

> "As part of Ontario's 2024 budget, the provincial government is investing up to $19.75 million in capital funding to build 84 new adult hospice beds and 12 new pediatric hospice beds."
>
> "Since 2018, Ontario has invested over $26.5 million to add 153 new hospice beds, bringing the total to 768, giving more families the option of high quality and dignified end-of-life care."
>
> "The province is making it easier and faster for people of all ages to connect to the care they need, where and when they need it. This includes investing up to $147.4 million over three years to expand access to palliative care services, including increasing funding by 45 per cent for all hospice beds across the province."[56]

64. Palliative care research has also thrived post-legalization of MAiD. For example, the Pan-Canadian Palliative Care Research Collaborative was founded in 2017 with a mission to "develop a Pan-Canadian network of practice-focused research groups producing high-quality palliative care research."[57] There are now more than 25 active programs of research

---

[55] https://www.canada.ca/en/health-canada/services/publications/health-system-services/framework-palliative-care-five-years-later.html

[56] https://news.ontario.ca/en/release/1005056/ontario-expanding-access-to-palliative-care

[57] https://pcpcrc.ca/

PKI

in the PCPCRC, over 100 "investigators, healthcare providers, trainees, community and policy stakeholders, and patient and family partner members" with more than 5 million dollars in contributions and peer-reviewed grant funding.

65. MAiD and palliative care are both expressly considered part of "end-of-life care" in Québec.[58]

e. ***What has been Canada's experience in relation to instances of abuse since the legalization of assisted dying? Have any medical professionals been charged or disciplined for non-compliance with the regulatory regime?***

66. There have been 60,301 MAiD provisions in Canada. No medical professionals have been charged by police for abuse or non-compliance with the regulatory regime. There is one known instance of a physician being disciplined in relation to a MAiD provision (for a 2017 case not indicating non-compliance with the *Criminal Code* – details below).

67. There is detailed information about the results of the oversight of MAiD available through the Office of the Chief Coroner of Ontario and the Québec Commission on end-of-life care.

<u>Ontario</u>

68. All MAiD deaths in Ontario are reported to the Ontario Office of the Chief Coroner. Under the authority of the *Coroners Act*, the MAiD Review Team (a centralized specialized team of Registered Nurses overseen by a manager reporting to the Chief Coroner) reviews all MAiD deaths "[f]or compliance with legislative requirements/regulatory guidelines; Clinical assessment/diagnostic approach; Need for further investigation." [59] The evaluation includes a review of information submitted electronically by MAiD providers (MAiD Death Report) and any requested additional records or information as well as telephone contact with the family/next of kin to provide opportunity for additional information sharing. Cases in which compliance concerns are identified are tracked and responded to on five levels:

---

[58] Both are included in the statutory definition of "end-of-life care": "'end-of-life care' means palliative care provided to end-of-life patients and medical aid in dying."*Act respecting end-of-life care*, s. 3(3).
[59] Dirk Huyer, "Lessons learned from the Coroner" at MAiD2024: The Changing Landscape, Ottawa, May 2024. On file with Jocelyn Downie.

MAC DKI

"Level 1: Informal Conversation

Applied when concerns relating to best practices and/or regulatory policies, guidelines, and standards (e.g., documentation/record-keeping practices, professionalism, etc.) are identified. [Does not apply to issues with compliance with statutory requirements.[60]]

Level 2: Educational Email

Applied when there are identified issues with statutory requirements (certain safeguards) or practice concerns. [Examples given: ensuring requester was eligible for health services funded by the government in Canada, informing pharmacist that the medication being sought was for the purposes of providing MAiD].

Level 3: Notice Email

Applied when there are identified issues with statutory requirements and/or repeated practice issues. [Examples given independence of provider from individual requesting MAiD and independence of provider from other assessor].

Level 4: Report to Regulatory Body

Applied when there are issues with statutory requirements (eligibility requirements) or significant practice issues. Requires team discussion and review with the Chief Coroner prior to implementing. [Example given whether requestor was 18 years of age. *Note: this example was subsequently changed to Level 5 by the Chief Coroner and he indicated that there had never been an occurrence of this in Ontario.]*

Level 5: Report to Police

Applied when there are egregious issues with statutory requirements. Report also submitted to applicable regulatory body. [Example given: Whether the requestor was capable of making decisions with respect to their health.]"[61]

---

[60] Medical assistance in dying memorandum: An update from the Chief Coroner on the first two years of medical assistance in dying legislation (October 28, 2021) https://www.ontario.ca/page/medical-assistance-dying-memorandum

[61] Dirk Huyer, "Lessons learned from the Coroner" at MAiD2024: The Changing Landscape, Ottawa, May 2024. On file with Jocelyn Downie.

DKI

69. Between October 2018 and December 2023, there were 16,258 MAiD deaths in Ontario. From these, there were 428 level responses (2.6% of all MAiD deaths).

- 372 level 1 or 2 responses (2.3% of all MAiD deaths)
- 52 level 3 responses (0.3% of all MAiD deaths)
- 4 level 4 responses (0.02% of all MAiD deaths). None of these were found to warrant discipline by the College of Physicians and Surgeons.
- No deaths were reported to the police.
- The 56 level 3 and 4 responses do not represent 56 different providers/assessors as some received more than one response.

70. There is one publicly reported death in which a physician was disciplined by the College of Physicians and Surgeons of Ontario.[62] It dates from a MAiD provision in February **2017**. The College Committee found that: "care did not meet the standard of practice and showed a lack of skill, knowledge and judgement." The physician was inadequately prepared as she had not read the College policy, contacted anyone with knowledge about the clinical protocol for providing MAiD, or sought advice from the Canadian Medical Protective Association or the Office of the Chief Coroner. The Committee sought undertakings from the physician that "she will not engage in the practice of MAiD in any respect, and, in her palliative care practice, will practise under the guidance of a supervisor, engage in professional education in palliative and end-of-life care, and undergo reassessment." She was also given an in-person caution with respect to the care in the case. This is not a case of non-compliance with the eligibility criteria (rather, e.g., bringing the wrong drugs, being late, and leaving patient for two hours).

Québec

71. When looking at the Québec data, it is important to understand that the Québec Commission on end-of-life care has a legislative mandate to review all MAiD cases for compliance **with**

[62] https://register.cpso.on.ca/physician-info/?cpsonum=63892

WAL DKT

the Québec MAiD legislation. Therefore, a finding of non-compliance by the Commission is not a finding of non-compliance with the *Criminal Code* (illustrated below). Furthermore, clinicians in Québec have been advised that they "will not be subject to disciplinary citation by the Collège, if they have rigourously observed one law or the other, in compliance with ethical and deontological rules." If actions are compliant with either the Québec legislation or the federal *Criminal Code*, their actions will not result in discipline.[63]

72. The most recent Commission report provides data on the review of all MAiD cases in Québec between April 1, 2023, and March 31, 2024.[64]

- 99.7% of cases were administered in accordance with the Québec MAiD legislation.
- 18 of 5,717 MAiD deaths raised concerns about compliance with the Québec legislation.
- There were two categories of cases in which concerns about non-compliance arose: critères relatifs aux conditions d'admissibilité à l'AMM [MAiD]" (cases related to the MAiD eligibility criteria); and ""critère relatifs aux verifications préalables par le médecin" (cases related to the preliminary verifications that must be undertaken by the physician)).[65]
- **16 cases** (0.27% of MAiD deaths) "critères relatifs aux conditions d'admissibilité à l'AMM [MAID]" (criteria relating to the MAiD eligibility criteria)
    - In **13 cases** "la personne n'était pas atteinte d'une maladie grave et incurable" (the person did not have a serious and **illness**)
        - in **four cases** "elle présentait une perte d'autonomie sévère reliée au vieillissement, mais sans qu'une maladie grave et incurable spécifique puisse être identifiée par la Commission." (the person had a severe loss

[63] Jocelyn Downie, "Who is actually eligible for medical assistance in dying in Quebec?" Policy Options (July 25, 2022) https://policyoptions.irpp.org/magazines/july-2022/assisted-dying-confusion-quebec/
[64] Commission sur les soins de fin de vie, "Rapport Annuel D'Activités, 1er avril 2023 – 31 mars 2024. https://csfv.gouv.qc.ca/fileadmin/docs/rapports_annuels/csfv_rapport_activites_2023-2024.pdf
[65] Quebec Commission Report at pp.8-9.

of autonomy related to aging, but without a specific serious and incurable illness that the Commisssion could identify)

But unlike the Québec MAiD legislation, the Criminal Code is not limited to a diagnosis of a "serious and incurable illness". Furthermore, frailty (which these cases may have been given the description and the Commission's view that frailty is not an eligible illness) is a condition for which one can be eligible under the Criminal Code[66]

- In **four cases** "elle présentait un ou des symptômes graves, mais sans qu'un diagnostic de maladie grave et incurable ait été posé." (the person presented with one or more serious symptoms but without a diagnosis of a serious and incurable illness)

  But unlike the Québec MAiD legislation, the Criminal Code is not limited to a diagnosis of a "serious and incurable illness"

- In **five cases** "la personne était atteinte d'un handicap alors que la déficience physique grave entraînant des incapacités significatives et persistantes n'était pas encore permise par la LCSFV." (a serious physical impairment causing significant and enduring disabilities; was not yet permitted by the LCSFV)

  But, unlike the Québec MAiD legislation at the time, the Criminal Code includes disability in its eligibility criteria

- In **all of the cases**, "la personne avait fait une demande libre et éclairée d'AMM, était apte et rencontrait tous les autres critères

[66] Fifth Annual Report at p.23.

d'admissibilité, dont la présence de souffrances persistantes, insupportables et inapaisables." (The person had made a free and informed request for MAiD, was capable and met all the other eligibility criteria, including the presence of enduring, intolerable, and unrelievable suffering.)

- In **3 cases** "le médecin qui a adminstré l'AMM n'a pas obtenu l'avis d'un second médecin, de façon contemporaine à la demande, pour confirmer le respect des conditions prévues à l'article 26" (the doctor who provided MAiD did not obtain the opinion of a second doctor, contemporaneously with the request, to confirm compliance with the criteria **in Article 26**)
  - In **two cases**, "le second médecin avait examiné la personne plus d'un mois avant que celle-ci n'ait formulé sa demande et n'avait pas eu d'autres entretiens avec elle par la suite." (the second physician examined the person **more than a month before** the person made the request and had not had any **further discussions** with the person thereafter)

    But the Criminal Code does not require a specific order for the assessments or a minimum amount of time between the assessment and request made under s.241.2(3)(e)

  - In **one case** "le médecin a administré l'AMM sans avoir obtenu l'avis du second médecin." (the physician provided MAiD without obtaining the opinion of the second physician)
    This appears to be a breach of the Criminal Code requirement of a second assessment (although with no finding that the person did not meet all of the eligibility criteria and other procedural safeguards).

MM DKI

- **2 cases** (0.03% of MAiD deaths) involved "critère relatifs aux verifications préalables par le médecin" (cases related to the preliminary verifications that must be undertaken by the physician)
    - In **1 case**, "la demande d'AMM a été contreseignée par une personne qui n'était pas un professionnel de la santé ou des services sociaux" (the MAiD request was countersigned by a person who was **not a health or social services professional**)
        - In this case the request was countersigned by a caregiver who was not a regulated health or social services professional

          This is not a requirement under the Criminal Code

    - **In 1 case**, "la personne qui a obtenu l'AMM n'était pas assuréee au sense de la loi sur l'assurance maladie" (the person who received MAiD was not insured within the meaning of the **Quebec Health Insurance Act**)
        - In this case, the person held a health insurance card valid in another Canadian province

          This is consistent with the Criminal Code

73. The reports from the Commission in previous years are similar in that they appear to reveal instances of non-compliance with the Québec legislation but compliance with the *Criminal Code*. Such actions are permitted in Québec.

74. In sum, the most recent Québec data reveals 99.7% compliance with the Québec MAiD legislation and likely 99.98% compliance with the *Criminal Code*.

PKI

75. Across Canada, allegations of abuse or non-compliance have been made by family members/friends of patients **through the media**. However, there is no valid evidence that anyone has received MAiD who did not meet the eligibility criteria (including voluntariness, capacity, and grievous and irremediable medical condition) or procedural safeguards. Family members/friends who disagreed with the person's decision to request MAiD have joined MAiD opponents in alleging abuse or non-compliance. But due to confidentiality duties, clinicians and institutions are unable to correct the media reports, and journalists rely solely on individuals who do not have access to all of the patient's information (and so cannot validly opine on whether eligibility criteria were or were not met). There have been no charges or discipline by police, courts, or regulatory bodies for abuse or non-compliance with the law or regulation related to these allegations in the media.

76. The issue of non-compliance is further discussed in response to question #4 myths iii-v.

f. ***What is your opinion on whether Canada is experiencing a "slippery slope" since assisted dying was decriminalized in 2016?***

77. Slopes can be slippery in **law** and in **practice**. In **law**, one would be able to say that Canada has experienced a slippery slope if there has been an expansion in eligibility criteria. In **practice**, one would be able to say that Canada has experienced a slippery slope if there has been movement from compliance with the law to non-compliance. It is my opinion that Canada has not experienced either of these slippery slopes.

78. In regard to the alleged **legal** slippery slope, there has been no expansion of the eligibility criteria. Some have argued that allowing MAiD when the person is not terminally ill is an expansion of the law. This is false. MAiD eligibility was never restricted to the terminally ill.[67]

79. Some have argued that removing the eligibility criterion of 'natural death has become reasonably foreseeable' is an expansion of the law. This too is false. "Natural death has

[67] See *Carter, Canada (Attorney General) v E.F.*, 2016 ABCA 155 and *Truchon.*

DKI

become reasonably foreseeable" was not an eligibility criterion in *Carter.*[68] It was added by Parliament through *Bill C-14* and its addition was struck down as unconstitutional in *Truchon.*

80. Some have argued that allowing MAiD for persons with a mental illness as their sole underlying medical condition (MI-SUMC) is an expansion of the law. This too is false. MAiD for mental illness (including where it is the sole underlying medical condition) was allowed under *Carter* (expressly confirmed by the Alberta Court of Appeal[69] and the Québec Superior Court,[70] and conceded by the federal government[71]).

81. The evolution of the law can be depicted graphically, demonstrating that the parameters established by *Carter* have not been expanded:

---

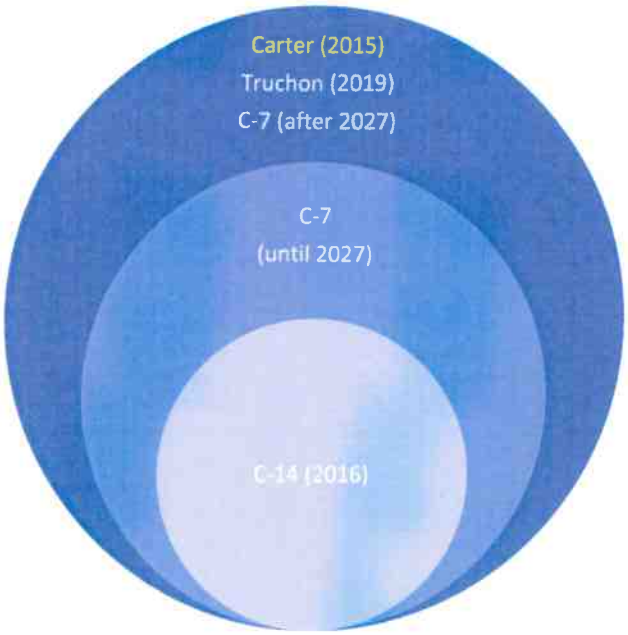
[68] The parameters set in *Carter* are "a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." [para 127]

[69] *Canada (Attorney General) v E.F.*, 2016 ABCA 155.

[70] *Truchon*.

[71] See, e.g., "Justice Minister David Lametti announces delay to assisted dying changes – December 15, 2022. Available online at https://www.google.com/search?q=justice+minister+david+lametti+announces+delay+to+assisted+dying+changes+youtube&oq=justice+minister+david+lametti+announces+delay+to+assisted+dying+changes+youtube+&aqs=chrome..69i57.11956j0j4&sourceid=chrome&ie=UTF-8#fpstate=ive&vld=cid:237a22a3,vid:iHbOn6hYxCk,st:0. See also Downie J, "From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada" HEC Forum 2022; 34(4): 321–354.

PKI



82. Just as there has been no slide down the **legal** slippery slope, there has been no slide down the **practical** slippery slope. Canada began with people with a grievous and irremediable medical condition causing enduring and intolerable suffering receiving MAiD and that is all and only who has been receiving MAiD. In regard to allegations to the contrary, see previous comments on allegations of non-compliance above in response to question #2(e) and question #4 myths iii-v.

83. Some have suggested that the increases over time in the rates of MAiD are evidence of a descent down a slippery slope. However, that there have been increases over time is not evidence of a slippery slope. There will inevitably be an increase as one moves from prohibition to permission. There will also be an increase as awareness and access to the now legal intervention increases. Increases in the number of cases is only evidence of a **practical** slippery slope if the number includes cases in which the eligibility criteria are not met, but there is no evidence of this happening (see #2(e) and question #4 myths iii-v).[72] Furthermore,

[72] Downar J, MacDonald S, Buchman S, "Medical Assistance in Dying, Palliative Care, Safety, and Structural Vulnerability" Journal of Palliative Medicine, August 31: 26(9) For a more detailed ethical response to concerns about the increasing numbers, see Eric Mathison, "How Many Assisted Deaths Should There Be? The best answer

MK DKI

the rate of increases (or lack thereof) is consistent with people not getting access even though they are eligible (e.g., because of barriers such as institutional religious objection or shortage of providers see response to question #2(c)).

84. It is also worth noting that the rate of increase dropped in 2023 to 15.8% (average growth rate from 2019 to 2022 was 31%). While too soon to be sure, this may be an indication of the demand plateauing after the natural ramp up to a stable state.

3. **What is your expert assessment of assisted dying in Canada so far? In this regard, please set out any noteworthy successes, failures and/or lessons learnt from medical assistance in dying in Canada that would be useful for South Africa to know as it embarks on this journey.**

85. I draw the following lessons from the Canadian experience (both successes and failures):

85.1. Engage in wide and deep public consultations before drafting the legislation. This was done in Québec but not the rest of Canada. As a result, Québec has had a much smoother process of implementation and a deeper level of support for (among clinicians and the public) and trust in the system.

85.2. Ensure that government lawyers and legislative drafters (reflecting the policy position taken by Parliament in legislation) work closely with clinicians and health lawyers on legislative drafting instructions and text to avoid unintended consequences. For example, clinicians could have told the lawyers/drafters that "natural death has become reasonably foreseeable" would not be understood by clinicians and "incurable" is not a term that is generally used in the clinical context where the underlying pathophysiology of the condition is not well understood (e.g., many mental disorders) and "mental illness" is not a term used by clinicians. Health lawyers could have told the lawyers/drafters that "natural death has become reasonably foreseeable" would fail in a *Charter* challenge. This consultation should be prior to the introduction of the legislation (not during process of

---

to an uninteresting question" Value Judgements August 3, 2023 available online at: https://valuejudgments.substack.com/p/how-many-assisted-deaths-should-there

MA PKI

moving through Parliament) as it is much harder for lawyers/drafters to walk back from a legislative text that has been introduced than to amend it while in the drafting stage.

85.3. Clearly define terms used in legislation. Terms that were not defined, e.g., "reasonably foreseeable", "incurable," and "mental illness" caused great confusion and unnecessary controversy.

85.4. Establish with the insurance industry that MAiD will not have a negative impact on life insurance (the insurance industry in Canada was very clear from the start that there would be no negative impact so long as the MAiD law was followed).[73]

85.5. Do not required judicial pre-authorization. This was suggested, debated, and rejected because it was seen as an unjustifiable barrier to access. It is helpful to quantify in advance what the costs of going to court for pre-authorization as well as other barriers to accessing courts would be so legislators can make an informed decision about the barrier this creates.

85.6. Make clear that publicly funded faith-based healthcare institutions must allow MAiD within their walls. To do otherwise leaves opting out as an option and this creates hurdles and absolute barriers to access to MAiD for individuals who meet the eligibility criteria.

85.7. Establish a direct point of information and entry through which patients can access MAiD assessments and provision (this counters the barriers to access that may arise if the patient does not have a clinician they can ask for information/assessment/provision whether that be because of conscientious objection or physician shortages or lack of knowledge).

---

73 https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/page/8AB98E904CD6659085258122006754 19!OpenDocument

DE I

85.8. Establish systems of MAiD patient navigators. Patients will not necessarily know how to navigate the system (who to ask etc.) and some clinicians will not be forthcoming because of religious or conscientious objections to MAiD. Navigators are needed so that patients have somewhere to turn for help. Patient navigators also help the system to run efficiently as they can filter out people who do not meet even the bare non-medical criteria (e.g., eligible for health services, 18 years of age).

85.9. Support the development and implementation of a national curriculum for MAiD assessors and providers.[74] It is much more efficient and reliable to have a curriculum available to all willing clinicians.

85.10. Support the development of a national association of MAiD assessors and providers. They can develop guidance documents, best practices, support each other, provide informal consultations, provide education etc.[75] This improves the number of willing assessors and providers, the quality of care for patients and their families, and the well-being of assessors and providers.

85.11. Ensure the monitoring system is comprehensive from the start. Canada had to add demographic metrics after the first regulations were implemented.

85.12. Do not require two witnesses (many people know no one to ask to witness and this becomes a barrier to access without any countervailing protection). Canada had to reduce the number of witnesses from two to one to reduce this barrier.

85.13. Allow for two exceptions to the requirement of express consent immediately prior to the provision of MAiD (what Canada calls final consent waiver and advance consent failed self-administration). These exceptions prevent two situations. First, a person meets all of the eligibility criteria but would like to continue living for a while longer (e.g., to see one

[74] Canadian Association of MAiD Assessors and Providers https://camapcanada.ca/curriculum/
[75] CAMAP https://camapcanada.ca/for_clinicians/publications/

MA DKT

last Christmas, birthday, anniversary, birth of a grandchild). But they are at risk of losing decision-making capacity. If express consent is required immediately prior to provision, they are confronted with the cruel choice of accessing MAiD earlier than they would like or risk losing decision-making capacity and being left in a state of intolerable suffering without the ability to get MAiD.[76] Second, a person self-administers MAiD but does not die and is left in a worse state than before but they no longer have decision-making capacity and so cannot give express consent immediately prior to provider-administered MAiD. Canada had to amend its initial legislation to respond to these unintended consequences of the blanket requirement of express consent immediately prior to provision.

85.14. Be sure that, if permitting self-administered MAiD, the appropriate drugs are licensed and available. Secobarbital had fallen out of use in Canada and there were initial challenges in sourcing the medications needed for self-administered MAiD.

85.15. Establish how MAiD will be handled on medical certificates of death. Canada had inconsistencies with respect to whether MAiD was to be reported as the underlying cause of death or antecedent cause, as the manner of death, or not mentioned on the death certificate at all. This led to confusion and erosion of trust.

85.16. Establish payment mechanisms for clinicians acting as MAiD assessors and providers before the legislation takes effect. Patients were ready for MAiD but unable to access in some cases because the mechanisms were not in place.

85.17. Engage in clear and proactive communication from the government about what the MAiD law and data actually are. The Canadian government was largely passive (apart from releasing an annual report once a year) and, as a result, misinformation and

[76] Jessica Leeder and Kelly Grant, "Assisted death, but not on her terms: Audrey Parker is bent on changing Canada's last-stage consent rule – if only posthumously," Globe and Mail, November 1, 2018 https://www.theglobeandmail.com/canada/article-assisted-death-but-not-on-her-terms-audrey-parker-is-bent-on/

disinformation from MAiD opponents was left unchallenged by the government and consequently given credence it didn't warrant. This undercuts trust in the system.

4. **Finally, we understand that there are certain common myths or misperceptions about assisted dying in Canada, please can you address the most common of these, why they are misplaced, and what the true position is.**

i. Myth/misperception: Eligibility criteria for MAiD have been expanded over time.

86. Facts: The eligibility criteria for MAiD in 2024 are no broader than the eligibility criteria established by the Supreme Court of Canada in *Carter* – the first and foundational articulation of what the law must allow.[77] The evolution (which has involved shrinking not expansion) is is fully explained above at question #1(a) and #2(f).

ii. Myth/misperception: Canada is considering expansions in eligibility criteria such as "allowing MAiD for severely disabled newborns" and allowing MAiD "on demand".

87. Facts: No legislator, Minister, or Parliamentary Committee has suggested they are considering expanding MAiD eligibility criteria beyond the parameters of *Carter* generally or, specifically, allowing MAiD for severely disabled newborns or allowing MAiD "on demand" let alone moving toward doing so (nor is there any serious advocacy for these changes).

iii. Myth/misperception: MAiD is available "on demand."

88. Facts: There are eligibility criteria that must be met and procedural safeguards that must be observed. There is no reliable evidence that people are gaining access to MAiD by demanding it and not being assessed as meeting the criteria and safeguards. To the contrary, no oversight bodies (described above in response to question #1(f)), reviewing 91.1% of cases in Canada, have reported a single case of MAiD "on demand." Indeed, there is no verified case of MAiD "on demand."

---

[77] As explained above, Bill C-14 narrowed the eligibility criteria from the Supreme Court of Canada criteria in *Carter* (by adding the requirement that a person's natural death had to have become reasonably foreseeable). *Truchon* returned the criteria to *Carter*. Then Bill C-7 narrowed them again (by excluding individuals with a mental illness as their sole underlying medical condition). For further details see Jocelyn Downie, "From Prohibition to Permission: The Winding Road of Medical Assistance in Canada" *HEC Forum* (2022) 34: 321-354.

MK DCI

iv. Myth/misperception: People can get MAiD for poverty, loneliness, or other forms of socioeconomic vulnerability

89. Fact: The law requires that the person's enduring and intolerable suffering be caused by their serious and incurable illness, disease, or disability or their advanced state of irreversible decline in capability. It is therefore not permissible to provide MAiD for poverty or other forms of socioeconomic vulnerability. Poverty is not an eligibility criterion for MAiD, someone whose only complaint is poverty would not meet the eligibility criteria for MAiD, and there is no evidence of any cases in which a person has been provided with MAiD where eligibility was based on poverty. The same can be said for loneliness and other forms of socioeconomic vulnerability.

90. Beyond the data that debunks this myth/misperception (see response to question #2(e)), allegations of people receiving MAiD for poverty and other forms of socioeconomic vulnerability have been discredited.[78] For example, the story of one woman that has been repeatedly cited[79] as evidence that individuals are receiving MAiD for homelessness, was expressly responded to by her physician, with her permission, and using her own words after her death:

> I will comment on a patient whose life and death received considerable media attention following her MAiD death. She asked me to advocate for others in her situation. She gave permission to share information about her publicly. This thoughtful, mature, intelligent woman has been mischaracterized as choosing MAiD simply because of lack of housing. Hers was a much more complex and considered decision than media reports suggest. She was aware the only effective treatment for her condition was protection from all triggers, all the time. Her written appeals

[78] For detailed analysis of such reports, see Eric Mathison, "Assisted Dying in Canada is Working Great," Value Judgments, 16 August 2022, online: <https://valuejudgments.substack.com/p/assisted-dying-in-canada-is-working>. See also Chantal Perrot, Brief submitted to the Special Joint Committee on Medical Assistance in Dying, online: <https://www.ourcommons.ca/Content/Committee/441/AMAD/Brief/BR11824538/br-external/PerrotChantal-e.pdf>.

[79] Eg by opponents of MAiD including some members of the Ontario Chief Coroner's MAiD Death Review Committee. Chief Coroner of Ontario MAiD Death Review Committee, "MAiD Death Review Committee Report 2024 – 3 Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths" available online at: https://valuejudgments.substack.com/p/the-ontario-chief-coroners-reports

PCI

focused on housing. She was hurt by the lack of response from government officials, but she knew better housing was not a cure. She might have enjoyed more time, but living in a more pleasant "dungeon" was not the life she wanted. She wrote a note I received after her death: "...THANK YOU for helping me to end my suffering... for believing that MCS [multiple chemical sensitivity] is real, that my suffering is REAL... for continuing to be in my corner, and believe I deserved to have MAiD, rather than trying to persuade me to stay alive... Even if I were to find a medically-safe, affordable home, I would still be isolated from the rest of the community, unable to go into public buildings OR visit friends/family [due to the risk of exposure to triggers]... With my health deteriorating... I made the only decision that I felt was available: I chose MAiD now...".

She has also been mischaracterized as living in poverty. She would be appalled. Yes, she received social assistance, but, apart from not being able to build that safe bubble, she was clear that she had: adequate resources to live; no debt; savings; and financial concerns were not contributing to her choice to have MAiD. Unfortunately, those opposed to MAiD and special interest groups wanting to misuse her life and history have created a false impression of who she was and how she chose to live and die.[80]

91. Of course, a person can seek MAiD due to suffering from a grievous and irremediable medical condition where their suffering is exacerbated and made intolerable by poverty, loneliness, or other forms of socioeconomic vulnerability. In the absence of such social conditions, such a person might not seek MAiD. It might be argued that delivering MAiD to such a person would be illegal because the federal legislation is silent on the permissible causal role of such social conditions, simply stating instead that the suffering must be caused by the person's medical condition. I disagree. Federal legislation, like all legislation, must be read to be consistent with the *Charter,*[81] and the declaration of constitutional invalidity from the Supreme Court of Canada in *Carter* expressly refers to "suffering that is intolerable to the individual *in the circumstances of his or her condition*" (emphasis mine). I conclude that, even if an individual's suffering **caused by a serious and incurable illness, disease, or disability** is

[80] Chantal Perrot, AB, MD, CCFP, FCFP, MDPAC(C), "Submission to the Special Joint Committee on Medical Assistance in Dying regarding Statutory Review: Medical Assistance in Dying" (May 30, 2022) available online at: https://www.ourcommons.ca/Content/Committee/441/AMAD/Brief/BR11824538/br-external/PerrotChantal-e.pdf
[81] *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038

DKI

exacerbated and made intolerable by the circumstances of their social conditions, that suffering can nonetheless be sufficient to meet the eligibility criteria for MAiD (efforts must, of course, be made to relieve the suffering). Furthermore, data from the Ontario Chief Coroner MAiD Death Review Committee Reports and the Fifth Annual Report from Health Canada demonstrate that MAiD recipients are **more privileged** than people who die naturally.[82]

92. To those who make the *ethical* argument that delivering MAiD to such a person *should* be illegal (such that Canada's law should be changed, and any jurisdiction thinking of legalizing MAiD should not follow Canada's lead here), I would point to the fact that people all regularly make high stakes decisions that are influenced by poverty, loneliness, or other forms of socioeconomic vulnerability. The closest analogy is decisions to refuse life-sustaining treatment which are of course made and respected even in the face of such influences. I would also point to the ethical implications of denying someone access to MAiD on the grounds that their suffering is exacerbated by poverty, loneliness, or other forms of socioeconomic vulnerability. For example, rich people would have access to MAiD to end their enduring, intolerable, and unrelievable suffering, while poor people would have to continue to suffer. As argued by Eric Mathison, "A ban on MAiD for low-income people is a bad idea for the obvious reason that income shouldn't affect healthcare access, but also because people should be allowed to decide for themselves when they want to die. Holding them hostage while we wait for houses to be built or the government to increasing funding is unethical." [83] Similarly, talking about the analogous palliative care argument made against allowing MAiD at all, Justice Smith in *Carter v. Canada* noted "the argument that legalization should not be contemplated until palliative care is fully supported rests, as Dr. van Delden

---

[82] Detailed explanation is provided in James Downar and Jocelyn Downie, "The Ontario Chief Coroner's reports are clear – alarm about MAID in Canada isn't warranted", Value Judgements https://valuejudgments.substack.com/p/the-ontario-chief-coroners-reports

[83] For an ethical analysis of the arguments against MAiD grounded in concerns about socioeconomic vulnerabilities, see Eric Mathison, "Lack of Housing is a Housing Issue: Banning MAiD would be unethical" Value Judgements October 19, 2022. Available online at: https://valuejudgments.substack.com/p/lack-of-housing-is-a-housing-issue. See also, Eric Mathison, The Better World Argument: Postponing MAiD until the world improves isn't the answer" Value Judgements November 17, 2022. Available online at: https://valuejudgments.substack.com/p/the-better-world-argument.

DCI

observed, on a form of hostage-taking. In other words, this argument suggests, the suffering of grievously ill individuals who wish to die will serve as leverage for improving the provision of adequate palliative care."[84]

v. *Myth/misperception: People are receiving MAiD when ineligible (e.g., incapable, when don't have an incurable medical condition, for trivial medical conditions, etc.)*

93. Facts: This myth/misperception arises from widely disseminated media reports that are based upon incomplete information, misinformation, and disinformation. For example, friends and family members that disagree with a case of MAiD being performed can go to the media and give their incomplete versions of events, but the patient isn't there to give their views and health care professionals involved must, because of patient confidentiality, remain silent.[85] Consider the example of Sophia discussed above (in response to question #4 myth iv) – a case of access to MAiD with alleged ineligibility. This case is unusual because Sophia's physician was given permission by her to speak out and her physician disclosed publicly (to the Senate of Canada) that what was being alleged wasn't true. This example shows the importance of scepticism in the face of allegations being made and repeated about people receiving MAiD when ineligible.

94. Furthermore, as noted above, contexts within which allegations can be properly investigated and tested reveal that there are no cases of clinicians being charged criminally or disciplined by their regulatory bodies for providing MAiD to individuals who do not meet the eligibility criteria despite allegations, reports, and exhaustive reviews.[86] Giving people MAiD when they are ineligible would obviously be a breach of the law.

---

[84] *Carter v. Canada (Attorney General)*, 2012 BCSC 886 ("*Carter* trial") at para 1274. Available online at: https://www.canlii.org/en/bc/bcsc/doc/2012/2012bcsc886/2012bcsc886.html

[85] See, for example, Eric Mathison, "Assisted Dying in Canada is Working Great" Value Judgements August 16, 2022. Available online at: https://valuejudgments.substack.com/p/assisted-dying-in-canada-is-working

[86] Downar J, MacDonald S, Buchman S, "Medical Assistance in Dying, Palliative Care, Safety, and Structural Vulnerability," Journal of Palliative Medicine, August 31, 2023: 26(9).

95. Since no clinician has been charged by police or disciplined by their College for providing MAiD to ineligible people, either these cases are being disclosed to the media but not reported to authorities or they are being reported but the police/Colleges are determining that there was compliance with the law and practice standards.

96. If these cases are not being reported, it worth asking why not. It is also worth pointing out that, as noted above, for clinicians who are repeating allegations of provision of MAiD to ineligible people, they are at risk of themselves being in breach of their professional obligations – if they believe there has been non-compliance, they are under a professional obligation to report it (whether that be to the coroner or their College). So, either they don't believe the cases they are repeating are evidence of non-compliance in the system or they are possibly breaching their own legal and professional obligations.

97. It is not reasonable to conclude that (as has been alleged) the fact that there have been no criminal charges or discipline for providing MAiD to ineligible people means that those who complain are not being listened to. Rather, it is reasonable to assume that they are being listened to, but they are not presenting facts and subsequent investigations do not lead to facts that support charges or discipline. It is also not a reasonable response to the point that there have been no criminal charges or discipline to suggest the police, coroners, and colleges are not to be trusted/are protecting providers. To assume that is to say we can't rely on the police, coroners, and the system of regulation of health care providers for the regulation of any health care. They can't only be untrustworthy in the context of MAiD.

98. Some allegations of non-compliance with the eligibility criteria in the *Criminal Code* are also the result of people not understanding the law[87] (e.g., in Québec, the relationship between the federal and provincial law and the different mandates of the Québec Commission on End-of-Life Care and the College of Physicians and Surgeons). The Québec Commission on End-of-Life Care has a mandate to refer cases of concern with respect to non-compliance with the

[87] Jocelyn Downie, "Who is actually eligible for medical assistance in dying in Québec?" Policy Options (July 25, 2022) https://policyoptions.irpp.org/magazines/july-2022/assisted-dying-confusion-quebec/

PCT

Québec legislation to the College of Physicians and Surgeons. The College has a mandate to act in the public interest and it has stated that it will not discipline physicians for non-compliance if they are compliant with one or other of the two governing statutes (the Québec legislation and the federal *Criminal Code*). The Québec legislation is more restrictive than the federal *Criminal Code*. Eligibility under the Québec legislation is restricted to "serious illness" whereas eligibility under the *Criminal Code* is restricted to "serious illness, disease, or disability." Therefore, the Commission has an obligation to refer where MAiD was provided to a patient with a serious disease or disability (but not illness) yet the provision of MAiD to that person is not a breach of the *Criminal Code*. Therefore, the fact that there has not been discipline of a physician in Québec for non-compliance in relation to MAiD eligibility can be assumed to demonstrate that there have been no substantiated cases of non-compliance with the *Criminal Code*.

vi. Myth/misperception: People choose MAiD because they can't get access to palliative care or disability support services

99. Fact: As noted in response to question #2(d), 75% of MAiD recipients required and accessed palliative care. 2.8% of MAiD recipients required but did not receive palliative care – in only 6 cases was palliative care needed but not accessible.

100. Similarly, for disability support services, according to the Fifth Annual Report:

- 33.8% of MAiD recipients required and received disability support services.
- 2.8% required but did not receive them.
- <0.1% required disability support services but care was not accessible
- 1.0% care was accessible
- 1.9% unknown if care was accessible[88]

[88] Fifth Annual Report at p.49.

101. In other words, only five patients out of 15,343 required but did not have access to disability support services.

102. Furthermore, even beyond this data, there is evidence that lack of access to palliative care or disability support services is not driving requests for MAiD. For example, "if unmet supportive needs [for palliative care or disability supports] were driving requests for MAiD to any substantial degree, the incidence of MAiD would be higher in populations with greater supportive needs or lower socioeconomic status. Once again, the opposite is true."[89]

vii. Myth/misperception: MAiD causes a torturous death ("painful death akin to drowning" "neither painless nor dignified")

103. Facts: This myth/misperception was started by a clinician from the United States. He based his claims on his review of autopsies of individuals who received capital punishment in the United States. He claimed that MAiD could feel like drowning. However, he had no experience with the Canadian MAiD system nor knowledge of the specific protocols used by Canadian providers. His claims have been refuted by clinicians with knowledge of and experience with the drugs and dosages used for MAiD and the possible side effects[90] – which do not include the misinformation promulgated by Dr. Joel Zivot[91] and repeated and amplified by Kelsi Sheren and Jordan Peterson[92] among others. For example, the drug protocol used in Canada differ from those used in capital punishment in the United States. Most significantly, the drug Zivot claims causes the lung damage he rests his assertions re: suffering upon is not used in the Canadian protocols and a study of the lungs donated post-mortem for transplantation found that the lungs of donors who had received MAiD performed **better** than those from donors who did not receive MAiD.[93]

---

[89] Downar J, MacDonald S, Buchman S, "What Drives Requests for MAiD?" CMAJ 2023 Oct 16; 195(40): E1385-E1387.

[90] See https://www.dyingwithdignity.ca/blog/dr-stefanie-green-disproves-content-in-anti-maid-video/.

[91] https://sencanada.ca/en/Content/Sen/Committee/432/LCJC/11EV-55129-E

[92] https://www.youtube.com/watch?v=3YYxOfwrsrU

[93] Watanabe T, Kawashima M, Kohno M, Yeung J, Downar J, Healey A, Martinu T, Aversa M, Donahoe L, Pierre A, de Perrot M, Yasufuku K, Waddell TK, Keshavjee S, Cypel M. Outcomes of lung transplantation from organ donation after medical assistance in dying: First North American experience. Am J Transplant. 2022 Jun;22(6):1637-1645. doi: 10.1111/ajt.16971. Epub 2022 Mar 7. PMID: 35108446. https://pubmed.ncbi.nlm.nih.gov/35108446/

viii. Myth/misperception: Allowing MAiD for persons with disabilities is discrimination on the basis of disability.

104. Facts: This is an argument rather than a fact statement. It has effectively already been litigated as Justice Baudouin of the Québec Superior Court found in *Truchon* that prohibiting persons with disabilities from accessing MAiD (which the "natural death has become reasonably foreseeable" eligibility criterion did) is discrimination on the basis of disability.[94] David Lametti, then Minister of Justice, explained why the government accepted this decision and did not appeal: "Madam Speaker, the simple fact of the matter is this: Had we appealed the decision through the Court of Appeal, or possibly the Supreme Court of Canada, so many more Canadians would have had to suffer for so much longer. It is that simple. That would be on a case in which we strongly believed legally we would lose on its constitutionality. The reasoning of the Québec Superior Court was compelling, and it will ultimately be upheld. Why make people suffer in the meantime?"[95]

105. It should also be noted that Justice Smith in the trial decision in *Carter* found that the prohibition on MAiD violated the plaintiffs' equality rights under s.15 of the *Charter*. The appeal was allowed by the BC Court of Appeal in respect of the s.15 analysis, but this was on the grounds of *stare decisis* rather than disagreement with the actual equality analysis. The Supreme Court of Canada overturned the BC Court of Appeal on the *stare decisis* point[96] but then concluded that it was unnecessary to consider the s.15 question since it had already concluded that there was a s.7 breach.[97]

---

[94] For a logical, empirical, and ethical analysis of disability-based arguments against MAiD, see Ben Colburn, "Disability-based arguments against assisted dying laws" Bioethics 2022 Jul;36(6):680-686.

[95] Lametti, D. House of Commons Debates. Tuesday, February 23, 2021 Edited Hansard Volume 150, No. 064, 2nd Session, 43rd Parliament.

[96] *Carter* at para 48

[97] *Carter* at para 93

106. It should also be noted that there is litigation ongoing in Canada on this point.[98] Others are repeating the claims made in the notice of application (and in other places by the plaintiffs and their supporters) as if they are facts without acknowledging that the claims have not yet been tested in court and so are not proof of anything.[99]

ix. Myth/misperception: Allowing MAiD has put women at risk

107. Facts: The MAiD rates do not reveal that women have been put at risk. More men (52%) than women (48%) receive Track 1 MAiD. More women (58.5%) than men (41.5%) receive Track 2 MAiD. Median age of all MAiD recipients in 2023 was 77.6 years. The average age was 77 (this is 2022 data[100] as there isn't data on average age in the 2023 data but given the consistency of data across years on related metrics, it is reasonable to use this number for these purposes). 85.8% of MAiD recipients in 2023 were over 65.

108. Given the distribution in the Canadian population, in a group with an average age of 75 and 85.8% over 65, there would be more than 55% women.[101]

109. Furthermore, as noted by Health Canada in its Fifth Annual Report, "These findings are consistent with overall population health trends. Women are more likely to experience long-term chronic conditions, such as osteoarthritis, osteoporosis, dementia, asthma and

---

[98] *Mentler, Inclusion Canada, et al v. Canada (Attorney General)* CV-24-0072847-0000 (filed September 26, 2024).
[99] See also Paul Magennis and Kim Carlson, "Trading One Injustice for Another: The UN's Recommendations Undermine Disability Rights" (March 31, 2025) Available online: https://maidincanada.substack.com/p/trading-one-injustice-for-another
[100] Health Canada, Fourth Annual Report on Medical Assistance in Dying in Canada (October 2023) at p.29 https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html#a4.2
[101] https://www.canada.ca/en/public-health/services/publications/diseases-conditions/aging-chronic-diseases-profile-canadian-seniors-report.html#:~:text=Demographic%20shift,-Canada's%20population%20demographic&text=As%20such%2C%20the%20proportion%20of,could%20reach%2022.7%25%20in%202031.&text=In%202019%2C%20around%206.6%20million,the%20most%20recent%20population%20estimates. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021004/98-200-x2021004-eng.cfm. https://www.canada.ca/en/public-health/services/publications/diseases-conditions/aging-chronic-diseases-profile-canadian-seniors-report.html#:~:text=Demographic%20shift,-Canada's%20population%20demographic&text=As%20such%2C%20the%20proportion%20of,could%20reach%2022.7%25%20in%202031.&text=In%202019%2C%20around%206.6%20million,the%20most%20recent%20population%20estimates.

DC 1

rheumatoid arthritis. While such conditions can cause enduring suffering, they would not typically make a person's death reasonably foreseeable."[102]

110. Therefore, the distribution of men and women in Track 2 is consistent with gender distribution across ages and disease prevalence. The only potentially anomalous fact is that more men than women receive Track 1 MAiD which, if anything, undercuts the claim of women being put at risk by the legalization of MAiD.

x. Myth: Allowing MAiD has put racialized people at risk

111. Facts: 95.8% of MAiD recipients who responded to the race question in the Health Canada monitoring process identified as Caucasian (White). Whereas only 70% of Canadians, according to the most recent census, self-identify as white.[103] MAiD recipients are disproportionately White. There is no evidence of racialized people disproportionately receiving MAiD – in fact, the opposite.

xi. Myth: Allowing MAiD has put people with disabilities at risk

112. Facts: This claim was canvassed and rejected in *Carter* at trial in relation to the data on MAiD in permissive jurisdictions.[104] It was similarly canvassed and rejected in *Truchon* (the same jurisdictions as well as Canada).[105] Since MAiD has been available (as early as December 2015 in Québec), there is no evidence that anyone with disabilities who did not meet the strict eligibility criteria and procedural safeguards has received MAiD.

xii. Myth/misperception: Persons with disability are opposed to/fearful of MAiD

113. Facts: In *Carter*, there were plaintiffs, witnesses, and intervenors with disabilities who argued for MAiD. The plaintiffs in *Truchon* were two individuals with disabilities who argued (successfully) that the eligibility criterion of "natural death has become reasonably

---

[102] Fifth Annual Report, at page 18.
[103] https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026b-eng.htm
[104] *Carter* trial, see especially paragraphs 748-883.
[105] *Truchon*, see especially paragraphs 274-310 and 423-466.

DKT

foreseeable" violated their *Charter* rights. While some disability advocacy groups opposed MAiD in *Carter*, opposed the removal of "natural death has become reasonably foreseeable" in *Truchon*, and are advocating against Track 2 MAiD, a strong majority of persons with disabilities support MAiD (83% support the *Carter* decision and 78% support persons whose natural death is not reasonably foreseeable (Track 2) having access to MAiD).

114. Some people with disabilities have expressed fear about MAiD.[106] Some people with disabilities have expressed fear about MAiD not being available to them.[107]

xiii. Myth/misperception: Legalizing MAiD will conflict with efforts to reduce suicide rates/prevent suicide.

115. Facts: There is no evidence that legalization conflicts with efforts to reduce suicide rates or suicide prevention.[108]

116. There were 3,978 deaths by suicide in 2016 and 3,769 in 2021.[109] Suicide was the 9th leading cause of death in 2016 (through 2019), then 11th in 2020, 12th in 2021, 13th in 2022, and 12th in 2023.[110]

117. This claim was canvassed and rejected in *Truchon*:

> "The Court thus finds that the evidence adduced by the applicants draws a more accurate portrait of the reality and differences between medical assistance in dying and suicide. [382] ... They [Dr. Downar and Dr. Dembo – experts for the applicants] claim that there is nothing to indicate that removing the impugned requirement ["natural death has become reasonably foreseeable"] will lead to an increase in requests for medical assistance in dying, influence the suicide rate in Canada, or undermine suicide prevention efforts.[384] ... In summary, the Court finds that the expert

---

[106] https://www.cmaj.ca/content/193/14/e493
[107] https://bccla.org/our-work/lamb/
[108] For more in depth analysis of the sub-myths underlying this myth, see Tyler Black, "Special Joint Committee on Medical Assistance in Dying: Evidence" 1st Sess, 44th Parl, 26 May 2022, online: <https://www.parl.ca/DocumentViewer/en/44-1/AMAD/meeting-9/evidence>.; See also Tyler Black "Evidence Regarding MAiD and Suicide", Brief submitted to Special Joint Committee on Medical Assistance in Dying, May 7, 2022.
[109] https://www.statista.com/statistics/437713/suicide-numbers-canada/
[110] www.150.statcan.gc.ca

DKT

evidence filed by the applicants is clearly more conclusive in this area than that of the Attorney General of Canada." [385][111]

118. Furthermore, like palliative care, funding for suicide prevention (practice and research) has increased since the legalization of MAiD. The Federal Framework for Suicide Prevention was launched in 2016 and the National Suicide Prevention Action Plan in May 2024. For example:

- Budget 2021 included "$30 million over five years to support crisis lines that provide critical support services to survivors of gender-based violence."
- "$177 million investment to support the launch of the 9-8-8: Suicide Crisis Helpline in Canada, now in place since November 30, 2023."
- "Through Budget 2024, the Government of Canada announced $500 million over five years for the creation of a new Youth Mental Health Fund to help young people in Canada access the mental health care they need. In addition, the Government of Canada announced $7.5 million over three years to support Kids Help Phone in providing mental health, counselling and crisis support to young people in Canada. In addition, the Government of Canada also announced $630.2 million over two years to support Indigenous people's access to mental health services, including through distinctions-based mental wellness strategies."[112]

xiv. Myth/misperception: Physicians are being forced to provide MAiD.

119. Facts: As explained in more detail in response to question 1(g), no physician in Canada has an obligation to provide MAiD. There is no reliable evidence of any physician being forced to provide MAiD. One clinician has stated publicly (and this has been used to support this myth): "I've certainly had cases where I felt compelled to provide MAiD against my better clinical

---

[111] Justice Baudoin's full consideration of the evidence presented on "Persons Who Are Vulnerable to Suicide and the Phenomenon on Suicide Contagion" is presented at paragraphs 317-372 (Attorney General of Canada paragraphs 317-350, Plaintiffs 351-357, Documentary evidence 358-368, Foreign jurisdictions 369-372). Justice Baudouin's analysis and judgement on this evidence is presented at paragraphs 373-385. *Truchon v Procureur général du Canada*, [2019] QCCS 3792 [*Truchon*].

[112] https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/diseases-conditions/national-suicide-prevention-action-plan-2024-2027/national-suicide-prevention-action-plan-2024-2027.pdf

judgment because the law did not adequately protect." [113] However, there was nobody to compel this physician to provide MAiD. If she provided it when it was against her better clinical judgment, it was only herself who "compelled" her to do so.

xv. Myth/misperception: There is no or inadequate oversight of MAiD.

120. Facts: As noted above, provincial oversight bodies review 91.1% of MAiD deaths in Canada. In addition, all of the regular mechanisms for oversight of clinical practice (*Criminal Code*, civil suits, professional regulatory bodies) also provide oversight for MAiD (as they do all clinical practice). In addition, related to oversight, through the federal monitoring system, all requests for MAiD must be reported to the federal government and Health Canada produces an annual report with details on requests for and provisions of MAiD.

121. MAiD receives the most oversight of any clinical intervention in Canada: a) even those with serious consequences including death (e.g., palliative sedation, withholding/withdrawal of life-sustaining treatment); and b) including those affecting the well-being of far more people.

xvi. Myth/misperception: The legalization of MAiD harms the development of palliative care.

122. Facts: See response to the question #2(d) for the facts that debunk this myth/misperception.

xvii. Myth/misperception: MAiD is contrary to the values and principles of palliative care.

123. Facts: See response to the question #2(d) for the facts that debunk this myth/misperception.

xviii. Myth/misperception: Canada has descended down a slippery slope/fallen off a cliff

124. Facts: See responses to questions #2(e) and (f) and #4 myths i, iii, iv, v, ix, x, xx for facts that debunk this myth/misperception.

---

[113] Madeline Li, testimony before Special Joint Committee on Medical Assistance in Dying, Tuesday, October 18, 2022. No. 20, 1st Sess, 44th Parl.

PEI

Name: Jocelyn Downie

Signature: Jocelyn Downie

Date: March 29, 2026

PCT

RESOURCES

Court cases

Carter v. Canada (Attorney General), 2012 BCSC 886 (trial decision contains lengthy analysis of all of the expert evidence introduced at trial including empirical evidence and philosophical analysis of active/passive distinction)

Carter v Canada (AG), 2015 SCC 5 (Supreme Court of Canada decision establishes parameters within which MAiD must be permitted in order to be compliant with the Canadian Charter of Rights and Freedoms)

Canada (Attorney General) v E.F., 2016 ABCA 155 (Alberta Court of Appeal holds that persons who are not terminally ill and persons with mental disorders as their sole underlying medical condition can be eligible for MAiD under the parameters of the *Carter* decision)

Truchon c. Procureur général du Canada, 2019 QCCS 3792 (Québec Superior Court agrees with Alberta Court of Appeal decision in *E.F.* and expressly finds that to prevent persons with disabilities from accessing MAiD is a breach of the protection against discrimination guaranteed under the *Charter*)

Reports

- Special Senate Committee on Euthanasia and Assisted Suicide, Of Life and Death – Final Report, 1995
- Royal Society of Canada Expert Panel on End-of-Life Decision Making, Report, November 2011
- Quebec National Assembly Select Committee on Dying With Dignity, Report, March 2012
- Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report, November 2015

- Federal Expert Panel on Options for a Legislative Response to *Carter v. Canada*, Consultations on Physician-Assisted Dying: Summary of Results and Key Findings: Final Report, December 2015
- Special Joint Committee on Physician-Assisted Dying, Medical Assistance in Dying: A Patient-Centred Approach, February 2016
- Council of Canadian Academies Expert Panel on Medical Assistance in Dying, Medical Assistance in Dying: The Expert Panel on Medical Assistance in Dying, December 2018
- Le Groupe d'experts sur la question de l'inaptitude et l'aide médicale à mourir, L'aide médicale à mourir pour les personnes en situation d'inaptitude : le juste équilibre entre le droit à l'autodétermination, la compassion et la prudence, October 2019
- Association des médecins psychiatries du Québec, Access to medical assistance in dying for people with mental disorders: Discussion paper, November 2020
- Rapport de la Commission spéciale sur l'évolution de la loi concernant les soins fin de vie, December 2021
- Expert Panel on MAiD and Mental Illness, May 2022, Final Report of the Expert Panel on MAiD and Mental Illness, May 2022
- Special Joint Committee on Medical Assistance in Dying, Medical Assistance In Dying And Mental Disorder As The Sole Underlying Condition: An Interim Report, June 2022
- Commission sur les soins de fin de view, "Rapport Annuel d'Activités Du 1er avril 2021 au 31 mars 2022 December 2022
- Special Joint Committee on Medical Assistance in Dying: Medical Assistance in Dying: Choices for Canadians, February 2023
- MAID Practice Standards Task Group, "Model Practice Standard for Medical Assistance in Dying (MAID)" and "Advice to the Profession", March 2023
- Quebec Commission sur les soins de fin de vie, "Rapport Annuel d'Actitiés, 2024
- Health Canada, Fifth Annual Report on Medical Assistance in Dying, December 2024
- Office of the Chief Coroner of Ontario Reports, 2024

Websites

http://www.eol.law.dal.ca

WM OK-I

http://camapcanada.ca

DKI

JOCELYN DOWNIE
CM, FRSC, FCAHS, SJD
Dalhousie University
PO Box 15000 Halifax, N.S. B3H 4R2
Phone: (902) 494-6883 - Fax: (902) 494-1316
E-mail: jocelyn.downie@dal.ca

EDUCATION

S.J.D., The University of Michigan, Ann Arbor, Michigan, USA	1999
LL.M., The University of Michigan, Ann Arbor, Michigan, USA	1996
LL.B., The University of Toronto, Toronto, Canada	1993
M.Litt. (Philosophy), The University of Cambridge, Cambridge, England	1990
M.A. (Philosophy), Queen's University, Kingston, Canada	1985
B.A. Honours (Philosophy), Queen's University, Kingston, Canada	1984

PROFESSIONAL AWARDS AND HONOURS

Queen Elizabeth II Platinum Jubilee Medal	2022
Order of Canada	2018
The President's Research Excellence Award – Research Impact	2018
CIHR Barer-Flood Prize for Health Services and Policy Research	2016
The Canadian Academy of Health Sciences Scientific Lecture Award	2016
University Research Professor, Dalhousie University	2016-21
Fellow of the Pierre Elliott Trudeau Foundation	2015-18
Fellow of the Royal Society of Canada	2010
Fellow of the Canadian Academy of Health Sciences	2010
Canadian Association of Law Teachers Award	2008
Canada Research Chair in Health Law and Policy	2008-13
Canada Research Chair in Health Law and Policy	2003-08
IWK Health Centre Research Centre of Excellence Scholar Award	2003-08
Abbyann D. Lynch Medal in Bioethics, Royal Society of Canada	2005
Dalhousie Medical Research Foundation Award of Excellence in Medical Research	2003
Social Science and Humanities Research Council of Canada Doctoral Fellowship	1994-96
Jean Royce Memorial Doctoral Fellowship (Queen's University)	1994
James B. Milner Bronze Medal	1993
Class of 1967 Prize	1993
Honours Standing	1993
Dean's Honours List	1991-93
Fasken Campbell Godfrey Award	1991
Laskin Prize in Constitutional Law	1991
Canada Law Book Prize in Civil Procedure	1991
Overseas Research Student Award (U.K. Government)	1987-88
Queens' College (Cambridge) Bursary Award	1987-88
Queens' College (Cambridge) Bursary Award	1985-86

PKI

Queen's University Graduate Student Award	1984-85
First Class Honours, Queen's University	1984

SELECTED EMPLOYMENT

Professor, Faculties of Law & Medicine, Dalhousie University, (Professor Emeritus 2024-present; Professor 2006-2024; (Associate Professor 2001-2006; Assistant Professor 1996-2001).

Adjunct Professor, Australian Centre for Health Law Research, QUT, Australia, 2014-present.

University Research Professor, Dalhousie University, 2016-2022.

James S. Palmer Chair in Public Policy and Law, 2018-2021.

Associate Dean Graduate Studies, Faculty of Law, Dalhousie University, 2013-2016.

Faculty Associate, Health Law Institute, Dalhousie University, 2006-Present.

Director, Health Law Institute, Dalhousie University, 1996-2006.

Special Advisor, Senate Committee on Euthanasia and Assisted Suicide, 1994-95.

Law Clerk, Chief Justice Lamer, Supreme Court of Canada, 1993-94.

Research Associate, Westminster Institute for Ethics and Human Values, London, Ontario,1988-90

PUBLICATIONS 2019-2024

Chapters in Books

Eliana Close and Jocelyn Downie, "Medical Assistance in~~Assisted~~ Dying in Canada", in Ben P White (ed) Research Handbook on Voluntary Assisted Dying Law, Regulation and Practice~~Law and Assisted Dying Handbook~~ (Edward Elgar ~~forthcoming~~ 2025~~4~~)

Jocelyn Downie, "The Value of a Feminist Approach in the Ethics of End of Life Care" in Vikki Entwistle and Wendy Rogers , eds., Routledge Handbook of Feminist Bioethics (Abingdon: Routledge, 2022).

"From *Rodriguez* to *Carter* to *Bill C-14*: Lessons learned from Canada's journey to legal medical assistance in dying" Jocelyn Downie and Kate Scallion forthcoming in *International Perspectives on End-of-Life Reform: Politics, Persuasion and Persistence* edited by Ben While and Lindy Willmott (Cambridge: Cambridge University Press, 2021).

Ben White, Lindy Willmott, Jocelyn Downie, Penney Lewis, Celia Kitzinger, Jenny Kitzinger, Kenneth Chambaere, Thaddeus Pope, Luc Deliens, Mona Gupta, Emily

JDI

Jackson, Agnes van der Heide, Eliana Close, Katrine Del Villar and Jodhi Rutherford, in *International Perspectives on Reforming End-of-Life Law: Politics, Persuasion and Persistence*" edited by Ben While and Lindy Willmott (Cambridge: Cambridge University Press, 2021).

Peer-Reviewed Articles

Ruthie Jeanneret, Eliana Close, Jocelyn Downie, and Ben P White, "A qualitative study of key 'regulatory' factors influencing patient access to medical assistance in dying in Canada" 49:1 *Dalhousie Law Journal* (forthcoming 2026).

Mona Gupta and Jocelyn Downie, "Interpreting and operationalizing the incurability requirement in Canada's assisted dying legislation" 16 *Frontiers in Psychiatry* 2025.

Jocelyn Downie, "Ending Toxicity: A Call to Reintroduce Constructive Discourse About Contentious Health-Related Issues in Medicine" 8 *Canadian Journal of Bioethics* 2025, 159-61.

Eliana Close, Jocelyn Downie, and Ben P White, "Monitoring medical assistance in dying (MAiD) in Canada: Perspectives of physicians, nurse practitioners, and organizational regulatory actors" *Death Studies*, 2025.

Eliana Close, Mona Gupta, Jocelyn Downie, and Ben P White, "Medical assistance in dying in Canada: A review of regulatory practice standards and guidance documents for physicians" *Palliative Care and Social Practice*, 2025.

Katrine Del Villar, Ben P. White, Lindy Willmott, Jocelyn Downie, Christopher Stackpoole, "Does a Refusal of Treatment Need to be Informed? Towards a Resolution of the Current Confusion in English, Canadian and Australian Common Law" 16:1 *McGill Journal of Law and Health* 2024.

Ruthie Jeanneret, Eliana Close, Jocelyn Downie, Lindy Willmott, and Ben P White, "Patients' and Caregivers' Suggestions for Improving Assisted Dying Regulation: A Qualitative Study in Australia and Canada" 27(3) *Health Expectations* 2024.

Ruthie Jeanneret, Eliana Close, Jocelyn Downie, Lindy Willmott, and Ben P White, "'My advocacy is not about me, my advocacy is about Canadians': A qualitative study of how caregivers and patients influence regulation of medical assistance in dying in Canada" *Medical Law Review*, 2024.

Eliana Close, Jocelyn Downie, and Ben White, "Practitioners' experiences with 2021 amendments to Canada's medical assistance in dying law: a qualitative analysis" 17 *Palliative Care and Social Practice* 2023.

Eliana Close, Ruthie Jeanneret, Jocelyn Downie, Lindy Wilmott, and Ben White, "A qualitative study of institutional objection of medical assistance in dying: ongoing challenges and catalysts for change" 24(1) *BMC Medical Ethics*, 2023.

PK1

Jocelyn Downie, Mona Gupta, Stefano Cavalli, Samuel Blouin, "Assistance in Dying: A comparative look at legal definitions" 46(7) *Death Studies* 2022, 1547-1556.

Jocelyn Downie, "From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada", 34:4 *HEC Forum* 321-354.

Ben P White, Lindy Willmott, Katrine Del Villar, Jaynet Hewitt, Eliana Close, Laura Ley Greaves, James Cameron, Rebecca Meehan, Jocelyn Downie, "Who Is Eligible For Voluntary Assisted Dying? Nine Medical Conditions Assessed Against Five Legal Frameworks" (2022) 45:1 *UNSW Law Journal* 401-444.

Ben P White, Eliana Close, Lindy Willmott, Katrine Del Villar, Jocelyn Downie, James Cameron, Jayne Hewitt, Rebecca Meehan, Laura Ley Greaves, "Comparative And Critical Analysis Of Key Eligibility Criteria For Voluntary Assisted Dying Under Five Legal Frameworks" *University of New South Wales Law Journal* (2021) 44:4 1663-1700.

Gina Bravo, Lieve Van den Block, Jocelyn Downie, Marcel Arcand, and Lise Trottier, "Attitudes toward withholding antibiotics from people with dementia lacking decisional capacity: findings from a survey of Canadian stakeholders" (2021) 22:119 *BMC Med Ethics* DOI: 10.1186/s12910-021-00689-1.

Udo Schuklenk and Jocelyn Downie, "Social determinants of health and slippery slopes in assisted dying debates: Lessons from Canada" (2021) *Journal of Medical Ethics*. DOI: 10.1136/medethics-2021-107493.

Mona Gupta, Jocelyn Downie, Samuel Blouin, and Stefano Cavalli, "Assistance in Dying: A Comparative Look at Legal Definitions" (2021) *Death Studies*, DOI: 10.1080/07481187.2021.1926631.

Ben White, Lindy Willmott, Eliana Close, and Jocelyn Downie, "Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia" (2021) 3 *UNSW Law Journal Forum* 1-19.

Ben White, Lindy Willmott, Jocelyn Downie, Andrew Geddis, and Colin Gavaghan, "Assisted dying and evidence-based law-making: a critical analysis of an article's role in New Zealand's referendum" (2020) 133:1520 New Zealand Medical Journal 83-90.

Adeline Iftene and Jocelyn Downie, "End-of-Life Care for Federally Incarcerated Individuals in Canada" (2020) 14:1 *McGill Journal of Law and Health* 1-50.

Jocelyn Downie, Adelina Iftene, and Megan Steeves, "Assisted dying for prison populations: Lessons from and for abroad" (2019) *Medical Law International* 1-19.

Jocelyn Downie and Matthew J. Bowes, "Refusing Care as a Legal Pathway to Medical Assistance in Dying" (2019) *Canadian Journal of Bioethics* 2 (2) 73-82.

Gina Bravo, Lise Trottier, Claudie Rodrigue, Marcel Arcand, Jocelyn Downie, Marie-France Dubois, Sharon Kaasalainen, Cees M. Hertogh, Sophie Pautex & Lieve Van den

JDI MAL

Block, "Comparing the attitudes of four groups of stakeholders from Quebec, Canada, toward extending medical aid in dying to incompetent patients with dementia" (2019) *International Journal of Geriatric Psychiatry* 1-9.

Reports

Medical Assistance in Dying (MAiD) Practice Standard Working Group, Model MAiD Practice Standard for Medical Assistance in Dying (MAiD) and Advice to the Profession: Medical Assistance in Dying (MAiD), March 2023 (available at https://www.canada.ca/en/health-canada/services/medical-assistance-dying/model-practice-standard.html)

Sumner, L.W., Downie, J., Gupta, M., Wales, J. (Royal Society of Canada Policy Briefing Committee on End-of-Life Decision Making) "End-of-Life Decision Making: Policy and Statutory Progress (2011-2020)" (October 2020) (available at https://rsc-src.ca/sites/default/files/EOL%20PB_EN_0.pdf).

Jocelyn Downie, Jennifer Chandler, Melissa K. Andrew, Jennifer A. Chandler, Colleen M. Flood, Arthur Frank, Kwame McKenzie and Tanya Park, "MAiD Legislation at a Crossroads: Persons with Mental Disorders as their Sole Underlying Medical Condition" (30 January 2020) (available at https://on-irpp.org/2uGgID4)

Non-Peer-Reviewed Articles

Jocelyn Downie, "Why feminist philosophy (especially Sue Sherwin's) matters: Reflections through the lens of medical assistance in dying" (2020) 13:2 *IJFAB* 21-27.

OpEds, Blogs, and Newsletters

James Downar and Jocelyn Downie, "If you think that assisted dying in Canada is a mess, thing again" (April 4, 2025) *The Hill Times*.

Jocelyn Downie and Daphne Gilbert, "Forced transfers for assisted dying are cruelty cloaked as compassion" (June 26, 2024) https://vancouversun.com/opinion/op-ed/opinion-forced-transfers-assisted-dying-cruel

Jocelyn Downie, "The Senate should say no to yet another delay in expanding MAID" (February 26, 2024) https://www.theglobeandmail.com/opinion/article-the-senate-should-say-no-to-yet-another-delay-in-expanding-maid/

Jocelyn Downie, Mona Gupta, Daphne Gilbert, "The case for adding an exemption order to the government's MAID legislation" (February 26, 2024) https://www.hilltimes.com/story/2024/02/26/the-case-for-adding-an-exemption-order-to-the-governments-maid-legislation/413043/

Jocelyn Downie and Daphne Gilbert, "Access to MAiD should not cater to faith-based interests" (February 14, 2024) https://policyoptions.irpp.org/magazines/february-2024/maid-forced-transfers/

Jocelyn Downie and Mona Gupta, "Laws are like sausages: it's best not to see them being made" (February 1, 2024) https://www.hilltimes.com/story/2024/02/01/laws-are-like-sausages-its-better-not-to-see-them-made/410226/

Jocelyn Downie, "Comparisons Only Yield Valid Mutual Learnings if Based on Accurate Descriptions of the Comparators" (October 25, 2023) https://www.tandfonline.com/doi/full/10.1080/15265161.2023.2256285

Jocelyn Downie and Daphne Gilbert, "It's time for B.C. government to stand with patients like Sam O'Neill" (July 7, 2023) https://theprovince.com/opinion/op-ed/opinion-its-time-for-b-c-government-to-stand-with-patients-like-sam-oneill

Jocelyn Downie, "In a nutshell: the special joint committee on maid tackles mental disorders" (March 24, 2023) https://impactethics.ca/2023/03/24/in-a-nutshell-the-special-joint-committee-on-maid-tackles-mental-disorders/

Jocelyn Downie, "In a Nutshell: Correcting the record about medical assistance in dying" (May 17, 2022) https://impactethics.ca/2022/05/17/in-a-nutshell-correcting-the-record-about-medical-assistance-in-dying/

Mona Gupta and Jocelyn Downie, "Quebec's Commission on MAiD misses the mark on mental disorders" (March 2, 2022) https://policyoptions.irpp.org/magazines/quebec-maid-report-mental-disorders/

Jocelyn Downie and Stefanie Green, "For people with dementia, changes in MAiD law offer new hope" (April 21, 2021) https://policyoptions.irpp.org/magazines/april-2021/for-people-with-dementia-changes-in-maid-law-offer-new-hope/.

Jocelyn Downie, "In a Nutshell: The Continuing Saga of Canada's Medical Assistance in Dying Legislation" (March 19, 2021) https://impactethics.ca/2021/03/19/in-a-nutshell-the-continuing-saga-of-canadas-medical-assistance-in-dying-legislation/.

Jocelyn Downie, "What critics of feds' bill on medical assistance in dying overlook" (February 24, 2021) https://www.hilltimes.com/2021/02/24/maid/285470.

Jocelyn Downie, David Wright, Mona Gupta, "What's the relationship between suicide and MAiD?" (February 15, 2021) https://policyoptions.irpp.org/magazines/february-2021/whats-the-relationship-between-suicide-and-maid/.

Jocelyn Downie, "Medical assistance in dying bill an important step forward for Canadians with dementia" (October 27, 2020) https://policyoptions.irpp.org/magazines/october-2020/medical-assistance-in-dying-bill-an-important-step-forward-for-canadians-with-dementia/.

Jocelyn Downie, "In a Nutshell: An Attempted Assault on Access to MAiD" (October 22, 2020) < https://impactethics.ca/2020/10/22/in-a-nutshell-an-attempted-assault-on-access-to-maid/>.

PEI

Cal deWolfe & Jocelyn Downie, "It's time for Canada to follow Ontario's critical care triage protocol" (August 12, 2020) online < https://policyoptions.irpp.org/magazines/august-2020/its-time-for-canada-to-follow-ontarios-critical-care-triage-protocol/>.

Jocelyn Downie, "An indefensible amendment to medical assistance in dying legislation" (July 23, 2020), online < https://policyoptions.irpp.org/magazines/july-2020/an-indefensible-amendment-to-medical-assistance-in-dying-legislation/>.

Jocelyn Downie & Cal deWolfe, "La COVID-19 et les protocols de triage" (July 12, 2020), online < https://www.lapresse.ca/debats/opinions/2020-07-12/la-covid-19-et-les-protocoles-de-triage.php>.

Jocelyn Downie, "Return to sport should be about safety, not prizes" (July 6, 2020), online < https://www.thestar.com/opinion/contributors/2020/07/06/return-to-sport-should-be-about-safety-not-prizes.html>.

Jocelyn Downie & Jon Goud, "Four years (and counting) of unconstitutional barriers to MAiD" (June 26, 2020), online <https://impactethics.ca/2020/06/26/four-years-and-counting-of-unconstitutional-barriers-to-maid/>.

Jocelyn Downie, "Will Parliament take steps to clarify medical assistance in dying law?" (June 9, 2020), online < https://policyoptions.irpp.org/magazines/june-2020/will-parliament-take-steps-to-clarify-medical-assistance-in-dying-law/>.

Jocelyn Downie, "Coronavirus triage protocols: Hard choices over ventilator shortages shouldn't put doctors at legal risk" (April 13, 2020), online < https://theconversation.com/coronavirus-triage-protocols-hard-choices-over-ventilator-shortages-shouldnt-put-doctors-at-legal-risk-135534>.

Jocelyn Downie, "The Federal Government requests an extension on MAiD," Impact Ethics (February 21, 2020), online < https://impactethics.ca/2020/02/21/the-federal-government-requests-an-extension-on-maid/>.

Jocelyn Downie, "Experts split on best path forward for assisted dying legislation," *The Hill Times* (February 3, 2020), online < https://www.hilltimes.com/2020/02/03/experts-split-on-best-path-forward-for-assisted-dying-legisation/232998>.

Jocelyn Downie, "It can happen here: MAiD and dementia in Canada" (October 18, 2019), online <https://blogs.dal.ca/dlj/2019/10/18/it-can-happen-here-maid-and-dementia-in-canada/ >.

Jocelyn Downie, "A watershed month for medical assistance in dying" (20 September 2019), online < https://policyoptions.irpp.org/magazines/september-2019/a-watershed-month-for-medical-assistance-in-dying/>.

PKI

Jocelyn Downie and Daphne Gilbert, "Nova Scotia now a leader in medical assistance in dying" (19 September 2019) <https://www.thechronicleherald.ca/opinion/local-perspectives/opinion-nova-scotia-now-a-leader-in-medical-assistance-in-dying-353838/>.

Jocelyn Downie and Daphne Gilbert, "Parliament should not wait to act on medical assistance in dying ruling" (16 September 2019), online < https://policyoptions.irpp.org/magazines/september-2019/parliament-should-not-wait-to-act-on-assisted-dying-ruling/>.

VIDEOS, WEBINARS. PODCASTS

"Delays to MAiD and Constitutional Consequences" No Nonsense with Pamela Wallin (March 1, 2024). https://www.youtube.com/watch?v=-25WyN-XnNk

"Medical Assistance in Dying: A Legal Overview" online video for Dying with Dignity Canada https://www.dyingwithdignity.ca/get_the_facts_assisted_dying_law_in_canada.

"Medical Assistance in Dying: A Legal Update" online video for Dying with Dignity Canada https://www.dyingwithdignity.ca/get_the_facts_assisted_dying_law_in_canada.

"In Focus: Advance Requests for MAiD" No Nonsense with Pamela Wallin (March 1, 2021). https://www.stitcher.com/show/no-nonsense-with-pamela-wallin/episode/in-focus-advance-requests-for-maid-ron-posno-darrell-bricker-and-jocelyn-downie-82049175

Episode 47, "Fixing our assisted dying laws with Jocelyn Downie" Uncommons with Nate Erskine-Smith (October 15, 2020), https://uncommons.ca/2020/10/15/episode-47-fixing-our-assisted-dying-laws-with-jocelyn-downie/.

Jocelyn Downie and Mona Gupta, "Medical assistance in dying for Canadians with mental disorders" Policy Options (January 23, 2020), online < https://policyoptions.irpp.org/magazines/january-2020/medical-assistance-in-dying-for-canadians-living-with-mental-disorders/>.

Jocelyn Downie, "Medical assistance in dying in Canada: Lessons from the Great White North" (20 March 2019), online <https://azbioethicsnetwork.org/sites/default/files/webinar/recordings/GreatWhite.mp4>.

PRESENTATIONS 2019-2024

International

"Canada's Human Rights-Based Values-Driven Journey to Legalisation of MAiD" (World Federation of Right to Die Societies Conference, Dublin, Ireland, September 2024).

"Medical Assistance in Dying: A Constitutional Journey" ("Demographic Change and Constitutional Law" 13th International Symposium, Constitutional Research Institute, Constitutional Court of Korea (Seoul, Korea, August 26, 2024).

"Comparative International Review: Legal Status of Assisted Dying around the World: The Americas" (International Conference on End of Life Law, Ethics, Policy, and Policy (ICEL 4), Salt Lake City, Utah, March 6, 2024).

"Interdisciplinary Perspectives on Irremediability in the Context of Assisted Dying for Persons with Mental Disorders" with Mona Gupta and Sisco Van Veen, (International Conference on End of Life Law, Ethics, Policy, and Policy (ICEL 4), Salt Lake City, Utah, March 8, 2024).

"Legalising Medical Assistance in Dying (MAiD) for Neurological Disorders: A Canadian Perspective" (Neurological Association of South Africa 2021Virtual Congress, May 4, 2021)

"Through an International Lens: Implications of Medical Aid-in-Dying" (The Completed Life Conference, online, September 24, 2020).

"The Long-Term View on End-of-Life Practice" Global Panel Member (3rd International Conference on End of Life Law, Ethics, Policy, and Practice (ICEL3), Ghent, Belgium, March 9, 2019).

"Understanding the concept of suicide in an age of assisted dying (a global issue through the lens of Canadian experience)" (3rd International Conference on End of Life Law, Ethics, Policy, and Practice (ICEL3), Ghent, Belgium, March 8, 2019).

"Recent developments and the future of MAiD in Canada" (Latest Developments in Assisted Dying Around the World - Opening Plenary, (3rd International Conference on End of Life Law, Ethics, Policy, and Practice (ICEL3), Ghent, Belgium, March 7, 2019).

"Latest Developments in Assisted Dying Around the World" Global Panel, (3rd International Conference on End of Life Law, Ethics, Policy, and Practice (ICEL3), Ghent, Belgium, March 7, 2019).

National

"Institutional Religious Obstructions – Update on the Litigation (with Daphne Gilbert, MAiD 2024: Changing Landscapes, CAMAP Annual Conference, May 4, 2024).

"Advocacy Issues: The Future of Advance Requests" (with Tim Holland and Ben Schiff, MAiD 2023, May 5, 2023)

"End in Mind: MAiD and Mental Disorders (Panel with Justine Dembo, Dying with Dignity Canada, March 9, 2023).

"Mental illness and MAiD: Legal aspects and tips for assessing patients with concurrent mental illness" (CAMAP Annual Symposium, online, April 27, 2022).

"10 things to know about MAiD in Canada" (Dying With Dignity Canada Webinar, January 13, 2022).

DFL

"Challenges with final consent waiver in track 1 patients" (CAMAP Fall Symposium, online, October 13, 2021).

"MAiD in Canada: Review of requirements for track 2 assessments with particular attention to challenges with respect to procedural safeguards" (CAMAP Fall Symposium, online, September 28, 2021).

"Medical Assistance in Dying in Canada" (Humanist Canada, online, June 27, 2021).

"Integrating Bioethics into Your Career & Pathways in Bioethics" (Student Symposium: Canadian Bioethics Society Conference, online, May 25, 2021).

"MAiD in Canada 2021: From C-14 to C-7" (CAMAP Symposium on MAiD, online, March 31, 2021).

"Update on Medical Assistance in Dying and the *Truchon* Decision" (Canadian Bar Association, online, November 24, 2020).

"Medical assistance in dying through the lens of dementia" (10th Canadian Conference on Dementia, Quebec City, Quebec, October 4, 2019).

"Case Studies in Advance Requests for Medical Assistance in Dying in Canada" ((10th Canadian Conference on Dementia, Quebec City, Quebec, October 5, 2019).

"Providing MAiD near the edge of the law (Frailty, Quadriplegia, etc.)" (with Amanda Hill, Simon Oczkowski and Galt Wilson) (2019 CAMAP Conference, Vancouver, BC, June 1, 2019).

"VSED in the Days of MAiD" (with Daniel Quellet) (2019 CAMAP Conference, Vancouver, BC, June 1, 2019).

"Report from the Canadian Council of Academics" (2019 CAMAP Conference, Vancouver, BC, May 31, 2019)

"The Edges of Canada's MAiD Laws" (with Grace Pastine) (3rd Annual National Conference on Medical Assistance in Dying, Vancouver, BC, May 28, 2019).

"Voluntary Stopping Eating and Drinking" (3rd Annual National Conference on Medical Assistance in Dying, Vancouver, BC, May 28, 2019).

"The Edges of Canada's MAiD Laws" (Public Panel Discussion with Ellen Wiebe, Daniel Ouellet, and Andre Picard), Vancouver, BC, May 29, 2019).

"Medical Assistance in Dying: Next Steps for Canada" (Royal Society of Canada, Ottawa, Ontario, March 15, 2019).

"A Feminist's Reflection on Medical Assistance in Dying in Canada" (Greenberg Speaker

PKI

Series, University of Ottawa, Ottawa, Ontario, February 14, 2019).

Other Invited Presentations

"Medical Assistance in Dying: What's on the Horizon? (Panel with Michael Eleff, Kimberly Jakeman, Derryck Smith, Continuing Legal Education British Columbia, May 24, 2023).

"MAiD in Canada: A Cautionary Tale or Model?" (QUT Global Law, Science, and Technology Seminar Series, Monday, May 8, 2023).

"Requests Made in Advance of Loss of Capacity: The Current Law and The Future of Advance Requests" (Canadian Association of MAiD Assessors and Providers Annual Conference, May 5, 2023)

"MAiD in Canada" (Ethics Grand Rounds, Trillium Health Partners, May 2, 2023).

"Ethical Issues in Health Care with a focus on Physician Assisted Dying" (Panel with Kerry Bowman and Daphne Jarvis, Osgoode Certificate in Health Law, April 5, 2023).

"When freedom of religion and freedom of conscience meet medical assistance in dying" (Harold G Fox Distinguished Lecture, Lakehead University, online, January 25, 2022).

"Relevant and promising intervention strategies, practices, and safeguards for medical assistance in dying (MAiD) for people with mental illness" (FRQS Quebec Network on Suicide, Mood Disorders, and Related Conditions, Pragmatic Health Ethics Research Unit, and Montreal Clinical Research Unit, October 27, 2021)

"Medical Assistance in Dying: Impacts on Patients and Families" (Elder Abuse Prevention (ON), online, October 19, 2021).

"Law & Impact" (The Graduate Law Research Transition Conference 2021, online, May 21, 2021).

"Canadian Legal and Medical Perspectives on Aid-in-Dying" (The Completed Life Initiative, online, May 20, 2021).

"Learning from Elsewhere: An overview of assisted dying in Canada" (Jersey Assisted Dying Citizens' Jury, online, March 20, 2021).

"Bill C-7: Medical assistance in dying" (Liberal Party Caucus, online, March 4, 2021).

"Medical Assistance in Dying: Bill C-7 and what it means for healthcare organizations and professionals" (Healthcare Insurance Reciprocal of Canada, March 1, 2021)

"Advance Requests for Medical Assistance in Dying: Through the lens of dementia" (Geriatric Medicine Rounds, Halifax, NS, October 21, 2020).

PKI

"Hot Topics in Health Care" (Dalhousie Health Science Students Association, Halifax, NS, March 28, 2019).

"Medical Assistance in Dying: Two Years In" (Weekly Research Hour Schulich School of Law, Halifax, NS, March 28, 2019).

"MAiD" (Guest Lecturer 4th year medical students, Dalhousie School of Medicine, Halifax, NS, March 18, 2019).

"MAiD in Canada" (Guest Lecturer for Sarah Clifft's course "Reflections on Death", Kings College, Halifax, NS, March 18, 2019).

"Medical Assistance in Dying in Canada: Past, Present, Future" (Canadian Bar Association NS Elder Law Group, Halifax, NS, February 27, 2019).

"Medical Assistance in Dying in Canada" (Dalhousie School of Medicine, Halifax, NS, February 5, 2019).

"Assisted Dying in Canada" (Mini Law School, Schulich School of Law, Halifax, NS, January 23, 2019).

Testimony Before Committees

Special Joint Committee on Medical Assistance in Dying, Parliament of Canada, March 24, 2026.

Joint Committee on Assisted Dying, Oireachtas (Ireland Parliament), online October 17, 2023.

Special Joint Committee on Medical Assistance in Dying, Parliament of Canada, online, May 9, 2022.

Special Joint Committee on Medical Assistance in Dying, Parliament of Canada, online, June 21, 2021.

Commission spéciale sur l'évolution de la loi concernant les soins de fin de vie, Quebec National Assembly, online, May 24, 2021.

Standing Senate Committee on Legal and Constitutional Affairs, Senate of Canada, Pre-Study to examine the subject matter of Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), November 24, 2020.

Standing Senate Committee on Legal and Constitutional Affairs, Senate of Canada, Pre-Study of Bill C-14, Ottawa, Ontario, May 2016.

Standing Committee on Justice and Human Rights, Canadian House of Commons, Second Reading Review of Bill C-14, Ottawa, Ontario, May 2016.

PFI

Parliament of Victoria, Australia, Standing Committee on Legal and Social Issues (Legislation and References) Inquiry into End of Life Choices, Ottawa, Ontario, April 2016.

Special Joint Committee of the House and Senate of Canada on Physician-Assisted Dying, Ottawa, Ontario, January 2016.

Quebec National Assembly, Quebec City, Quebec (by videoconference), October 2013.

Quebec National Assembly Select Committee on Dying with Dignity, Quebec City, Quebec (by videoconference), March 2010.

Subcommittee of the Senate Standing Committee on Social Affairs to Update "Of Life and Death" Ottawa, Ontario, February 2000.

Invited Panel Participation

"MAID and Geriatrics: A Growing and Complex Relationship" Canadian Geriatrics 2021 Annual Scientific Meeting, online, May 27, 2021) (with Genevieve Casey, James Silvius, Jocelyn Chase, and Laura Wilding).

Online Resources

Educational website on end of life law and policy in Canada http://eol.law.dal.ca/

Online personal directives app https://www.legalinfo.org/forms/personal-directive

RESEARCH GRANTS 2019-2024

A mixed-methods study to develop a jurisdiction-level resource allocation framework to guide the use of triage and triage-avoidant strategies during an overwhelming surge in demand for critical and acute care, $499,944, Canadian Institutes of Health Research, Co-Applicant (Principal Investigator: James Downar) 2022-2024.

Better end-of-life care through an optimal, holistic regulatory framework, Futures Fellowship, Project Collaborator, $1,024,671, Australian Research Council (Principal Investigator: Ben White), 2020-2024.

Targeted Health Law & Policy Interventions for an Efficient, Effective and Equitable Response to COVID-19, $50,000, Canadian Institutes of Health Research, Co-applicant (Principal Investigators: Constance MacIntosh and Matthew Herder). 2020-2021.

RESEARCH/CONSULTING CONTRACTS 2019-2024

Updated MAiD Tool, $2,000 Centre for Effective Practice, 2021.

TEACHING AT DALHOUSIE

PEI

LLB/JD Program: Law and Public Policy in Practice; From Legal Research to Public Policy Impact; Case Studies in Public Policy and Law; Legal Ethics; The Legal Profession and Professional Responsibility; Health Care Ethics and Law; Legal Research and Writing; Directed Research Projects.

LLM and PhD supervision/committees: Greg Affleck (ongoing), Tim Holland, Wendy McDonald, Joshua Shaw, Jacquelyn Shaw, Isabelle French, Sara Josselyn, Michael Taylor, Cheluchi Onyemelukwe, Leah Hutt, Martina Munden, Fiona McDonald, Patrycia Maksalam, Jeff Kirby, Cindy Blancher, Dorothy Barnard.

Post-doctoral Fellow supervision: Cheryl Cline, Chris Kaposy

MD Program: Professional Competencies I and II; Clerkship program years 3 and 4; Research in Medicine supervision.

SERVICE 2019-2024

Member, *pro bono* legal team, *Charter* challenge to state action excluding from MAiD for persons with mental illness as their sole underlying medical condition, 2024-present.

Member, *pro bono* legal team, *Charter* challenge to state action allowing and engaging in institutional religious obstruction of MAiD in British Columbia, 2023-present.

Member, Planning Committee, 4th International Conference on End of Life: Law, Ethics, Policy, And Practice held in Utah, March 2024, 2023-2024.

Member, Advisory Board, The Completed Life Initiative, New York, 2022-present.

Member, Foundations Module Working Group, National Curriculum, Canadian Association of MAiD Assessors and Providers, 2021-2023.

Founding Member, Board of Directors, Canadian Centre for Legal Innovation in Sexual Assault Response (renamed Watershed Legal Projects), 2019-present.

Member, Board of Directors, Canadian Centre for Ethics in Sport (renamed Sport Integrity Canada), 2014–present (Vice-Chair 2017-2023, Chair 2023-present).

Member, Board of Directors, Andrus on Hudson, New York, 2013-present (Vice-Chair 2023-present).

Member, Board of Directors, Helen Andrus Benedict Foundation, 2013-present.

Member, federal MAiD Practice Standards Task Group, September 2022-2023.

Member, COVID-19 Impact Committee, Pierre Elliott Trudeau Foundation, 2020-2021.

Member, Board of Directors, Surdna Foundation, 2007-2019 (Chair 2013-2016).

DCI

Member, *pro bono* legal team, *Lamb v. Canada (Attorney General)*, 2016-2019.

Member, Board of Directors, Caregivers Relief Initiative, Halifax, Nova Scotia, 2016-2019.