1. Summary of Qualifications

1.1. I am Udo Schuklenk, Ph.D. I am a Professor of Philosophy and the Ontario Research Chair in Bioethics and Public Policy at Queen's University at Kingston, Ontario, Canada.

1.2. I was the founding Head of the Wits University Faculty of Health Sciences Division of Bioethics (now Steve Biko Centre for Bioethics) in Johannesburg between 2000 and 2005.

1.3. I have served as Chair of an international group of experts in law, medicine and ethics, that was tasked with researching and writing a report for Canada's Royal Society (also known as the Academies of Arts, Humanities, and Sciences of Canada) on end-of-life issues in Canada.[1] I have published extensively in academic journals and books on medical assistance in dying. I am currently working on a book for Oxford University Press under the working title *Dying Well* which provides an ethical defence of permissive assisted dying policy regimes.

1.4. My most recent book for Oxford University Press focuses on the ethics of conscientious objection in medicine, an issue I was also asked to comment on.[2]

1.5. For the last 25 years I have been a Joint Editor-in-Chief of Bioethics, the official journal of the International Association of Bioethics.

1.6. *This Report was compiled with the assistance of Ryan Levy, cand J.D., Queen's University at Kingston.*

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[1] SCHÜKLENK, U., VAN DELDEN, J.J.M., DOWNIE, J., MCLEAN, S.A.M., UPSHUR, R. and WEINSTOCK, D. (2011), End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision- Making. Bioethics, 25: 1-73. https://doi.org/10.1111/j.1467-8519.2011.01939.x

[2] Alberto Giubilini, Udo Schuklenk, Francesca Minerva, Julian Savulescu. 2025. Rethinking Conscientious Objection. Oxford University Press: Oxford.

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2. Abuse of Policy

2.1. All practices or policies are subject to potential abuse. No regulations, reporting, transparency and safety mechanisms could eliminate the potential for abuse, as well as actual abuse, of MAiD if it became available.

2.2. However, concerns about the "abuse" of a policy yet to be implemented do not arise within a vacuum; they typically presume that the status quo, without the policy, is better than risking abuse after the policy is implemented. When considering introducing any policy, what must be at the forefront of the conversation is the cost of introducing the policy (inclusive of the risk of abuse) in comparison to the cost of maintaining the status quo without the policy in effect.

2.3. For that reason, the possibility of abuse cannot itself be determinative of whether a policy should be implemented. Here are some illustrative examples:

2.3.1. Welfare or student financial aid should not be abolished because there is a risk that people who do not actually need it 'qualify' and receive it. The introduction of this financial support grants many people who do truly need it a great benefit, despite the fact that some people will abuse the system. The benefits of implementing the policy outweigh the risks of abuse of the policy.

2.3.2. If taxation would only be implemented if it lacked the possibility of abuse (e.g. by finding loopholes, or ways to hide income from the government), then we would have no taxes. The benefit of introducing tax policy is that most people are law-abiding, and will pay their taxes at the prescribed rate, thereby permitting the state to function in order to further the public good.

2.3.3. If the introduction of speed limits would be made dependent on nobody speeding after the introduction of limits, no speed limits would ever have been introduced. Speed limits were introduced because once they exist the vast majority of people abide by them, and so speed- caused accidents are reduced, as well as the preventable loss of lives.

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2.4. What these examples show is that the relevant question that needs a well-considered answer is not whether a policy is abused or disregarded, but whether the introduction of a policy is preferable to the status quo. If the answer is in favour of introducing a new policy, a secondary question is how abuse can be minimised while achieving the objective that motivated the introduction of the policy.

2.5. Specific concerns about potential abuse can serve as red flags, issues that legislators and regulators should pay close attention to when they legislate and regulate in order to arrive at a policy that maximally furthers the public good.

2.6. One also needs to be explicit about what constitutes abuse, and why, and what doesn't. Intuitions on this particular question vary widely even among knowledgeable contributors to these debates.

3. Risks of Abuse in the MAiD Context

3.1. The main abuse-focused concerns raised in the academic literature, in the context of MAiD, appear to be the following:

3.1.1. MAiD might be administered without the consent of the patient;[3]

3.1.2. There will be a "slippery slope" towards unwanted MAiD eligibility;[4]

3.1.3. Impoverished or otherwise vulnerable people might be unjustly influenced towards seeking MAiD.[5]

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[3] Pereira, J. "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls." Current oncology (Toronto, Ont.) vol. 18,2 (2011): e38-45. doi:10.3747/co.v18i2.883

[4] https://www.thestar.com/opinion/contributors/canada-is-going-too-far-with-medical-assistance-in-dying-the- danger-of-abuse-is/article_2b127093-ea28-54c3-a0d5-9704c5eb89e5.html ; Kim, S. Y. (2023). "Canadian Medical Assistance in Dying and the Hegemony of Privilege". THE AMERICAN JOURNAL OF BIOETHICS2023, vol. 23 (11): 1–6. https://doi.org/10.1080/15265161.2023.2264096; Pullman, D. (2023). "Slowing the Slide Down the Slippery Slope of Medical Assistance in Dying: Mutual Learnings for Canada and the US." The American Journal of Bioethics vol. 23 (11): 64–72. doi:10.1080/15265161.2023.2201190.

[5] https://nationalpost.com/news/politics/patients-not-doctors-should-initiate-conversations-on-assisted-dying- qualtrough; https://www.ourcommons.ca/Content/Committee/441/AMAD/Brief/BR11768826/brexternal/Schuttenjames-e.pdf

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4. MAiD Without Voluntary Consent

4.1. There is a concern that doctors will ignore a patient's lack of consent to an assisted death. This could be out of a moral stance on their patient's current circumstances or diagnosis, out of compassion, or to remove them as a 'drain' on the medical system. This would be involuntary euthanasia.[6] Any of this could also occur if MAiD remained a criminal offence.

4.2. Such a practice would be uncontroversially illegal in any jurisdiction that currently permits MAiD. Anyone who provides MAiD without voluntary consent, and without following due process, including evaluative processes by independent third-party experts, is breaking the law in Canada.[7] Likewise, in a country where MAiD is illegal, anyone providing MAiD does so contravening the law of that country. Therefore, MAiD being legal or illegal does not change whether the MAiD provider's actions in such situations are actionable from a law enforcement perspective. The question thus turns appropriately into an enforcement issue, not a policy issue.

4.3. Furthermore, physician-assisted suicide and euthanasia occur even where it is illegal. While exact figures documenting the extent are difficult to come by, for obvious reasons, some evidence is available. These practices are known to occur in jurisdictions where they are illegal, such as in the United States in 1996, where 4.7% of physicians in a nationwide survey responded that they had administered at least one lethal injection before assisted suicide was legalized in some states of the country.[8] A smaller survey of Social Workers in the Canadian Province British Columbia reported that 1.1% of those surveyed were involved in acts of voluntary euthanasia when that practice was illegal in that province.[9] During the early years of the AIDS pandemic nurses caring for AIDS patients were surveyed on their views on assisted suicide and

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[6] Pereira, supra note 4.
[7] Criminal Code, RSC 1985, c C-46, ss 241.2(1), (3)(h).
[8] Meier, D. E. et al. (April 23, 1998). "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States". N Engl J Med, vol. 338 no. 17, pp. 1193-1201. DOI: 10.1056/NEJM199804233381706.
[9] Ogden RD, Young MG. Euthanasia and assisted suicide: a survey of registered social workers in British Columbia. Br J Soc Work. 1998 Apr;28(2):161-75.

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euthanasia. Reportedly fewer than one in five nurses responded that they would not report a colleague who provided MAiD when that would have been illegal.[10]

4.4. If one is truly concerned that a physician may have provided MAiD against the law, then this should be investigated, and the party should be charged accordingly. People in South Africa have provided assisted deaths in violation of existing laws and were successfully prosecuted.[11]

5. Slippery Slopes

5.1. With regard to concerns known as slippery slope arguments, opponents of assisted dying in Canada have charged that the country has gone down the slippery slope to a system that is out of control. I have written extensively on this subject,[12] but let me state at the beginning that I do think slippery slope arguments are typically erroneous and are often simply an indication of sharply differing intuitions. For instance, someone in favour of a permissive assisted dying regime will find no immediate fault in annually rising numbers of patients seeing their lives terminated by means of MAiD, they might even express surprise at how low the numbers are, given the oftentimes low quality of our natural dying processes. Someone opposed to assisted dying will see rising numbers of patients who see their lives terminated by means of MAiD as a sign of something having gone badly wrong. Rising numbers of MAiD cases may or may not be the result of a slippery slope problem, depending on the nature of the system that provides the services. In their own right they signify nothing. Opponents of MAiD typically present rising numbers of patients availing themselves of this service as evidence of a slippery slope, and as evidence that something untoward is occurring. That is false.

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[10] Young MG, Ogden RD. End-of-life issues: a survey of English-speaking Canadian nurses in AIDS care. J Assoc Nurses AIDS Care. 1998 Mar-Apr;9(2):18-25.

[11] Kotzé, C., and Roos, J. L. (Jan. 18, 2022). "End-of-life care in South Africa: Important legal developments." The South African Journal of Psychiatry vol. 28:1748. doi:10.4102/sajpsychiatry.v28i0.1748; S v De Bellocq 1975 (3) SA 538 (T); S v Marengo 1991 (2) SACR 43 (W).

[12] Downie J, Schuklenk U. Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada. Journal of Medical Ethics 2021;47:662-669.

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5.2. Slippery slope arguments come in various forms. What they have in common is that they claim that a particular practice X, once implemented, will invariably – cue the slippery slope – change from a possibly defensible practice X to a practice Y that is clearly indefensible. Say, as an example, in the case of MAiD it may initially have been designed to assist terminally ill, unbearably suffering, and decisionally-capable patients to receive an assisted death, based on their explicit, voluntary request. In the case of a successful slippery slope the jurisdiction that implemented this regime could find itself at the bottom of the slippery slope where, like in Nazi Germany, disabled, and unhoused people are murdered against their express wishes. Clearly, if this was the case one should reconsider starting off at the top of the slippery slope. In other words, one would be well advised not to make assisted dying legally available to prevent the unwanted outcome, given that the outcome is so evil that it outweighs any benefits derived by those who asked for an assisted death. What is important here is that the outcome is uncontroversially evil, and it is not wanted. This gives rise to the question whether Canada's assisted dying regime has gone down such a slippery slope.

5.3. In my considered view that is not the case.

5.4. I have already noted that an increase in the number of people availing themselves of this service, in its own right, is not evidence of a slippery slope.

5.5. A different kind of slippery slope argument maintains that Canada's evolution from a restrictive assisted dying regime, limited to decisionally-capable, unbearable suffering adults whose death is reasonably foreseeable, to a more permissive regime, that includes now people whose death isn't reasonably foreseeable, is evidence of a slippery slope. The concern is that an unwarranted extension of eligibility criteria has occurred that is quite different to the malevolent-intent situation described above in the Nazi example. This sidesteps the question of whether or not this extension is ethically defensible. If one concludes, as I do, that this extension of eligibility criteria is ethically defensible, and well-considered, the more permissive standard isn't problematic. More needs to be shown by opponents of the more permissive regime than to point to the widening of eligibility criteria to substantiate the claim of a slippery slope.

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5.6. If one were to take a mere shift from a restrictive to a more permissive regime as *prima facie* evidence of a slippery slope, Canada's MAiD policy evolution from restrictive to more permissive might raise suspicion. However, such an interpretation would be erroneous, beyond the reason I just mentioned. In order to appreciate this one must be cognizant of the criteria that govern Canada's assisted dying regime, namely the criteria laid out in the Supreme Court of Canada judgment that led to the elimination of parts of the country's *Criminal Code* provisions that criminalized MAiD.

5.7. The Court found, that 'section 241 (b) and s. 14 of the Criminal Code unjustifiably infringe s7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.' While the Court didn't define what constitutes a 'grievous and irremediable medical condition' it is quite obvious that nowhere among the criteria listed does it require that a person must suffer from an illness where 'death is reasonably foreseeable'.[13] Furthermore, notably the Court explicitly included disability among the eligibility criteria. The inclusion of people on grounds of their disability may be opposed by some, but it is not a result of a slippery slope.

5.8. Opponents of assisted dying may disagree with these Supreme Court of Canada criteria, but what is uncontroversial is that they should have given rise to legislation that is quite permissive in nature. However, Canadian legislators responded to the judgment in the first incarnation of MAiD legislation with fairly restrictive eligibility criteria, including the already mentioned 'death reasonably foreseeable' standard, among other restrictions. This restrictive regime was arguably unconstitutional. It very quickly gave rise to legal challenges. As a result of various successful court challenges – Professor Downie and I have outlined them in some detail here[14] - legislators responded by making the regulations more permissive and MAiD became available to

[13] The terminology used in Canada, it doesn't map exactly on how 'terminal illness' is understood elsewhere.

[14] Downie J, Schuklenk U. Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada. Journal of Medical Ethics 2021;47:662-669.

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an increasing number of people. Even at the time of writing the eligibility criteria are arguably more restrictive than should be the case, given the Supreme Court judgment.

5.9. Two comments are in order here:

5.9.1. Anyone may legitimately disagree with the Supreme Court's findings.

5.9.2. If one disapproves of the permissive nature of the Court's criteria one may not legitimately argue that the country's legislators, who were responding to the judgment by aligning the country's MAiD legislation, in successive changes, with the criteria laid out in the judgment, were sliding the country down a slippery slope toward an unwanted and indefensible permissive regime.

5.10. It matters to be clear where the country's MAiD journey began. It started with the permissive eligibility criteria given in the Supreme Court judgment, and not with the country's restrictive first legislation. Opponents of assisted dying inside Canada and elsewhere arbitrarily chose the unconstitutionally restrictive initial legislation as their starting point in order to sustain their slippery slope charge. That is implausible.

5.11. This analysis does not take a stance on whether the Supreme Court's criteria, or the current more permissive regime is desirable. It merely notes that the evolution from restrictive to more permissive legislation in Canada cannot reasonably be interpreted as a slippery slope type scenario.

5.12. A country that decides – as many jurisdictions do – to limit MAiD eligibility to people who suffer from a terminal illness, by some definition or another, could effectively prevent extensions of eligibility criteria by some kind of mission creep, as long as it chooses to maintain such a restrictive threshold.

5.13. At the same time, nothing should stop policy makers in liberal democracies from reviewing existing policy regimes when they see fit in order to determine whether they serve the public good best. There is nothing special about MAiD that would justify declaring the first legislative effort a jurisdiction is undertaking sacrosanct and not amenable to change. Quite to the contrary, a responsible government should revise policies in light of existing evidence and public needs.

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5.14. The same holds true for jurisdictions where MAiD is illegal. As an ever-increasing number of jurisdictions globally introduce MAiD, both in the global north as well as in the global south,[15] more evidence is accumulating, evidence that should influence policy making.

6. MAiD for the Socially Deprived

6.1. There are a few types of arguments against MAiD that are based on concerns about the abuse of socially vulnerable people. Among the arguments mounted in this context, by opponents of assisted dying, are the following:

6.1.1. Some groups of vulnerable people are sufficiently vulnerable that all individuals belonging to them cannot truly consent to the procedure

6.1.2. Marginalized people are more likely to request MAiD, which means that MAiD disproportionately hurts the marginalized

6.1.3. Doctors or others will unduly pressure or otherwise influence the socially vulnerable to end their life because of their bad social situation

6.2. Many of the arguments here are centred around the idea that particular kinds of decisionally-capable patients are sufficiently vulnerable that it becomes necessary to remove their agency to make MAiD related choices, and that this is best achieved by making them ineligible to access MAiD. It remains unclear in this context what would qualify whoever is tasked with overriding these decisionally-capable people's choices with their own to make a better choice, unless one were to assume that every life is better than a MAiD-facilitated end of life.

6.3. Let me use a case as an example that received much public attention in Canada at the time. It might be relevant to the South African situation because of the persistent high levels of poverty in the country.

[15] Schuklenk, U. (2024), Medically Assisted Dying in the Global South. Developing World Bioethics, 24: 51-51.

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6.4. A 51-year-old female reportedly requested and received MAiD. On her own account she chose an assisted death because she suffered from severe sensitivities to chemicals that were used for cleaning purposes in her Salvation Army run housing, as well as to cigarette smoke in the building. Reportedly, she 'chose medically-assisted death after her desperate search for affordable housing free of cigarette smoke and chemical cleaners failed.'[16]

6.5. I should note here that Canada's MAiD regime would not have made the patient eligible for MAiD based on these reported allergies alone. It is likely that other health conditions made her eligible, but what ultimately motivated her – based on the reports about the case - to seek an assisted death was her inability to find more suitable accommodation. The Salvation Army housing administration reportedly denied her repeated requests, as did the province's social services' department.

6.6. She eventually sought MAiD and received it. Intuitively this seems wrong. In a good society authorities would have accommodated her reasonable needs. In the real world her pleas fell on deaf ears. For the purpose of this Report the question is whether the availability of MAiD made any appreciable ethical difference in this case. To put it in stark terms: Was this patient any worse off for the availability of MAiD? Was she harmed by MAiD? The answer to that is: No. The patient was, in fact, better off for the availability of MAiD.

6.7. Cases like these are tragic. However, a simple thought experiment assists in determining whether the availability of MAiD in this case, and in similar situated cases, was morally objectionable. Let us take at face value what has been reported about this patient and her views on this matter. If one wants to establish whether the availability of the provision of assisted dying, on her request and after extensive capacity assessments took place, was morally problematic, one should ask the following question: Would she have been any better off if assisted dying had not been available to her?

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[16] Avis Favaro, "Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing," CTV News August 24, 2022 https://www.ctvnews.ca/health/woman-with-chemical-sensitivities-chose- medically-assisted-death-after-failed-bid-to-get-better-housing-1.5860579 [accessed August 4, 2023]

6.8. Evidently, the availability of assisted dying had no impact on whatever other government and landlord assistance was available to her. If one were to remove assisted dying from the equation, she would still have found herself in the very same situation that triggered her request in the first place. She would have been worse off for not being able to request an assisted death. That does not diminish the tragic nature of the situation, and it can support the view that the social determinants of health that contributed to her decision were the result of living in an unjust society. In a good society, where either government or her landlord had acted and had provided her with suitable accommodation, she might not have chosen an assisted death.

6.9. It follows that in either situation she was not worse off for the availability of assisted dying; rather, she was better off for it in her real, reported situation and she would have been no worse off for its availability if appropriate housing and services had been provided to her and she had chosen to continue living.

6.10. There is no evidence that I am aware of that demonstrates that all, or even most, people who find themselves in difficult life circumstances, and who could be seen to be vulnerable by some definition of vulnerability, are therefore decisionally incapable. The same legal capacity assessment standards should apply to them as they apply to anyone else whose capacity is assessed. It has to occur on a case-by-case basis. This analysis is in line with today's standard conceptualisations of vulnerability, for instance by the World Medical Associations, or by the Council for International Organisation of Medical Sciences. [17]

6.11. It is also worth noting here relevant Canadian court judgments on the proposition that labelling someone 'vulnerable' is sufficient to remove their agency, as is proposed by opponents of MAiD. In the first case, two people with severe disabilities argued that the that time exclusion of disabled people from access to MAiD violated their *Charter* rights.

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[17] World Medical Association (WMA). 2024. Declaration of Helsinki: ethical principles for medical research involving human subjects. Adopted by the 18 WMA General Assembly, Helsinki, Finland, June 1964, 8th edition, 75 WMA General Assembly, Helsinki, Finland, October 2024; Council for International Organizations of Medical Sciences (CIOMS). 2016. International ethical guidelines for health-related research involving humans. Fourth Edition. Geneva. https://doi.org/10.56759/rgxl7405

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6.12. Justice Baudoin in *Truchon* considered and addressed arguments grounded in concerns about social determinants of health, specifically, "lack of access to appropriate care; poverty; unemployment; ongoing abuse or violence"[18] (note 263); "socioeconomic factors such as income, education, race, age, health insurance and institutionalization" (note 263); "poverty or financial precariousness" (note 298); "stigma and discrimination, poverty, low self-esteem, isolation, and inadequate resources" (note 433); and "lack of access to adequate medical resources and services."

6.13. She wrote, inter alia,

> [252] The Court cannot accept the concept of collective vulnerability suggested by the Attorney General because the broad protection that results therefrom is too general an application of a precautionary principle. Vulnerability (tied to various external factors including the social determinants of health) should not be understood or assessed on the basis of a person's belonging to a defined group, but rather on a case-by-case basis, at least for the purposes of an analysis under section 7 of the Charter. In other words, it is not the person's identification with a group characterized as vulnerable—such as persons with disabilities, Indigenous persons or veterans—that should bring about the need to protect a person who requests medical assistance in dying but, rather, that person's individual capacity to understand and consent in a free and informed manner to such a procedure, based on his or her specific characteristics.
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> ...
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> [309] In the Court's view, however, we cannot, in the name of the principle of protecting certain persons from themselves or of socially affirming the inherent value of life, deny medical assistance in dying to an entire community of persons with disabilities precisely because of their disability. That is what the legislator is doing indirectly by providing wide- ranging protection of certain groups instead of implementing strict structural conditions to ensure that such persons are well protected, should it deem it appropriate. Again, collective vulnerability cannot be conceptually used as a basis to refuse medical assistance in dying.
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> [310] Mr. Truchon and Ms. Gladu, who belong to this category of persons, want to be given the choice to decide for themselves. The Court agrees with this. To do otherwise could lead to discrimination against persons with disabilities on the sole basis of their disability. These people are full citizens and consequently have the same rights as all other citizens, especially those that involve making decisions of utmost importance to their bodily integrity and dignity as human beings. Respect for their individual

[18] Truchon v. Attorney General (Canada) 2019 QCCS 3792

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freedom that is expressed thoughtfully, freely and clearly also contributes to the affirmation of the inherent value of their lives.

6.14. In this context it is also often argued by those opposed to MAiD that access to MAiD should only be offered to people with disabilities or those affected severely negatively by social determinants of health if access to timely and high-quality care is guaranteed. This view has some intuitive plausibility to it, but it is ultimately based on flawed reasoning. In fact, this type of argument is defeated by historical precedent in arguments about the legalization of MAiD in Canada as well as in other jurisdictions that chose to make MAiD available. In those days MAiD opponents were concerned about patchy access to palliative care and it was suggested that the introduction of MAiD should be postponed until there is guaranteed timely access to high-quality palliative care for everyone who needs it.

6.15. This line of reasoning was rejected by both the Canadian Parliament and the country's courts.[19] The argument re: disability and social determinants of health fails for the same reason. As Justice Smith observed in Carter: 'the argument that legalization should not be contemplated until palliative care is fully supported rests, as Dr. van Delden 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.[20]

6.16. It follows that the availability of assisted dying to people who report that their disability or social determinants of health have caused their request for an assisted death is not morally objectionable.

6.17. It also follows that it isn't justifiable to label a whole group of individuals as vulnerable and use that label as a justification for removing the agency of every individual belonging to that group. Capacity must be established on an individual person level.

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[19] De Lima L , Woodruff R , Pettus K , et al International association for hospice and palliative care position statement: euthanasia and physician- assisted suicide. J Palliat Med 2017;20(1):8–14

[20] Carter v. Canada (Attorney General) 2012 BCSC 886, para 1274.

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6.18. It is worth noting that various jurisdictions that have introduced MAiD have taken measures to improve timely access to quality palliative care provision, but this occurred after the introduction of MAiD.[21] [22]

6.19. **"Doctor Shopping"**

6.19.1. An abuse-of-policy concern that is occasionally raised is the one of "doctor shopping", which claims that MAiD eligibility can be easily obtained by just going around to enough doctors until one of them eventually gives up and deems the patient eligible. This would defeat the purpose of the stringent eligibility requirements to access MAiD, and could result in people receiving MAiD despite an assessor finding them to not qualify. Of course, this scenario tells us nothing about who of the assessors made the right decision.

6.19.2. Empirically this concern is not well-supported in Canada.[23] Out of all assisted deaths in Ontario during 2023, 0.3% of Track 1 and 3% of Track 2 recipients had previously been found ineligible before later being found eligible. That equates to only 17 patients, where 13 of which were Track 1 patients, and 4 of which were Track 2 patients.[24] These rates are so small that they are not indicative of "doctor-shopping" being a real-world issue. It seems more plausible to take these approval figures as a reflection of the changes in circumstances that happen to people on different tracks.

6.19.3. For patients in Track 1, they must have an illness where death is reasonably foreseeable. Such illnesses can have varying symptoms and states of capacity as the patient's medications, treatments, and conditions change. This can lead to one assessor finding them ineligible during a period where they lack capacity, and then later, upon

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[21] Dierickx S , Deliens L , Cohen J , et al . Involvement of palliative care in euthanasia practice in a context of legalized euthanasia: a population-based mortality follow-back study. Palliat Med 2018;32(1):114–22.
[22] Parliamentary Budget Office, "Federal investments in palliative care", 2020. Available: https://www.pbo- dpb.gc.ca/en/blog/news/BLOG-2021-007-federal-investments-in-palliative-care-investissements-gouvernement- federal-dans-soins-palliatifs
[23] Downar, J. and Downie. J. (Dec. 6, 2024). "The Ontario Chief Coroner's reports are clear — alarm about MAID in Canada isn't warranted". Blog post. Value Judgments. https://valuejudgments.substack.com/p/the-ontario-chief- coroners-reports.
[24] MAiD Death Review Committee. MAiD Death Review Committee (MDRC) Report 2024 – 2. Office of the Chief Coroner for Ontario, Oct. 2024, https://cdn.theconversation.com/static_files/files/3517/2024.2NRFND_Complex_Conditions_Final_Report_%281%29.pdf?1729708724

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being more lucid, being determined to have capacity. This does not constitute doctor-shopping or is evidence of abuse.

6.19.4. Patients in Track 2 are ineligible for MAiD if they have not considered the range of reasonable alternatives offered to them besides MAiD. Some patients with non-life shortening illnesses and unbearable suffering might, for instance, approach their doctor with a MAiD request as their first choice, without having fully considered the available alternatives. A physician would then give the patient time to consider the available reasonable alternatives in order to determine which decision would be in their best interests, considering their own values. Only after they evaluated these alternatives, and if they still request MAiD, the patient may then be approved for the procedure. This could account for the 4 patients who were once found ineligible, and later found eligible. It is also not evidence of doctor-shopping.

6.19.5. Doctor-shopping does not appear to be a genuine abuse concern, from a MAiD policy perspective in Canada, according to the only available data.

7. Risks of Harm Where MAiD is Illegal

7.1. Keeping MAiD illegal (maintaining the status quo) is not cost neutral. When people are unable to access a physician's assistance in ending their life, there are some who continue to experience suffering that is intolerable to them, and where the suffering is such that they have decided that they do not wish to experience it any longer, that continued living is not worth it in their best considered judgment, and where they have no way out. Where MAiD is illegal, those that wish to end their lives must resort to other means, which may include traumatically or illegally involving family

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members,[25] travelling to Switzerland if they are wealthy and well-supported enough to do so,[26] or using methods that can lead to botched suicides.[27]

7.2. The above means are only available if the patient can utilize those means without assistance. If assistance is required, this would place a severe undue burden on those close to the patient to either contravene the law out of compassion for their loved one's sincere wish and risk criminal charges,[28] or on physicians to contravene the law in order to act professionally, in this case to respect patient autonomy and benefit their patient.[29]

7.3. Some people with disabilities who experience unbearable suffering are unable to end their lives without assistance, but are fully capable of expressing their wish to die. Some such people approached the Canadian courts, either with a life-shortening illness (Sue Rodriguez and Gloria Taylor [ALS]) or with a disabling illness (Kay Carter [spinal stenosis], Elayne Shapray [MS], Jean Truchon [cerebral palsy], and Nicole Gladu [post-polio syndrome]). Unbearably suffering people such as these have vigorously and voluntarily expressed that they wish to die. Yet, they had at the time of their petition no option to die without assistance besides starving themselves to death, which is distressful, and unnecessarily prolonging their suffering. Given the state of Canadian legislation at the time they would have been forced to live out the rest of their lives experiencing suffering they considered unbearable.

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[25] Tal Young, I. et al. "Suicide bereavement and complicated grief." Dialogues in Clinical Neuroscience vol. 14,2 (2012): 177-86. doi:10.31887/DCNS.2012.14.2/iyoung; See: R v Dufour, 2010 QCCA 2413 (Court of Appeal); See also: Del Valle, L. (Jun. 21, 2019). "A Connecticut man is charged with manslaughter for allegedly assisting in wife's suicide". CNN, https://www.cnn.com/2019/06/21/us/connecticut-man-manslaughter-wife-assisted- suicide/index.html; Taylor, M. (Oct. 20, 2006). "Devoted husband gets suspended sentence for helping wife to die". The Guardian, https://www.theguardian.com/society/2006/oct/20/health.medicineandhealth1.

[26] Bird, N. (Nov. 15, 2022). "Assisted dying: 'I was arrested for taking someone to Dignitas'". BBC. Retrieved from: https://www.bbc.com/news/uk-wales-63599107.

[27] Cai, Ziyi, et al. (2021). "The Lethality of Suicide Methods: A Systematic Review and Meta-analysis." Journal of Affective Disorders, vol. 300, pp. 121–29. https://doi.org/10.1016/j.jad.2021.12.054.

[28] See: Taylor, M. (Oct. 20, 2006). "Devoted husband gets suspended sentence for helping wife to die". The Guardian. Retrieved from https://www.theguardian.com/society/2006/oct/20/health.medicineandhealth1.

[29] See: Lings v Denmark, (App. No. 15136/20) [2022] ECHR 15136/20.

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7.4. The costs of the harms that result when MAiD is criminalized must be weighed against the costs that potential risks of abuse could incur. I will explore here some (but by no means all) of the costs of maintaining *status quo*.

7.5. Costs for Decisionally-Capable People Who Resort to Other Means

7.5.1. When someone wishes to die, but cannot utilize MAiD to do so in a controlled, effective, and safe environment, they may resort to other means.

7.5.2. Problems with "Just" Committing Suicide

7.5.2.1. One of the problems with alternative means of ending one's own life is their efficacy. When someone experiences unbearable suffering, MAiD provides a safe way to escape the suffering that they endure, with a physician present for assurance in the rare case that something goes wrong. In South Africa, for instance, the most common reported methods of suicide are hanging, poisoning and firearms (in that order).[30] These methods are somewhat likely to fail, resulting in botched suicides. Hanging has an estimated lethality rate of ~84.6%, gas poisoning ~56.6%, drug or liquid poisoning ~8%, and firearms 89.7%.[31] This means that for people who wish to die but do not have the option of MAiD, there is a varying risk - depending on method chosen - that they will fail in their attempt, resulting in further suffering and distress for both themselves and their loved ones.

7.5.2.2. In contrast, legalizing and regulating MAiD allows unbearably suffering patients to involve their family in the process, if they so choose. Knowing in advance how many days their loved one has left offers them time to process grief and create a "parade of lasts" to celebrate the remaining life that the individual has.[32]

7.5.3. Travelling to Receive an Assisted Death in Switzerland

7.5.3.1. If they are sufficiently well-off, as mentioned already, then one of the available alternate means is to leave the country and receive MAiD in a country such as

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[30] Kootbodien, T. et al. (2020). "Trends in Suicide Mortality in South Africa, 1997 to 2016." International Journal of Environmental Research and Public Health vol. 17 (6) 1850. doi:10.3390/ijerph17061850.
[31] Cai, Z., et al. (2021). "The Lethality of Suicide Methods: A Systematic Review and Meta-analysis." Journal of Affective Disorders, vol. 300, pp. 121–29. https://doi.org/10.1016/j.jad.2021.12.054.
[32] Korbin, K. (Nov. 9, 2024). "How we can make MAID meaningful". The Globe and Mail, https://www.theglobeandmail.com/opinion/article-how-we-can-make-maid-meaningful/

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Switzerland. - Let me note in passing that this constitutes an ethically difficult to defend equity issue, where access to a peaceful death for those suffering unbearably is limited to those with the financial resources to escape restrictive policy regimes. - For instance, Kay Carter, the mother of the principal plaintiff in the Supreme Court of Canada case Carter v Canada, did not have the time to wait until MAiD was legalized.[33] The agony Carter suffered made her fly to receive MAiD via Dignitas in Switzerland, and her family launched the constitutional challenge in honour of Kay's fierce determination to choose the manner of her own death.[34]

7.5.3.2. The average cost of an assisted death for people flying to Switzerland from the UK in 2017 averaged around £10,000.[35] The process to receive an assisted death in Switzerland takes on average three months or longer from request to assisted death.[36] It involves a copious amount of documentation that is legally required to be completed within the period six months before administering the assisted dying medication, alongside several consultations to inform the patient of all of their possible alternatives and ensure that they truly wish to die. In all likelihood, someone in this position will need loved ones there to support them, or physically transport them, and have the resources to take time off work to do so. Even the Swiss police will be involved as part of the process to interrogate friends or family members to ensure that the wish is not a result of undue pressure, and some family members have been interrogated by authorities further upon returning home.[37]

7.5.3.3. Lastly, having to make travel plans to receive an assisted death in Switzerland would imply that one is well enough to travel that far. This likely will force already

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[33] Todd, D. (Feb. 4, 2015). "The story at the heart of Friday's Supreme Court ruling on assisted suicide". Vancouver Sun, https://vancouversun.com/news/staff-blogs/b-c-woman-chooses-a-dignified-death-in-switzerland.

[34] Carter, J. (Sep. 11, 2021). "Assisted dying around the world". Webinar. Dying with Dignity Canada, https://www.dyingwithdignity.ca/education-resources/assisted_dying_around_the_world_recording_september2021/.

[35] Riley, L. and Hehir, D. (Nov. 2017). "The True Cost: How the UK outsources death to Dignitas". Dignity in Dying UK, https://features.dignityindying.org.uk/true-cost-dignitas/. See also: Wiener, N. (May 7, 2023). "Opinion: The story of my mother-in-law's assisted suicide". LA Times, https://www.latimes.com/opinion/story/2023-05- 07/assisted-suicide-right-to-die-law-dignitas-alzheimers-dementia (In this article, the author reveals that in 2023 it cost $12 000 USD to obtain an assisted death at Dignitas).

[36] Dignitas. (May 2014). "How Dignitas Works". Brochure. http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf

[37] Bird, supra note 17; Dignity in Dying UK, supra note 26.

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unbearably suffering people to choose to die earlier than they would otherwise, before their condition progresses to the point that they would not be able to subject themselves to the journey and the lengthy Swiss processes that I mentioned earlier. To many it may also be undesirable to have to die in a foreign country far away from home, their life so far, and their loved ones who are unable to make the journey to Switzerland.

7.5.3.4. Receiving an assisted death in Switzerland is arguably suboptimal for anybody who doesn't reside in Switzerland, and it would be significantly less stressful, costly, and onerous in their time of suffering to be able to receive an assisted death in their home country.

7.6. Costs for Decisionally-Capable People who Cannot Choose MAiD

7.6.1. Where MAiD is illegal, people who cannot end their own life are bound to continue to experience avoidable suffering for weeks, months, years, or even decades beyond when they wish they could have passed away. It is hard to overstate how difficult this suffering can be on a subjective level, and the individuals themselves know their own tolerance level for suffering better than anyone else can. People who experience unbearable suffering as a result of non-life-shortening illnesses are arguably worse off than people with a significantly life-shortening illness. At least the latter will know that there is a reasonably foreseeable end to their unbearable suffering. The same cannot be said for people who experience unbearable suffering as a result of conditions that are not imminently life-shortening.

7.6.2. Patients with advanced stages of cancer have stated that "the fear of pain was sometimes greater than the fear of death itself".[38] One patient recounted, "Sometimes I have been known to start yelling that this is horrible that why don't I just die now... that it's going to get worse and worse, the pain is going to get worse and worse... why do I have to live through that until I die".[39] Further, most end-of-life cancer patients

[38] Coyle, N. (2004). "In their own words: seven advanced cancer patients describe their experience with pain and the use of opioid drugs". Journal of Pain and Symptom Management, vol. 27(4):300-09, https://doi.org/10.1016/j.jpainsymman.2003.08.008.
[39] Ibid.

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have reported that they experience significant loss of personal autonomy.[40] This is important to note as the suffering caused by losing autonomy is one of the major reasons why people request MAiD.[41] Some people watch their autonomy get stripped away bit by bit as they lose full control of their muscles due to ALS, resulting in them feeling "useless" while they are "writhing and contorting, scratching, clawing, gnawing, hurting others around [them], trying to escape the jaws of death".[42] There is no good reason why such thoughts should be considered reasonable only as long as they are limited to physical illness. For example, patients with severe mental illness experience "emotional pain that seems impossible to escape from while living".[43] Some of these patients are decisionally capable.[44] Interestingly, and quite implausibly so, people who are eligible for MAiD in Canada, because they meet Track 1 or 2 eligibility standards, do not lose their eligibility if they have a mental illness that is not decisionally incapacitating them. However, if that very same mental illness is the cause of their unbearable suffering, they are currently ineligible for MAiD.

7.6.3. It is worth noting here that pain and suffering are frequently conflated, especially but not exclusively by those opposed to MAiD. The argument is, essentially, that pain can be successfully controlled through good palliative care, and, so proceeds the argument, MAiD is superfluous. However, suffering goes beyond pain. Pain causes suffering, so can loss of meaning in life, so can one's loss of control over one's bodily functions and so on. Even if pain could be reliably controlled by means of good palliative care, that would not result in the end of unbearable suffering. At the time of writing the majority of MAiD recipients in Canada, as in most other jurisdictions permitting MAiD, are late-stage cancer patients. However, uncontrolled pain is not motivating

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[40] Bovero, A. et al. (2023). "Loss of Personal Autonomy and Dignity-Related Distress in End-Of-Life Cancer Patients". American Journal of Hospice and Palliative Medicine, vol. 41(2), https://doi.org/10.1177/10499091231166373.

[41] Downar, J., MacDonald, S., and Buchman, S. (2023). "What drives requests for MAiD?" CMAJ, 195:E1385-7. doi: 10.1503/cmaj.230259.

[42] Schuppe, J. and Bencosme, M. (Apr. 13, 2019). "An ALS patient's dilemma: End his own life, or die slowly of the disease?". NBC News, https://www.nbcnews.com/news/us-news/als-patient-s-dilemma-end-his-own-life-or-die- n993421.

[43] Hawke, L. D., et al. (2024). "Medical Assistance in Dying for Mental Illness as a Sole Underlying Medical Condition and Its Relationship to Suicide: A Qualitative Lived Experience-Engaged Study". The Canadian Journal of Psychiatry, vol. 69(5):314-325. doi:10.1177/07067437231209658.

[44] Dembo J, Schuklenk U, Reggler J. "For Their Own Good": A Response to Popular Arguments Against Permitting Medical Assistance in Dying (MAID) where Mental Illness Is the Sole Underlying Condition. The Canadian Journal of Psychiatry. 2018;63(7):451-456.

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many of the intolerable-suffering-related MAiD requests; rather, it is suffering of a different nature. Inadequate pain control or anxiety about the possibility of inadequate pain control are reported as the nature of suffering by 57.6 percent of recipients. While this is a significant number of patients, this figure suggests that more than 40 percent of MAiD recipients are not primarily motivated by the experience of pain or concerns about pain, but by other rationales. The intolerable physical or psychological suffering reported by individuals receiving MAID in Canada in 2021 was the loss of ability to engage in meaningful activities (86.3%), followed closely by the loss of ability to perform activities of daily living (83.4%). These results are very similar to 2019 and 2020 results, indicating that the nature of suffering that leads a person to request MAID has remained fairly consistent.[45] The 2022 report had similar statistics, but the 2023 report had an even higher rate of patients reporting the nature of their suffering to include a loss of ability to engage in meaningful activities (95.5% of Track 1, 96.3% of Track 2) and a loss of ability to perform activities of daily living (87.3% of Track 1, 83.1% of Track 2).[46]

7.6.4. Allowing such individuals, who do not wish to exist in their state of suffering, the option to access an assisted death offers them at a crucial juncture in their life their preferred method of avoiding future suffering.

7.7. Costs to Clinicians and Others with Interest in the Patient's Well-Being

7.7.1. People have empathy for other people. It is very difficult to watch someone suffer, especially if they are a loved one. Health care professionals are groups of people who often bear witness to their patients' unbearable suffering. They have an uncontroversial professional obligation to alleviate or end their patients' suffering. This generally comes in the form of various treatments, medications, or procedures.

7.7.2. A clinician may have someone tell them "I truly want to die. I have suffered for a long time, and I do not want to suffer anymore. Can you please help me die?" With MAiD

[45] Government of Canada, Third Annual Report on Medical Assistance in Dying in Canada 2021 (Ottawa: Government of Canada, 2022), https://www.canada.ca/en/health- canada/services/publications/health-system-services/annual-report-medical-assistance-dying- 2021.html

[46] Government of Canada. Fifth Annual Report on Medical Assistance in Dying in Canada 2023. (Ottawa: Government of Canada, 2024). https://www.canada.ca/en/health-canada/services/publications/health-system- services/annual-report-medical-assistance-dying-2023.html#f3.6a.

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being illegal, the clinician must shake their head, and instead offer alternative methods that may or may not alleviate some of the suffering that motivated the request. Suppose none of them are desirable or effective in the patient's situation, the patient is then left with an option that they would greatly wish for, death, and alternatives that they do not wish for. The clinician is legally obliged to tell them to continue to live in suffering.

7.7.3. Clinicians will thus see their patients suffer unbearably, with no realistic way out of that situation. Those who would be willing to provide MAiD would have to accept unreasonable risks to themselves, their careers and their lives, if they chose to break the law and do what is right by their patients.

7.7.4. I should note here that health care professionals arguably have a professional obligation to assist such patients when laws are designed in such a way as to prevent them from discharging their professional obligations, in this case to respect a patient's autonomous choice vis a vis a procedure that can reasonably be said to benefit the patient.[47] This remains true even if local professional associations disapprove of the procedure, provided professional associations elsewhere have carefully considered the practice under consideration and reached different conclusions, as is the case with regard to MAiD where the HPCSA considers it wrong and medical associations in various countries of the global north have reached different conclusions.[48] In cases where there is a dissensus among professional associations, on what constitutes the gold standard of care or on what should be considered reasonably beneficial to patients, health care professionals are well entitled to follow their own professional judgment on what can reasonably be seen to be beneficial to the patient, if what they consider reasonably beneficial to the patient is also autonomously requested by the patient.

[47] Giubilini A, Schuklenk U, Minerva F, et al. Conscientious commitment, professional obligations and abortion provision after the reversal of Roe v Wade Journal of Medical Ethics 2024;50:351-358.
[48] Among them the Canadian Medical Association.

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7.8. Comparing the Counterfactuals

7.8.1. Having explored the costs that can be incurred from risks of MAiD abuse and the costs that would be incurred from the continued illegality of MAiD, it is important to compare the two counterfactual scenarios to determine where the costs outweigh each other.

Scenario 1: MAiD is legal and regulated	Scenario 2: MAiD is illegal and unregulated
1(a): It is illegal to provide MAiD to someone who does not meet the eligibility criteria. Physicians who provide MAiD in non-compliance with these requirements should be charged accordingly.	**2(a)**: It is illegal to provide MAiD. Physicians who provide MAiD should be charged accordingly.
1(b): To a family member's claim that the physician acted wrongfully in providing MAiD, the physician may argue that they complied with the statute.	**2(b)**: To a family member's claim that the physician acted wrongfully in providing MAiD, the physician has no defence.
1(c): The socially vulnerable can access MAiD to end their own lives, provided that they also meet the eligibility requirements under the statute (e.g., grievous and irremediable medical condition).	**2(c)**: The socially vulnerable cannot access MAiD to end their own lives.
1(d): Someone who suffers unbearably and meets the eligibility requirements has the *option* to end their life, with their voluntary and informed consent.	**2(d)**: Someone who suffers unbearably and wishes to die must end their lives in a worse manner than if a clinician were able to assist, they may have to ask someone else to break the law, or they have to continue to live in suffering against their well-considered wishes.

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7.8.2. 1-a is not worse than 2-a, as both involve the deaths of people in contravention of the laws of the country and will be adequately punished if the law is enforced. Any worries about 1-a not resulting in the law being enforced can equally be said about 2-a.

7.8.3. 1-b is only worse than 2-b where a physician contravenes the law but manages to provide evidence that exonerates them, without sufficient evidence to rebut the physician's claim. In very rare situations like this, it may be generally said that the law is not perfect. A corporation may genuinely violate their employment regulations, but it provides sufficient evidence in defence that its actions were correct, and thus does not suffer consequences. This does not make regulating the actions of businesses a wasteful endeavour, or mean that employment should be outlawed. In contrast, 2-b is worse than 1-b because it means that physicians are unable to end their patient's suffering by peacefully ending their life, at risk of jail time and losing their job, no matter the extent of the horrors the patient is suffering.

7.8.4. 1-c is not worse than 2-c because socially vulnerable people can choose not to die if they do not want to, but can choose to die if they believe it would be the best choice for them under the circumstances. If we accept that continued suffering can be worse than death to some people on a subjective basis, then 1-c is better than 2-c for those people by giving them the option to die. It is better to provide patients the option of a peaceful death than no option at all. In 2-c, the patient has to either live with their suffering against their wishes, or find a more ineffective, undignified, painful, or traumatic method of suicide. This is worse than 1-c, where MAiD remains an option only with the patient's express voluntary consent (noting that the patient must still meet all eligibility requirements).

7.8.5. 1(d) is strictly better than 2(d), by a considerable amount. It is not worse to be provided the option to choose to die, and evidently many have made use of this option to end their continued state of suffering. Interestingly, no jurisdiction that has introduced MAiD in some form or shape has seen significant opposition to it. Citizens strongly support such policies, and no country that has introduced MAiD has seen it fit to end the provision of MAiD. The argument has been made that providing someone the option of MAiD condemns them to the "prison of freedom", wherein more choice

actually leads to less autonomy.[49] Proponents of this view state that in telling someone that MAiD is an option, you put them in a new scenario where they must make a justified decision whether or not to die. This essentially reverses the onus of justification onto the patient, requiring them to have a sufficient explanation not to die, rather than before when they did not need to justify their desire to live. This view is incorrect.[50] Most MAiD scenarios do not change a nondecision situation into a decision situation. At end-of-life, patients must make numerous decisions about how they would like the remainder of their life to go, such as whether they want to receive artificial nutrition and hydration. Thus, telling patients that MAiD is an option simply adds MAiD to a list of many end-of-life options that patients must choose from. MAiD legalization importantly provides a mere opportunity, which can be denied at any time, to decide their manner of death to avoid future suffering while including family and friends in the process. Therefore, from a patient's perspective, having the option to choose MAiD is better than not having the option to choose MAiD.

8. Minimizing Risk

8.1. As discussed, there are risks that occur where MAiD is criminalized, and there are risks that occur where MAiD is legalized. However, with MAiD legalized, the practice can be regulated so that physicians who want to provide this procedure to their patients do not have to decide for themselves the standards that they set for patient eligibility. In the following sections, I discuss briefly how procedural safeguards can lessen the risk of abuse where MAiD is legal, and also how to minimize risk of harm if MAiD were to continue to be illegal.

8.2. Procedural Safeguards Where MAiD is Legalized

8.2.1. Canada has many procedural safeguards in place, which help to lessen the risk of MAiD being abused. Some proposed safeguards create the illusion of safety but

[49] Hartling, O. (2021). "Euthanasia and assisted dying: the illusion of autonomy—an essay by Ole Hartling". BMJ 374:n135, http://dx.doi.org/10.1136/bmj.n2135.

[50] Petersen, T. S., & Dige, M. (2023). "Critique of autonomy-based arguments against legalising assisted dying". Bioethics, 37, 165–170. https://doi.org/10.1111/bioe.13125.

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actually severely compromise the well-being of the individuals who the safeguards are trying to protect. I will thus discuss briefly 'good' safeguards and 'bad' safeguards.

8.2.2. Good Safeguards

8.2.2.1. Written consent required, with required independent witness signature, and required informed consent before receiving MAiD.[51]

8.2.2.1.1. Provides assurance that the patient was truly eligible, and minimizes post-death concerns about capacity, undue influence, etc.

8.2.2.2. Requiring two independent MAiD assessors to assess patient eligibility.[52]

8.2.2.2.1. Increases the likelihood that only patients that are truly eligible will receive MAiD.

8.2.2.3. Two-Track system for patients: patients in Track 1 have a reasonably foreseeable natural death (RFND), and those that fall under Track 2 do not have a RFND.[53]

8.2.2.3.1. Allows for more urgent cases, with RFND, to be dealt with quicker under Track 1.

8.2.2.3.2. Provides additional safety against ill-considered decisions, because Track 2 patients must wait 90 days between request and receipt of MAiD. This waiting period is reducible or cancellable depending on the nature of the patient's condition (e.g., if future loss of capacity is a concern), so it does not represent too deep of an intrusion into the patient's autonomy (though it does likely require them to suffer unbearably for three more months which is far from insignificant a period of time).

8.2.2.3.3. Clinicians who assess the eligibility of a Track 2 patient must consult with someone who has expertise on the patient's condition if they or the other assessor do not have such expertise. Allows for extra assurance that the assessor is fully informed about the patient's condition if not RFND.

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[51] Criminal Code, RSC 1985, c C-46, ss 241.2(3)-(3.1).
[52] Criminal Code, RSC 1985, c C-46, ss 241.2(3)-(3.1).
[53] Criminal Code, RSC 1985, c C-46, ss 241.2(3)-(3.1).

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8.2.2.4. Required to make sure the patient knows that they can withdraw consent at any time.[54]

8.2.2.4.1. Ensures that the patient does not just go along with the process after submitting their request. They can cease their request at any point in time, if they determine that they would rather continue to live.

8.2.2.5. Reporting requirements for physicians involved in the MAiD process.[55]

8.2.2.5.1. Provides transparency and accountability. Will generally result in obtaining data that the physicians are following all the required steps, that patient eligibility is properly being assessed, and that various data are obtained (e.g., reasons for request, medical condition used for eligibility purposes, demographics, etc.).

8.2.2.6. Publishing publicly accessible annual reports.[56]

8.2.2.6.1. Ensures that the general public will be able to review statistics on MAiD, and be kept generally informed about the current state of MAiD within the country. Allows academics to thoroughly research MAiD, and permits policymakers to make better informed decisions on how well the current MAiD policy is working and determine whether there should be any changes.

8.2.3. Bad Safeguards

8.2.3.1. No reasonable alternatives to alleviate suffering requirement (MAiD as last resort).[57]

8.2.3.1.1. Some have suggested that MAiD was only ever intended to be a 'last resort', and that if there are reasonable options available to the patient, then MAiD should not be provided to the patient.

8.2.3.1.2. This is an unsound proposition because it suggests that the patient's subjective experience of suffering can be appropriately captured by objective measures of which

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[54] Criminal Code, RSC 1985, c C-46, ss 241.2(3)-(3.1).
[55] Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying: SOR/2022-222. https://www.gazette.gc.ca/rp-pr/p2/2022/2022-11-09/html/sor-dors222-eng.html.
[56] Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying: SOR/2022-222. https://www.gazette.gc.ca/rp-pr/p2/2022/2022-11-09/html/sor-dors222-eng.html.
[57] Lemmens, T. (2023). "When Death Becomes Therapy: Canada's Troubling Normalization of Health Care Provider Ending of Life". The American Journal of Bioethics, vol. 23(11), 79–84. https://doi.org/10.1080/15265161.2023.2265265; Pereira, supra note 4

procedures will be best for the patient's well-being. This constitutes strong paternalism that is difficult to reconcile with life in a liberal democracy.

8.2.3.2. Physicians mustn't initiate conversation about MAiD.[58]

8.2.3.2.1. See the statements made in this Report under the section: The Canadian Experience of MAiD Abuse.

8.2.3.2.2. This is a policy that seems like a good idea at first because it protects the interests of patients who do not want to infer that the state determined that their life is no longer worth living because a doctor informed them that they are eligible for MAiD.

8.2.3.2.3. However, this safeguard is indefensible because it violates a fundamental principle of medical ethics: informed consent. It prevents patients from knowing the full range of reasonable options available for them to consider, and thus they cannot make a truly informed decision. In some ways it also constitutes strong paternalism that is incompatible with life in a liberal democracy.

8.2.3.3. Reasonably foreseeable natural death requirement.[59]

8.2.3.3.1. This requirement may seem like a good idea because it restricts access to MAiD to people that were likely going to die soon. This prevents any potential 'abuse' cases from resulting in someone dying far earlier than they would have otherwise.

8.2.3.3.2. However, this was found to be an unconstitutional requirement in the Truchon decision. It is problematic for a few reasons:

8.2.3.3.2.1. It discriminates unfairly against those who have decisional capacity, and who express persistent and reasonable wishes to die, but their disease does not have a prognosis such that death is reasonably foreseeable. It prevents them from having equal access to MAiD, despite experiencing as much or more suffering than someone with RFND.

8.2.3.3.2.2. It prevents decisionally-capable people, who would otherwise suffer far longer than those whose deaths are reasonably foreseeable, from having the option to die via MAiD.

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[58] Bryden, J. (Nov 26, 2020). "Patients, not doctors, should initiate conversations on assisted dying, Liberal minister says". National Post, https://nationalpost.com/news/politics/patients-not-doctors-should-initiate-conversations- on-assisted-dying-qualtrough.

[59] This was the requirement under Canada's Criminal Code s. 241.2(2)(d), until it was found unconstitutional in the Truchon decision and repealed in 2021. https://laws-lois.justice.gc.ca/eng/acts/c-46/section-241.2.html; See: Truchon v Procureur général du Canada, 2019 QCCS 3792.

8.2.3.3.2.3. One of the comments the court in Truchon about the RFND requirement is pertinent here (para 574): "the limitation largely exceeds the object to such an extent that it has no real connection to the object of protecting vulnerable persons who might be induced to end their lives in a moment of weakness. It instead forces them to make the cruel choice described by the Supreme Court, by imposing that they either suffer intolerably for an undefined period that could last months, even years, or that they take their own lives their own way, all to satisfy a general precautionary principle."

8.2.3.4. Mental illness exclusion.[60]

8.2.3.4.1. The mental illness exclusion means that a decisionally capable patient cannot be eligible for MAiD if mental illness is their sole underlying medical condition.

8.2.3.4.2. This exclusion was supposed to be removed in Canada within the 2021 amendments that removed the RFND requirement after the *Truchon* decision. The amendment was delayed until 2027 to "to provide additional time to study how MAID on the basis of a mental illness can safely be provided and to ensure appropriate safeguards are in place to protect persons in those circumstances"[61]

8.2.3.4.3. This exclusion might superficially be considered justifiable because society would want to make sure people are making a well-considered choice to request MAiD. It could be said that we must protect individuals with mental illnesses who may in a moment of weakness decide they want to die, and in the next they decide to live.

8.2.3.4.4. However, this unjustly discriminates against people with mental illnesses. It presumes that as a class, those with mental illness are incapable of deciding whether or not they wish to continue living. Some people with mental illnesses uncontroversially have that capacity, and thus every person should be judged on an individual basis as to whether they have capacity or not.[62] See also what I said at **6.10.**

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[60] Criminal Code, RSC 1985, c C-46, ss 241.2(2.1).

[61] https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html.

[62] Rooney W, Schuklenk U, van de Vathorst S. Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying? Health Care Anal. 2018 Dec;26(4):326-343.

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8.3. Minimizing Risk Where MAiD is Criminalized

8.3.1. Where the status quo of MAiD's illegality is maintained, there are many risks of harm that arise. Arguably the best way to address these risks is to legalize MAiD.

9. The Canadian Experience of MAiD Abuse

9.1. There have been a few allegations of MAiD abuse reported in Canada by various news outlets, and the British Columbia Civil Liberties Association (BCCLA) has recently called for a review of the federal MAiD legislation to ensure that proper safeguards are in place.[63] This is in response to worries about two patients which allegedly improperly received MAiD, and other reports of people seeking MAiD due to their intolerable social determinants of health.

9.2. The allegations of abuse that Canada has seen do not demonstrate serious deficiencies within Canada's MAiD policy, procedural or other. It is reassuring that these cases, even if they were evidence of wrong-doing, represent only a very small number of cases, given the overall number of MAiD facilitated deaths in the country.

9.3. Canadian Cases Where Patients are Reportedly Influenced to Seek MAiD

9.3.1. Please find below some of the most prominent cases of people generally reported to be victims of MAiD abuse, besides ones already mentioned in this report:

9.3.1.1. Amir Farsoud[64]

9.3.1.1.1. A man who has received much media attention because he sought MAiD to avoid becoming unhoused. He ideally wanted housing, but he applied for MAiD because he said that he preferred death to being unhoused. Farsoud was eligible for MAiD because of his severe chronic back pain, which at its worst reportedly would result

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[63] The Canadian Press. (Dec. 20, 2024). "B.C. civil rights group that fought for MAID now wants it reviewed". CBC News, https://www.cbc.ca/news/canada/british-columbia/liberty-group-maid-1.7416929.

[64] Mulligan, C. and Bond, M. (Oct. 13, 2022). "Ontario man applying for medically-assisted death as alternative to being homeless" City News, https://toronto.citynews.ca/2022/10/13/medical-assistance-death-maid-canada/; CityNews Staff. (Nov. 17, 2022). "Ontario man not considering medically-assisted death anymore after outpouring of support". City News, https://ottawa.citynews.ca/2022/11/17/ontario-man-not-considering-medically-assisted- death-anymore-after-outpouring-of-support-6114759/.

9.3.1.1.2. in him "crying like a 5-year-old and not sleeping for days in a row."

9.3.1.1.3. He is not opposed to MAiD, and is actually interested in availing himself of MAiD in the future once his back pain becomes unbearable, but at the time of writing he just desires to be housed.

9.3.1.1.4. A public fundraiser through GoFundMe was launched for him after his story was shared publicly, and he raised $60000 CAD. The fundraiser was ended at that point to avoid breaching the threshold that would have made him ineligible for disability support payments. He then withdrew his MAiD application as the money he received was sufficient for him to live for at least four more years in his current housing.

9.3.1.2. Alan Nichols[65]

9.3.1.2.1. Nichols had a hearing and cognitive disability, a long history of seizures, and recurring episodes of depression. He was allegedly involuntarily admitted to the hospital after the police were sent to his residence for a wellness check.

9.3.1.2.2. He was then assessed to be capable of requesting MAiD shortly after arrival, and MAiD was administered to him 40 days after he was admitted to the hospital.

9.3.1.2.3. His family strongly objected to the procedure happening, and they were only informed 4 days before the procedure. "Nichols' family reported the case to police and health authorities, arguing that he lacked the capacity to understand the process and was not suffering unbearably — among the requirements for euthanasia."

9.3.1.2.4. This occurred when RFND was a requirement, and Nichols was allegedly not diagnosed with any illness that would warrant a finding of RFND (hearing loss being the condition listed).

9.3.1.2.5. The family tried to get legal recourse by contacting the Royal Canadian Mounted Police (RCMP), but the RCMP said they should instead contact the Royal College of Physicians and Surgeons (RCPS).

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[65] Coelho, R., Maher, J., Gaind, K. S., & Lemmens, T. (2023). "The realities of Medical Assistance in Dying in Canada". Palliative and Supportive Care, vol. 21(5), 871–878. doi:10.1017/S1478951523001025.; Cheng, M. (Aug. 11, 2022). "'Disturbing': Experts troubled by Canada's euthanasia laws". The Associated Press, https://apnews.com/article/covid-science-health-toronto-7c631558a457188d2bd2b5cfd360a867

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9.3.1.2.6. The RCPS said that they would not conduct a disciplinary investigation unless the RCMP launched a criminal investigation. The family has still not been able to get a legal action started.

9.3.1.2.7. The RCMP allegedly provided that "hearing loss" was the condition that Nichols received MAiD for. They claimed that they reviewed Nichols' file, and that he was indeed eligible to receive MAiD.

9.3.1.3. **Christine Gauthier**[66]

9.3.1.3.1. A veteran and paralympic athlete claimed that she was offered MAiD by a Veterans Affairs employee.

9.3.1.3.2. She initially claimed that she has "a letter saying that if you're so desperate, madam, we can offer you MAID, medical assistance in dying," but after being asked to produce the letter, she claimed that the offer was made verbally.

9.3.1.3.3. The internal investigation by Veterans Affairs revealed no evidence that anyone offered her this, but that there were four other instances of other veterans being recommended MAiD by one agent, who has since been suspended.

9.3.1.3.4. She was never at risk of receiving MAiD against her wishes, but she was deeply offended that it was suggested to her.

9.3.1.4. **Rose Finlay**[67]

9.3.1.4.1. Finlay is a disability rights advocate and a mother with quadriplegia and several other compounding conditions, who publicized her MAiD request in 2023.

9.3.1.4.2. Her condition worsened, and she was unable to work, so she had to go on ODSP (Ontario Disability Support Payment). ODSP did not provide her enough money to live or pay for her support workers. She stated that she primarily considered MAiD due to her lack of money.

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[66] Brewster, M. (Dec. 5, 2022). "Veterans Affairs says it has no proof former paralympian was offered assisted death". CBC News, https://www.cbc.ca/news/politics/medical-assistance-death-maid-veterans-christine-gauthier- 1.6674747; Brewster, M. (Dec. 1, 2022). "Former paralympian tells MPs veterans department offered her assisted death". CBC News, https://www.cbc.ca/news/politics/christine-gauthier-assisted-death-macaulay-1.6671721.

[67] Riches, S. "Quadriplegic Ontario mother says her only option is assisted suicide due to lack of support". National Post, https://nationalpost.com/news/canada/quadriplegic-ontario-mother-maid-assisted-suicide; Finlay, Rose [@wheelchair1derwoman]. Selfie with 2024 update. Instagram. Jan. 29 2024, https://www.instagram.com/wheelchair1derwoman/p/C2tBYiHpvxi/.

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9.3.1.4.3. Upon receiving hate comments on Instagram from people criticizing her for choosing to die, abandoning her children, she responded that she is not doing much to mother them in her current condition.

9.3.1.4.4. The article was published in June 2023, though beforehand she was apparently undergoing studies to enter the finance world. Finlay passed her mortgage broker exam in April 2023 and was fully licensed as of June 2023 (the time of the article). She is even going back to get dual-licensed. Finlay withdrew her MAiD request

9.3.1.5. **N. B.**[68]

9.3.1.5.1. An injunction was filed in the BC Supreme Court to stop the MAiD provision for NB, just the day before the date she was going to receive it.

9.3.1.5.2. NB suffered from bipolar disorder. In summer 2023, she had an intense manic phase and could not sleep, so she was prescribed a medicine called "quetiapine". After taking this medication, she began asking her common law partner to kill her.

9.3.1.5.3. In October 2023, she was admitted to the hospital, and prescribed quetiapine daily. After a week of negative side effects, she began to stop using the drug again. She reportedly experienced worsening side effects, and she experienced intense terrors, horrors, and nightmares. She had trouble sleeping or remaining still, and had continuous suicidal thoughts. Upon researching her situation she concluded that she has "akathisia".

9.3.1.5.4. Akathisia is treatable, and people get through it, according to her counsellor she consulted with (who had akathisia himself). She did not follow the counsellor's recommendations. A doctor she saw said she was experiencing akathisia because she tapered off quetiapine too quickly, and needed to go back onto it so she can wean off slower. She refused.

9.3.1.5.5. Her MAiD form stated that akathisia is her reason for seeking MAiD.

9.3.1.5.6. Justice Coval stated that he found there was an arguable case that NB's condition did not meet the eligibility criteria for MAiD and thus ordered an emergency 30-day injunction. This was done primarily to avoid the irreparable harm to NB in case she was not actually eligible, but he acknowledges that ordering this injunction is a severe intrusion into NB's autonomy. He thus also ordered that NB

[68] AY v NB, 2024 BCSC 2004.

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can set aside this injunction on "five clear business days' notice". He made no conclusions as to whether or not there was any actual foul play.

9.3.1.6. **JMM**[69]

9.3.1.6.1. A lawsuit being presently filed with the BC Supreme Court alleges that JMM received approval for MAiD, but then later expressed that he did not want MAiD, and wished to pursue other treatment options.

9.3.1.6.2. JMM allegedly had a long-standing history of mental illness, including bipolar disorder, but also experienced chronic back pain. According to the statement of claim, he received MAiD primarily because of the suffering from his mental illness, but the fact that he suffered from his back pain too is what actually may have made him eligible for MAiD, despite the pain reportedly being neither grievous nor irremediable.

9.3.1.6.3. The statement of claim states that the safeguard protecting people from seeking MAiD only for a mental illness "falls away" when they happen to have a physical impairment as well.

9.3.1.6.4. None of the allegations have been proven in court as of the time of writing.

9.4. One issue that is raised in cases like these, by opponents of MAiD, is that these patients' health care professionals should have never raised MAiD as an option. They argue that bringing this up in conversation may have been done in ways that put undue pressures on patients to accept or aim for this option. This may or may not have been the case in the situation Christine Gauthier reported.

9.5. Ethically speaking it is indefensible to withhold information from patients that they require in order to make an informed, autonomous choice of their own about the options that are available to them. Withholding information under such circumstances violates basic, uncontroversial tenets of medical ethics.[70]

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[69] Proctor, J. (Dec. 18, 2024). "Family sues after man allegedly got medically assisted death during day pass from hospital". CBC News, https://www.cbc.ca/news/canada/british-columbia/mental-physical-medical-assisted-death- 1.7412923.

[70] Ruth R Faden, Tom L Beauchamp. 1986. A Theory and History of Informed Consent. Oxford University Press: New York.

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9.6. What these concerns then might better be interpreted as is that of a red flag. Perhaps there should be more stringent regulations or scripts even that clinicians must use when they inform eligible patients about their MAiD eligibility.

9.7. What Would 'Victims of MAiD Abuse' Experience if MAiD Were Illegal?

9.7.1. The question that must be asked in every aforementioned case where some social deprivation reportedly caused someone to turn to MAiD is whether they would be better-off with MAiD being illegal. The answer in each case must be "no". These cases map on my earlier discussion in the context of the social determinants of health argument against MAiD.

9.7.2. It is truly tragic that someone could be losing their home due to the lack of social and financial support that they are able to attain, and that they would rather die than be unhoused. However, MAiD does not render such people unhoused. Difficulties obtaining housing or support for the vulnerable members of the population are entirely separate social issues that should be resolved in addition to MAiD, rather than instead of MAiD. They are not mutually exclusive. While it might be tempting to say that MAiD should be illegal until these issues are resolved, we should not encourage "hostage-taking" of suffering people as leverage for the government to create better social policies.[71]

9.7.3. Some critics decry the potential situation of a physician telling their patient to consider MAiD when the patient does not want to die. Hearing such an option could indeed be subjectively deeply insulting, as it could be interpreted as implying that one's standard of living is objectively sufficiently low so as to constitute possibly unbearable suffering where death might be a better alternative. However, clinicians should be able to discuss the full range of possible treatment options that a patient can receive, presuming that they are actually eligible for each of those treatment options. If the patient did not know that MAiD was an option for them in their current situation, then they are in effect incapable of providing informed consent to other forms of palliative treatment because they were not informed of the full range of reasonably available options. The patient is able to refuse consent at any time and can withdraw from

[71] Downie, J. and Schuklenk, U., supra note 29

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receiving MAiD, so no harm arises in this context any more than harm arises from suggesting other forms of potentially offensive end-of-life measures (for example, going on artificial nutrition or needing a breathing tube).

9.7.4. The cases where MAiD policy was allegedly abused by doctors who improperly provided MAiD to ineligible individuals are enforcement issues, not MAiD policy issues. For example, while it is deeply troubling to the family members of JMM that he could be found eligible for MAiD due to his allegedly neither grievous nor irremediable back pain, it must be considered that they have utilized their ability to file a civil lawsuit to try to punish this doctor for their actions. If we accept that the family's allegations are correct, then they are in no different of a situation for pursuing legal action against the wrongful actions of the physician than they would be if such a procedure was provided wrongfully where MAiD was fully illegal. However, if the family's allegations are unfounded, then there is no scandal here besides family members being surprised by a loved one's actions.

10. Conscientious Objection

10.1. Conscientious objection accommodation in health care services has become a highly politicised topic in recent years. At issue is that eligible patients seek particular health care services from a health care professional in whose scope of professional practice those services are. The health care professional doesn't deny the facts of the matter, namely that the patient is eligible to receive a particular service and that the service is considered the standard of care for the condition that motivates the patient to request the service for. The professional refuses to provide the service on grounds of their idiosyncratic private convictions. These convictions can be of a religious nature, but that doesn't have to be the case. They are normative private convictions that the professional decided are more important to them than to provide the professional services they voluntarily contracted to deliver when they joined the profession.

10.2. Importantly then, when we talk about conscientious objection what we actually mean is a conscience-based refusal to provide professional services. It's possible that a professional objects on grounds of conscience to, say, abortion, but acknowledges that

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it is their professional obligation to provide the reproductive health service, and so they provide the service while acting in their professional capacity. That wouldn't stop them from being opposed in their private lives to abortion care, and so they might lobby to see abortion related legislation change. However, they do appreciate that the bedside isn't the right location to litigate these issues. Patients do not see them in their capacity as private individuals but in their capacity as professionals.

10.3. I am concerned here about those who refuse to provide said services.

10.4. One of the reasons why the refusal to provide such services is incompatible with health care professionalism is to do with why societies maintain professions. Professions are in existence only to serve the public good through the high-quality delivery of particular specialist services on which society has granted these professions a monopoly. This explains oath giving graduation ceremonies where doctors pledge, inter alia, to serve the public good.

10.5. The refusal to provide such public good-serving services on idiosyncratic, untestable private conscience claims amounts to an abuse of one's monopoly powers. It undermines equal citizenship because it places professionals above the citizens that granted them the same monopoly powers that they abuse when they refuse to provide services to eligible patients.

10.6. For my ethical views on Conscientious Objection in medicine I refer to Alberto Giubilini, Udo Schuklenk, Francesca Minerva, Julian Savulescu. 2025. Rethinking Conscientious Objection. Oxford University Press: Oxford. We provide here a comprehensive ethical account against conscientious objection accommodation in medicine.

10.7. Oftentimes human rights arguments from religious freedom are extended to become freedom of conscience rights. It should be noted that even if one accepted such a line of reasoning, that couldn't possibly translate into an absolute right to refuse to provide professional services. Such rights are by necessity always limited to the extent that they infringe on other parties' rights. Here they would infringe on the rights of eligible patients to receive the care they are entitled to receive.

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10.8. This analysis notwithstanding, many societies – there are exceptions, a few liberal democracies exist in Northern Europe, that deny conscientious objection accommodation - have introduced conscientious objection policies that amount to compromise positions. The objective typically is to ensure that patients receive access to care while protecting conscientious objectors. This oftentimes is unproblematic for all health care intent and purposes, because the service can be attained without major difficulty, but that isn't always the case. Canada has seen cases where unbearably suffering, dying patients had to be transported sometimes hundreds of km's between hospitals because they were unable to access MAiD in a particular hospital, because of individual or institutional conscientious refusal to provide care. This is ethically and professionally difficult to defend for the reasons outlined above. Such activities arguably also constitute a suboptimal use of scarce public health care resources.

10.9. Canadian health care delivery is essentially a provincial responsibility and policies pertaining to conscientious objection are a matter for provincial regulators. For instance, in Ontario, where I reside, the relevant regulator is the College of Physicians and Surgeons. Its policy is, essentially, a compromise: clinicians can conscientiously object to assessing a patient for MAiD eligibility or providing MAiD, but they must be willing to refer the eligible patient to another clinician who will provide the service.[72]

10.10. A coalition of religious health care professionals' groups, as well as individual doctors, took the College responsible for regulating them to court over this policy.[73] It is understandable that in the view of a conscientious objector the compromise isn't a compromise, because if one believes that MAiD amounts to murder, asking one to ensure that a patient is transferred to a colleague willing to provide the service (and so undertake the 'murderous' act) is not a compromise. The court sided with the College of Physicians and Surgeons, and so conscientious objectors in Ontario are required to ensure a timely and effective referral of eligible patients to a doctor who will provide the relevant service.

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[72] CPSO - CPSO's Effective Referral Requirement Affirmed by Superior Court 31 January 2018.
[73] Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario, 2019 ONCA 393.

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10.11. From an ethical perspective such a policy is defensible, if it ensures timely access to care. In line with what I said about the societal rationale for the existence of professions, the College of Physicians and Surgeons Ontario aims with this policy to ensure equitable and timely patient access to care while minimally impairing its objecting members' consciences. To put it in the words of the Court, 'The goal of ensuring access to healthcare, in particular equitable access to healthcare, is pressing and substantial. The effective referral requirements of the Policies are rationally connected to the goal. The requirements impair the Individual Applicant's right of religious freedom as little as reasonably possible in order to achieve the goal.'[74]

10.12. It is possible that in practice this is leads to timely service delivery problems, but I am unaware of research that would have investigated how well, both in terms of reliability as well as in terms of timely access to care, this practice delivers from a patient perspective.

10.13. As in other areas of MAiD policy it is important that there are transparent public reporting mechanisms to ensure that regulators can adjust policies as is required, based on the available evidence.

11. Conclusions

11.1. A decision on whether or not MAiD should be legalised in a jurisdiction cannot be decided on grounds of whether or not there is the potential (or even the reality) of abuse.

11.2. The evolution of Canada's MAiD policies toward a more permissive regime did not lead the country down an unwanted slippery slope.

11.3. Someone's social determinants of health may impact their decisional capacity, but capacity assessments must occur on an individual basis as opposed to a group-basis.

[74] Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario, 2019 ONCA 393.

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11.4. Socially vulnerable patients are better off for the availability of MAiD.

11.5. Doctor shopping' doesn't appear to be a genuine abuse concern, from a MAiD policy perspective in Canada, according to the only available data.

11.6. The societal cost of keeping MAiD illegal is very high. Suboptimal consequences in terms of avoidable human suffering are the inevitable outcome.

11.7. The minimization of risk of abuse, when MAiD is legalised, is an ongoing process, but it is preferable to keeping MAiD illegal.

11.8. It is unacceptable not to raise MAiD as an option in conversation with eligible patients, because it violates basic tenets of medical ethics in that it undermines both patient autonomy and the validity of the informed consent process.

11.9. Conscientious objection accommodation is incompatible with medical (and health care) professionalism. Canadian regulators permit the accommodation of conscientious objectors, but objectors are obliged to transfer their patient to a colleague who they know will provide the service the patient is requesting and is eligible to receive.

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Kingston, Wednesday, 18 March 2026

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28. Intellectual Property, Pharmaceuticals and Public Health: Access to Drugs in Developing Countries, by KC Shadlen, et al. (eds). Reviewed in: *World Medical and Health Policy* 2013; 5(1): 66-69.

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2. AIDS and the Bioethics Debate: reading abstracts is not enough. In: K Joseph. (Ed.) Australian Association of Bioethics Conference Proceedings: Philosophy and Applied Ethics Re-Examined. University of Newcastle, Department of Philosophy: Newcastle 1996: 145-160.
3. Bioethics in a Multicultural World. In: S Horner. (Ed) Conference Proceedings: Consensus in Bioethics. University of Central Lancashire CPE 1998: 29-39.
4. Introduction to Bioethics. In: C Ernest (Ed.) Principled Choices: Medical Ethics in South Africa. Centre for the Study of Violence and Reconciliation: Johannesburg 2000: 7-18.
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Personal, Education & Employment

Born

- Waltrop, Germany

Citizenships

- Australian / Canadian

Tertiary education

- 1992 BA (Hons) equivalent in Philosophy/History: Ruhr-Universitaet Bochum, Bochum, Germany [Guest reader: Universities of Bonn, Bremen, (Free University) Berlin, Essen, and Muen-

ster. (Monash University evaluated my seminar documents from Germany and decided they are BA (Hons) equivalent).
- 1996 - PhD (Philosophy/Bioethics) Monash University Centre for Human Bioethics, Melbourne, Australia.

Employment history

- April 1996-April 1998, Lecturer in Applied Ethics, University of Central Lancashire Centre for Professional Ethics, Course Leader MA Bioethics, Preston, UK [tenured]
- May 1998-April 2000, Lecturer in Bioethics, Monash University Centre for Human Bioethics, Melbourne, Australia. [5-year contract]
- April 2000-2005: (Associate) Professor of Bioethics, Health & Human Rights, Head Division of Bioethics, University of the Witwatersrand Faculty of Health Sciences, Johannesburg, South Africa. [tenured]
- April 2005 – Chair in Ethics in Public Policy and Corporate Governance, Glasgow Caledonian University, Glasgow, UK [tenured].
- April 2007 – Professor of Philosophy and Ontario Research Chair in Bioethics and Public Policy, Department of Philosophy (externally endowed Chair), Queen's University, Kingston, ON, Canada [tenured].

Editorial Responsibilities

BIOETHICS

I am joint Editor-in-Chief of *Bioethics* (with Ruth Chadwick). We took this leading journal over from Peter Singer and Helga Kuhse at the end of 1999. Since then we have moved the journal from a quarterly to effectively a monthly publication (when taken with its companion journal *Developing World Bioethics*).

DEVELOPING WORLD BIOETHICS

I am joint Editor-in-Chief (with Debora Diniz), and Founding Editor of *Developing World Bioethics*. The journal currently publishes quarterly, and is the only bioethics / medical ethics journal focused exclusively on developing world issues.

MONASH BIOETHICS REVIEW

I was Editor-in-Chief of the *Monash Bioethics Review*, January 1999 to April 2000. During this period the journal was transformed into a peer-reviewed publication. It is now published by Springer publishing.

REVIEWER

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I am a reviewer for various peer-reviewed journals, including: *The British Medical Journal, The Lancet, The Journal of the American Medical Association (JAMA), Social Science and Medicine, The Medical Journal of Australia, The Journal of Medical Ethics, The Australia and New Zealand Journal of Public Health, The South African Medical Journal, Journal of medical* ethics, among many others.

Professional Service

- Diabetes Canada Clinical Practice Guidelines Expert Working Group (2022-2023)
- Federal Government expert panel on COVID-19 testing (2019-2020).
- Board of Directors International Planned Parenthood Association Canada, now Fos Feminista (since 2018)
- 2017 New Brunswick College of Pharmacists Bioethics Consultant
- 2015 Bioethics Consultant to MSF/Doctors without Borders (International)
- 2009-2011. I was Chair of the Royal Society of Canada's international expert panel on End-of-Life Decision-Making in Canada. The report was released to significant media echo at the end of 2011. It has since been cited in three landmark Canadian court decisions on assisted dying. The Supreme Court of Canada's 2015 judgment on the subject mirrors our recommendations. It has also been extensively referenced in other countries' legislative review processes and court cases, including in Australia, New Zealand and South Africa.
- I have served as an expert on a government commission planning the roll-out of antiretrovirals to HIV patients in South Africa.
- I was a Director of the Africa Genome Initiative and its Africa Genome Education Institute.
- I act as a book reviewer for a number of academic publishers, including *Cambridge University Press, Oxford University Press, Blackwell, Routledge, Academic Press, Rowman and Littlefield, Wiley,* and others.
- I have acted as reviewer for funding proposals submitted to the US NIH, Wellcome Trust, INSERM, SSHRC, CIHR, and other major research funders.
- I have been an invited speaker to a bioethics expert round-table organized by the German and French foreign ministries.
- I review for the CPA as well as the CBA.

Clinical Ethics Competencies

- I undertook (teaching) ward rounds in three major South African hospitals.
- I served as a member of a Data Safety and Monitoring Board for a multicenter study involving thousands of participants in Southern Africa.

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- I was a member of the WITS Human Research Ethics Committee (Medical).

Development of Bioethics Programs

- I developed teach at Queen's a 3rd year and a 4th year/graduate student bioethics course.
- I developed an asynchronous version of the Queen's 3rd year bioethics course.
- I regularly offer Directed Reading Courses to interested students.
- International: I was part of an international team of experts developing flexible delivery teaching materials on Global Health Ethics and Global Health Research Ethics for WHO.
- UK: I was instrumental in designing the MA in Bioethics currently offered at the University of Central Lancashire Centre for Professional Ethics.
- South Africa: I designed a compulsory 2nd year course in medical ethics for medical students.
- South Africa: I designed a compulsory 1st year flexible delivery introductory (general) medical ethics course for dentistry students.
- South Africa: I developed a new MSc (Med) in Bioethics and Health Law, which started successfully (15 students in the first intake) in 2004. This first on the African continent graduate degree program continues to run successfully with an average intake of about 30 students each year.
- South Africa: Part of my work was occupied with 'delivering' CPD points (compulsory continuing medical education ethics points doctors are required to obtain in order to remain registered with their statutory body) to practicing doctors across the various specialties.

Queen's University Administrative Responsibilities

- Graduate Chair
- Senator
- Non-academic discipline committee
- Member Editorial Review Committee McGill/Queen's University Press
- Reader Queen's Major Admission Awards

Member (Department)

- Strategic Planning Committee
- Board of Graduate Studies
- Equity Committee
- Library
- Newsletter
- Nominating Committee
- Renewal, Tenure and Promotion
- Appointments

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Media reports

Media reports about my work (including interviews) have appeared in *The New York Times*, *The Times* (London), *The Washington Post*, *The Globe and Mail* (Toronto), *The Toronto Star*, *The Vancouver Sun*, *The Ottawa Citizen Deccan Herald* (India), *The Star* (South Africa), *Business Day* (South Africa), *The Age* (Australia), *The Manila Post* (Philippines), *Sydney Morning Herald* (Australia), *The Guardian* (UK), *Focus* (Germany), *Gulf News* (United Arab Emirates), *AlJazeera Network* (Qatar), *Axess* (Sweden), *New Straits Times* (Singapore), various Indonesian newspapers, the *US Chronicle of Higher Education*, and were broadcasted by various national TV programs in South Africa, Australia, Canada and the UK, as well as on regional and national radio in these countries. I have also been a studio commentator on evening news TV broadcasts in South Africa (SABC) and Canada (CTV Global, CBC *The National*).

Invited Lectures (incomplete)

- I have been an invited speaker at conferences and congresses held by international organizations such as the International Association of Bioethics, WHO, UNESCO, and HUGO, as well as by specialist societies such as the South African Thoracic Society's annual summit, and by umbrella organizations involved in the provision of health care to patients in managed care environments. Since 2002, I have been an invited speaker (frequently the keynote address) at in excess of 100 conferences/symposia/colloquia. Here are a few highlights:
- In 2002, I was an invited plenary speaker at the United Arab Emirates Health Ethics Conference, and at a Bioethics Expert Round-Table organized jointly by the German and French foreign ministries.
- In 2003, I was an invited speaker at a Bioethics Expert Conference organized by the Ford Foundation in Beijing, China, a Bioethics and Public Policy conference organized by the European Academy in Germany, an International Bioethics Conference organized by the Iranian Science Organisation and UNESCO, a research ethics workshop organized by the Mexican National Bioethics Commission, a conference organized by the World Federation of Scientists in Italy, and at the Sydney 28th International Congress on Law and Mental Health, organized by the International Academy of Mental Health and Law.
- In 2004, I accepted speaking engagements in China, France, the UK, Germany, Egypt, Sri Lanka and various others countries. For

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2005 I accepted speaking engagements in Brussels, Cape Town, Princeton, and New York (twice).

- In 2006, I accepted speaking engagements in Cape Town, New York (twice), as well as many universities in the UK. I also presented on several occasions to audiences in North America in 2007. In 2010 I presented the Warren Steinkrauss Lecture on Human Ideals at SUNY Oswego.
- In 2011-2012, as a speaker I was more frequently in Asia (2011, China (Beijing, Shanghai), Thailand, Hong Kong (on two separate occasions), as well as in Europe (2011, Germany, twice, and the UK, once) and the Caribbean (2012).
- 2014: Germany, UK, USA.
- 2015: Germany – National Ethics Council/National Science Academy (keynote, annual meeting), ORC Symposium, Tuebingen Uni keynote, Science North talk, other invited lectures across Canada.
- 2016: Pitts Memorial Lecture, USA, Weiss Lecture, USA, World Congress Right to Die, NL keynote, other invited lectures across Canada.
- 2021: Keynote speaker European Society for Philosophy of Medicine and Healthcare Conference, Warsaw, Poland.
- 2023: Keynote speaker National Bioethics Commission of Mexico, Mexico D.F., Mexico

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