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2024

## The Expansion of Medically Assisted Dying in Canada: Reforming U.S. Policy to Follow MAiD

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## **Introduction**

An ethical and legal debate over medically assisted dying has been the focus of many countries in the last few decades. Only a limited number of jurisdictions have legalized medically assisted dying and those that have created limiting circumstances in which it is permitted. Medical assistance in dying refers to when a physician prescribes a lethal dose of medication to a patient for ingestion. Medical assistance in dying can take two forms. The first is when a prescription is prescribed to a patient who then ingests the drug.<sup>1</sup> The second form is when a physician administers a lethal injection to the patient.<sup>2</sup> Patient autonomy and the value of life are at the forefront of the contentions surrounding medical assistance in dying.<sup>3</sup> There is a trend towards more permissive legislation for medically assisted dying in various countries around the world. The United States, however, has largely remained behind.

In 2016, in *Carter v. Canada*, the Canadian Supreme Court held that an absolute prohibition against medically assisted dying infringed on rights protected under the Canadian Charter of Rights and Freedoms.<sup>4</sup> Following the Supreme Court decision, the Canadian Parliament announced the country's new law Medical Assistance in Dying (MAiD) law, which would allow medical assistance in dying to adults with an incurable illness.<sup>5</sup> To receive MAiD, the patient must: (1) be eligible for government funded healthcare; (2) eighteen years old and mentally competent; and (3) have a grievous and irremediable medical condition.<sup>6</sup> In March of 2021, Canada implemented an expansion on the country's laws for medically assisted dying. The legislation expanded eligibility

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<sup>1</sup> NATHAN CORTEZ, GLENN COHEN & TIMOTHY S. JOST, READINGS IN COMPARATIVE HEALTH LAW & BIOETHICS, (3d ed. 2020).

<sup>2</sup> *Id.* at 367.

<sup>3</sup> *Id.*

<sup>4</sup> *Carter v. Canada*, 1 S.C.R. 331 (Can. 2015).

<sup>5</sup> Candice Player, *ARTICLE: DEATH WITH DIGNITY AND MENTAL DISORDER*, 60 *Ariz. L. Rev.* 115, 133 (2018).

<sup>6</sup> *Canada's Medical Assistance In Dying (MAID) Law*, CANADA.CA (March 9, 2023).

requirements and procedural pathways to allow a greater proportion of the country to be able to access medical assistance in dying. Currently, the government is considering whether the legislation should be expanded to allow MAiD in advance directives and eligibility for mental illnesses. The government initially set March 2023 as the date for when MAiD would be expanded to include mental illnesses; however, that has now been postponed until March 2024.

Compared to the legislation in the United States, Canada's MAiD is largely permissive. In the United States in 1994, Oregon passed the Death With Dignity Statute that allowed physicians to prescribe a lethal dose of medication to a competent, fully informed patient.<sup>7</sup> Nine other states followed suit and created their own state laws for medically assisted dying and Montana has decriminalized medically assisted dying as a result of a state court's interpretation of the criminal law. In this paper, I argue every state in the United States should follow the progression of Canada and expand its legislation for medically assisted dying. I argue fully informed, competent adults across the United States should have access to medically assisted dying. Furthermore, the states should expand their legislation by allowing advance directives to be used for medical assistance in dying. Lastly, I argue in the United States every state should expand its eligibility requirements; thus, allowing those suffering solely from a mental illness to have access to medical assistance in dying.

This paper discusses in detail the expansion of medically assisted dying in Canada under the government's new legislation, MAiD. It then proposes that in the United States every state should expand its legislation to allow all competent, fully informed adults to receive medical assistance in dying. Part I of this paper explains Canada's law for medically assisted dying under

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<sup>7</sup> Death With Dignity Act, Or. Rev. Stat. §§ 127.800-.897 (1994).

MAiD and how this compares to United States' legislation on medically assisted dying. Part II of this paper analyzes MAiD and the United States' legislation regarding general arguments and concerns for medically assisted dying. Then I conclude that competent, fully informed adults should be allowed to receive medical assistance in dying in the United States. Part II further discusses additional issues and benefits for MAiD concerning advance directives and mental illness. I then conclude that every state in the United State should allow MAiD in advance directives and should allow those suffering solely from a mental illness to be eligible. In Part III, I conclude that in the United States every state should adopt and expand laws for medically assisted dying to allow for advance directives and allow access to those with a mental illness.

## **I. MAiD and U.S. Legislation on Medically Assisted Dying**

Canada and the United States have varying legislation for medically assisted dying. In 2016, Canada created legislation to allow medically assisted dying in the entire country. Just below Canada, the United States has very restrictive and limited aid-in-dying laws. The right to medically assisted dying is not constitutionally protected<sup>8</sup>; thus, state legislatures must pass their own laws for there to be access to medically assisted dying. In this section, I first begin by outlining MAiD. I will then provide an overview of the state legislations for medically assisted dying in the United States.

### **A) Canada's Medical Aid in Dying Laws**

In the 2015 case of *Carter v. Canada*, the Canadian Supreme Court held that an absolute prohibition against medically assisted dying infringes on the right to life, liberty, and security of the person under the Canadian Charter of Rights and Freedoms.<sup>9</sup> The Court struck down portions

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<sup>8</sup> *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997)

<sup>9</sup> *Carter v. Canada*, 1 S.C.R. 331 (Can. 2015).

of the Canadian Criminal Code that prohibited medically assisted dying for competent adults who clearly consent and have a grievous and irremediable medical condition that causes enduring and intolerable suffering.<sup>10</sup> The Supreme Court gave the Canadian government a timeline to create a new law that no longer prohibited medical assistance in dying.<sup>11</sup> By June of 2016, Bill C-14 passed, which allowed Canadians to request medical assistance in dying. This law allowed both the administration of a lethal substance to a patient by a physician and a prescription of a lethal substance that the patient could self-administer.<sup>12</sup> To access MAiD, the patient must be eligible for government funded healthcare, be a mentally competent adult, and have a grievous and irremediable medical condition.<sup>13</sup> The legislation was met with support as most Canadians support the accessibility to medically assisted dying in at least some instances.<sup>14</sup>

The first stage to access MAiD is by requesting it. After a person speaks with their health care practitioner about the end-of-life options and decides MAiD may be an option, the patient must make a formal request.<sup>15</sup> The request is for a practitioner to prescribe the lethal medication that the patient can either self-administer or the practitioner may administer.<sup>16</sup> The patient must sign the formal request form or authorize a proxy to do so in the presence of the patient.<sup>17</sup> Two other independent witness must be present at the time of signature.<sup>18</sup> Following the formal request, two mandatory eligibility assessments must be carried out by two independent practitioners.<sup>19</sup> The

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<sup>10</sup> *Id.*

<sup>11</sup> *Canada's Medical Assistance In Dying (MAiD) Law*, CANADA.CA (March 9, 2023).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> Ryan Tanner, *ARTICLE: AN ETHICAL-LEGAL ANALYSIS OF MEDICAL ASSISTANCE IN DYING FOR THOSE WITH MENTAL ILLNESS*, 56 *Alberta L. Rev.* 149, 151 (2018).

<sup>15</sup> Rose Carter, *ARTICLE: MEDICAL ASSISTANCE IN DYING: JOURNEY TO MEDICAL SELF-DETERMINATION*, 55 *Alberta L. Rev.* 795, 795 (2018)

<sup>16</sup> *Id.* at 795.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* at 796.

practitioners then must provide written confirmation that the patient meets the requirements.<sup>20</sup> Once a practitioner is satisfied that the patient has met the criteria, the practitioner must approve the request in writing.<sup>21</sup> The practitioner who will provide MAiD must then create a plan with the patient on where, when, and how MAiD will be provided, as well as a potential complication plan.<sup>22</sup> The patient may withdraw their request at any time during the process.<sup>23</sup> After ten days have passed from the day the request was signed, MAiD may be provided.<sup>24</sup> Immediately prior to the administration of the substance, the practitioner must provide the patient with another opportunity to withdraw their request.<sup>25</sup> The practitioner must ensure the patient provided express, informed, and voluntary consent to receive MAiD.<sup>26</sup> Once the patient has died, the practitioner may have to notify the coroner depending on the jurisdiction.<sup>27</sup>

In 2021, the government of Canada stated it was committed to ensuring that the law reflected Canadian’s needs, protected those who may be vulnerable, and supported autonomy and freedom of choice.<sup>28</sup> To reflect these values, on March 17, the 2021 changes to Canada’s MAiD legislation became law.<sup>29</sup> The changes in Canada’s MAiD legislation changed the eligibility criteria. Those who wished to access MAiD no longer needed to meet the standard of a “reasonable foreseeability of natural death.” This change greatly expanded the population of those eligible for medically assisted dying; however, it also left many questions, specifically if advance directives will be permitted to contain provisions for medically assisted dying and when those with a mental

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<sup>20</sup> Id.

<sup>21</sup> Id.

<sup>22</sup> Id.

<sup>23</sup> Id. at 797.

<sup>24</sup> Id.

<sup>25</sup> Id.

<sup>26</sup> Id.

<sup>27</sup> Id.

<sup>28</sup> *Canada’s Medical Assistance In Dying (MAiD) Law*, CANADA.CA (March 9, 2023).

<sup>29</sup> Id.

illness will be eligible. As of March 17, 2021, a person who wishes to receive MAiD needs to be eighteen years old and have decision-making capacity, make a voluntary request, provide informed consent, have a serious and incurable disease or disability, be in an advanced state of irreversible decline in capacity, suffer from enduring and intolerable physical or psychological suffering that cannot be alleviated under “conditions the person considers acceptable,” and be eligible for publicly funded health care.<sup>30</sup>

The new legislation includes a two-track procedural safeguard approach. This divides the population into two groups, those whose death is reasonably foreseeable and those whose death is not.<sup>31</sup> Safeguards for both groups include that a request for MAiD must be made in writing and two independent doctors or nurses must provide an assessment.<sup>32</sup> For those whose death is not reasonably foreseeable, additional safeguards were imposed to “address the diverse source of suffering and vulnerability that could potentially lead a person who is not nearing death to ask for MAiD.”<sup>33</sup> The additional safeguards require the eligibility assessment to take ninety days, but this period can be shorted if the person is about to lose decision making capacity and if both assessments have been completed.<sup>34</sup> If neither of the two practitioners who assess the eligibility of the patient have expertise in the medical condition the patient is suffering from, the practitioners must consult with a practitioner who has the expertise.<sup>35</sup> The patient also must be informed of available and appropriate means to relieve their suffering such as counseling, mental health support services, and palliative care<sup>36</sup>, and “must be offered consultations with professionals who provide

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<sup>30</sup> Id.

<sup>31</sup> Id.

<sup>32</sup> Id.

<sup>33</sup> Id.

<sup>34</sup> Id.

<sup>35</sup> Id.

<sup>36</sup> Id.

those services.”<sup>37</sup> The patient and practitioners must also discuss reasonable and available means to relieve the suffering and agree the patient has seriously considered those means.<sup>38</sup>

Under MAiD, the final consent requirement can be waived for those whose death is reasonably foreseeable. However, the agreement to waive final consent is invalid if the person demonstrates refusal or resistance to the administration of MAiD. To demonstrate refusal, the patient can use words, sounds or gestures.<sup>39</sup> Involuntary movements do not constitute refusal or resistance.<sup>40</sup> The provision to waive the final consent requirement, known as “Audrey’s Amendment,” was implemented to protect individuals from accessing MAiD earlier than they would want to out of fear of losing decision-making capacity.<sup>41</sup> As a result, individuals will be able to access MAiD at a time closer to their natural death than before.

If those suffering from mental illness were eligible, the procedural safeguards would follow under the criteria for a person whose death is not reasonably foreseeable. For instance, “mental illness” includes conditions “that are primarily within the domain of psychiatry, such as depression and personality disorder.”<sup>42</sup> However, it does not include “neurocognitive and neurodevelopmental disorders or other conditions that may affect cognitive abilities.”<sup>43</sup> In addition, the patient and practitioner must discuss reasonable and available means to relieve the patient’s suffering, and agree that the patient has seriously considered those means.<sup>44</sup> As of March 17, 2024, persons suffering from a mental illness and meet the eligibility criteria will have access to MAiD.<sup>45</sup>

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<sup>37</sup> Id.

<sup>38</sup> Id.

<sup>39</sup> Id.

<sup>40</sup> Id.

<sup>41</sup> Id.

<sup>42</sup> Id.

<sup>43</sup> Id.

<sup>44</sup> Id.

<sup>45</sup> Id.



In April of 2021, Parliament established a Special Joint Committee on Medical Assistance in Dying to review MAiD and answer outstanding important questions.<sup>46</sup> The Special Joint Committee is a pan-Canadian “data collection and monitoring system established to monitor trends and provide information to the public.”<sup>47</sup> Specifically, the Committee’s purpose was to review and obtain evidence on advance directives for medically assisted dying. In addition, the Committee was tasked with reviewing and obtaining evidence regarding the expansion of the eligibility requirements to those who suffer with a mental illness.<sup>48</sup> On February 15th, 2023, the Committee released its report, titled *Medical Assistance in Dying in Canada: Choices for Canadians*.<sup>49</sup> In its report, the Committee concluded MAiD should be allowed in advance directives and those with a mental illness should be eligible for MAiD.<sup>50</sup> The Government of Canada has tabled its response to the reports submitted by the Committee until June 15, 2023.<sup>51</sup>

## **B) United States’s Medical Aid in Dying Laws**

Unlike Canada, the United States does not have federal legislation on medically assisted dying. In 1997, the United States Supreme Court held there was no constitutional right to aid in dying in *Washington v. Glucksberg*.<sup>52</sup> Individual States have implemented legislation at the state level to allow patients to access medically assisted dying. In 1994, Oregon became the first state to implement medically assisted dying in its Death With Dignity Act and became the model for other states to follow. As of 2023, ten jurisdictions have enacted their own legislation for medically

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<sup>46</sup> *Id.*

<sup>47</sup> Carter, *supra* note 15, at 801.

<sup>48</sup> *Canada’s Medical Assistance In Dying (MAID) Law*, CANADA.CA (March 9, 2023).

<sup>49</sup> *Id.*

<sup>50</sup> 44<sup>th</sup> Parliament, 1<sup>st</sup> Sessions, *Medical Assistance in Dying in Canada: Choices for Canadians: Rep. of the Special Joint Committee on Medical Assistance in Dying (2023)* (Can.).

<sup>51</sup> *Canada’s Medical Assistance In Dying (MAID) Law*, CANADA.CA (March 9, 2023).

<sup>52</sup> *Washington v. Glucksberg*, 521 U.S. 702 (1997).

assisted dying in the United States. These jurisdictions are Oregon<sup>53</sup>, Washington<sup>54</sup>, Vermont<sup>55</sup>, California<sup>56</sup>, Colorado<sup>57</sup>, the District of Columbia<sup>58</sup>, Hawaii<sup>59</sup>, New Jersey<sup>60</sup>, Maine<sup>61</sup>, and New Mexico.<sup>62</sup> The statutes in each jurisdictions have adopted the same basic restrictions on medically assisted dying and the substantive criteria are identical across the states.<sup>63</sup> Generally, states have adopted the following three requirements: (1) patients must be adults with decision-making capacity; (2) patients must self-administer the prescribed drugs; and (3) patients must be terminally ill.<sup>64</sup> A terminal illness means “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”<sup>65</sup> Most states have supplemented their legislation with other protections as well, such as requiring patients to reaffirm their request for medical assistance in dying over a fifteen-day period<sup>66</sup> and state reporting requirements.<sup>67</sup> Physicians must also certify that their patient is terminally ill and making the request for medically assisted dying voluntarily as well as inform the patient of risks, benefits, and alternatives.<sup>68</sup>

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<sup>53</sup> Death with Dignity Act, OR. REV. STAT. ANN. §§ 127.800-.897.

<sup>54</sup> Death with Dignity Act, WASH. REV. CODE ANN. §§ 70.245.010-.901.

<sup>55</sup> Patient Choice at End of Life, VT. STAT. ANN. tit. 18, §§ 5281-5293.

<sup>56</sup> End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443.1-.22.

<sup>57</sup> End-of-Life Options Act, COLO. REV. STAT. ANN. §§ 25-48-101 to -123.

<sup>58</sup> Death with Dignity, D.C. CODE ANN. §§ 7-661.01-.16.

<sup>59</sup> Our Care, Our Choice Act, HAW. REV. STAT. ANN. §§ 327L-1 to -25.

<sup>60</sup> Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-1 to -20.

<sup>61</sup> Death with Dignity Act, ME. REV. STAT. ANN. tit. 22, § 2140.

<sup>62</sup> Medical Aid In Dying, NM. ST. ANN. § 21-1-43.

<sup>63</sup> Lois Weithorn, *ARTICLE: PHSCHOLIGCLA DISTRESS, MENTAL DISORDER, AND ASSESSMENT OF DEICIONMAKING CAPACITY UNDER U.S. MEDICAL AID IN DYING STATUTES*, 71 *Hastings L.J.* 637, 648 (2020).

<sup>64</sup> DAVID ORENTLICHER & JUDIT SÁNDOR, *Decisions at the End of Life*, in *THE OXFORD HANDBOOK OF COMPARATIVE HEALTH LAW* (David Orentlicher ed., 2021).

<sup>65</sup> Weithorn, *supra* note 63, at 648.

<sup>66</sup> ORENTLICHER, *supra* note 64, at 23.

<sup>67</sup> Megan Wright, *ARTICLE: EQUALITY OF AUTONOMY? PHYSICIAN AID IN DYRING AND SUPPORTED DECISION-MAKING*, 63 *Ariz. L. Rev.* 157, 165 (2021).

<sup>68</sup> *Id.* at 165.

Physicians must also determine that the patient has contemporaneous decision-making capacity<sup>69</sup> and their request is voluntary.<sup>70</sup> This generally requires a “professional clinical judgment as to whether a specific individual has the requisite cognitive, decisional, affective, and practical abilities to be judged to have the ability to complete a specific task or make a specific decision.”<sup>71</sup> This assessment includes an evaluation of a patient’s ability to understand medical information, the significance of the information, reason about the risks and benefits of treatment, and ability to make a decision.<sup>72</sup> The statutes do not permit a proxy decisionmaker, advance directives, or powers of attorney to choose medically assisted dying.<sup>73</sup> This restriction precludes persons whose medical condition leads to incompetence prior to the six month life expectancy.<sup>74</sup>

Legislation in the United States is not as permissive as in Canada. In the United States, a physician cannot administer the lethal injection; thus, all patients must self-administer the lethal medication themselves.<sup>75</sup> In addition, the standard for those eligible to access medically assisted dying in the United States is different than that in Canada. Only persons who are terminally ill, defined as having a life expectancy of less than six months, are eligible.<sup>76</sup> Persons who are seriously and chronically, but not terminally, ill and persons who have impaired decision-making capacity, for example because of dementia, are ineligible for medically assisted dying.<sup>77</sup> In addition, mental disorders are not qualifying conditions under the statutes because they are not terminal illnesses.<sup>78</sup> The statutes were designed to minimize risks, such as the risk that a patient

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<sup>69</sup> *Id.*

<sup>70</sup> Weithorn, *supra* note 63, at 648.

<sup>71</sup> Wright, *supra* note 67, at 165.

<sup>72</sup> *Id.* at 166.

<sup>73</sup> Weithorn, *supra* note 63, at 648.

<sup>74</sup> *Id.*

<sup>75</sup> ORENTLICHER, *supra* note 64, at 22.

<sup>76</sup> *Id.* at 22.

<sup>77</sup> Wright, *supra* note 67, at 166.

<sup>78</sup> Weithorn, *supra* note 63, at 649.

who is not suffering from a serious and irreversible illness could access medically assisted dying.<sup>79</sup> Likewise, states have incorporated the substantive and procedural protections to protect against abuses, discrimination, and barriers to voluntary decision-making.<sup>80</sup>

## II. Analysis of Canadian and U.S. Legislation on Medically Assisted Dying

Canada's new MAiD legislation left many unanswered questions regarding advance directives and eligibility. Two major questions remain: (1) would advance directives for MAiD be allowed; and (2) whether those suffering solely from a mental illness would be eligible. On its face, MAiD appears to allow advance directives to contain provisions for medically assisted dying by waiving the final consent requirement. This is because a person whose natural death is reasonably foreseeable and has been approved and arranged for MAiD to be provided can enter into a written agreement consenting to the administration of MAiD if they lose capacity to consent.<sup>81</sup> Currently, those with a mental illness cannot qualify for MAiD, however, this is subject to change by March 2024 when those suffering from mental illness are expected to be eligible.

Compared to Canada's MAiD legislation, the United States has restrictive state legislation for medically assisted dying. Advance directives cannot contain provisions that allow a patient to receive medically assisted dying after they have lost decision making capacity. Those suffering from a mental illness are not eligible for medically assisted dying in any state. I argue that every state in the United States should adopt legislation to allow medically assisted dying, advance requests for MAiD, and to allow those with a mental illness to receive medical assistance in dying.

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<sup>79</sup> ORENTLICHER, *supra* note 64, at 22.

<sup>80</sup> Weithorn, *supra* note 63, at 663.

<sup>81</sup> 44<sup>th</sup> Parliament, 1<sup>st</sup> Sessions, Medical Assistance in Dying in Canada: Choices for Canadians: Rep. of the Special Joint Committee on Medical Assistance in Dying (2023) (Can.).

In this section I begin by providing an overview of general concerns regarding medical assistance in dying as it relates to poverty and disabilities. Although there are ethical concerns about MAiD, medical assistance in dying should be allowed and expanded in every state in the United States. From there, I describe and detail two remaining issues in MAiD that Canada is still considering: advance directives and mental illness eligibility. I conclude each section by arguing that the risks and concerns are outweighed by the benefits of medically assisted dying, thus MAiD should be allowed in every state in the United States. In addition, MAiD should be allowed in advance directives and those suffering solely from a mental illness should be eligible as well.

### **A. General Arguments for Medically Assisted Dying**

Supporters of medically assisted dying generally rest their arguments on the idea that medically assisted dying laws encourage patient autonomy and self-determination.<sup>82</sup> Supporters believe these principles should be the prominent values recognized for determining whether medically assisted dying should be allowed and that there is no legitimate reason to prevent competent adults from making their own informed medical decisions.<sup>83</sup> Further arguments state that by having a complete ban on medically assisted dying, countries are allowing intolerable suffering of their constituents.<sup>84</sup>

General concerns over poverty have also been a part of the conversation about medically assisted dying. Specifically in Canada, there is a concern for the “lack of appreciation” in how MAiD is offered to those suffering “directly related to or even caused by poverty and social injustice combined with interrelated disability.”<sup>85</sup> Opponents argue MAiD could be viewed as a fully funded and organized standard medical practice that could greatly affect impoverished

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<sup>82</sup> CORTEZ, *supra* note 1, at 367.

<sup>83</sup> *Id.*

<sup>84</sup> ORENTLICHER, *supra* note 64, at 21.

<sup>85</sup> Trudo Lemmens, *Turning Human Rights Upside Down: Parliament’s Fast Track Review of Canada’s MAiD Regime and the Push for Further Expansion*, U. OF TORONTO FACULTY OF LAW BLOG, (June 16, 2022).

groups.<sup>86</sup> Opponents believe MAID could normalize “killing as a solution” to those suffering that otherwise could live for an extended period of time.<sup>87</sup> Another fear is that MAiD would be expanding the power of physicians and nurses by asking them to solve socio-economic problems. Opponents argue physicians and nurses are not qualified to address these types of problems and they could fail to recognize the inherent biases and conflicts of interest associated with medically assisted dying.<sup>88</sup>

Following the discussion of poverty, it is important to mention another affected group that often overlaps with the impoverished: the disabled. Opponents argue that “the federal and some provincial governments, with overall support by health professional regulatory colleges and medical organizations, have prioritized facilitating disabled persons’ death, rather than providing them the essential components for a dignified life.”<sup>89</sup> Instead, opponents believe the Canadian government should be focused on a solution to provide funding to cut wait times and access to health care so that vulnerable groups do not resort to MAiD.<sup>90</sup> Opponents concede that MAiD costs less than state and community care for the disabled and thus creates an incentive for the government to guarantee access to MAiD but not to community support.<sup>91</sup> In addition, an incentive is created for disabled people to access MAiD when there is limited support for them, leading them to believe a better solution to suffering is death.

The argument for additional support for vulnerable groups is furthered by the limited availability of support and palliative care services for those with a disability, which may increase

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<sup>86</sup> Id.

<sup>87</sup> Id.

<sup>88</sup> Id.

<sup>89</sup> Id.

<sup>90</sup> Ramona Coelho, Trudo Lemmens, et. al., *Normalizing Death as “Treatment” in Canada: Whose Suicides do we Prevent, and Whose do we Abet?*, WORLD MED. J. (2022).

<sup>91</sup> Id. at 30.

their desire to access MAiD.<sup>92</sup> Statistics show that 10.2% of disabled people who received MAiD did not have access to disability support and that 18% who received MAiD did not receive any palliative care before MAiD.<sup>93</sup> The failure of a standard of care resulted in gaps in the care for those who wanted to access MAiD. The fear is that this gap would grow from an increase strain on support services and the disproportionate impact on vulnerable populations from the coronavirus pandemic and could result in an increase in people with disabilities opting for MAiD.<sup>94</sup>

Legal and ethical debates have erupted across the United States although legislation that supports medically assisted dying is present in only ten jurisdictions. Ultimately, where the States do have legislation for medically assisted dying, the legislation is much more restrictive than in Canada. The difference in breadth of the legislation in the United States compared to Canada has various factors.<sup>95</sup> Both health care systems are built on the principle of patient autonomy, yet the United States stresses freedom for everyone.<sup>96</sup> 58% of Americans “value the freedom to pursue life goals over the importance of guaranteeing that no one is in need, versus 43% of Canadians.”<sup>97</sup>

Much of the conversation regarding poverty and disabilities remains the same across the two countries. In 2019, the National Council on Disability voiced concerns about the legalization of medically assisted dying. In the report, the Council stated their fears that “some people’s lives, particularly those of people with disabilities, will be ended without their fully informed and free consent, through mistakes, abuse, insufficient knowledge, and the unjust lack of better options.”<sup>98</sup>

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<sup>92</sup> Sera Whitelaw, Trudo Lemmens, et al., *The expansion of MAiD in the Covid-19 Pandemic Era*, CANADIAN J. OF INTERNAL MED. (2021).

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> Anna Vargo, *Death With Dignity in Canada: No Longer Limited to Only the Terminally Ill*, 8 *Voices in Bioethics*, Vol. 2 (2022).

<sup>96</sup> *Id.* at 2.

<sup>97</sup> *Id.* at 2.

<sup>98</sup> BRIETTA R. CLARK, et al., *HEALTH LAW CASES, MATERIALS AND PROBLEMS*, 1395 (9th ed. 2022).

As seen in Canada, there is a fear that there are not enough adequate safeguards and oversight to protect the vulnerable populations. The report noted the impact of structural biases, including against minority and impoverished groups, that in the United States could increase in certain populations seeking out medical assistance in dying.

The state legislation on medically assisted dying in the United States is more restrictive than in Canada. For instance, United States' legislation only allows self-administration of a lethal drug.<sup>99</sup> Health care practitioners are prohibited from administering the medication.<sup>100</sup> Supporters of this restriction rest their argument on the idea that self-administration of lethal injections protects patients' rights to change their mind at the last minute.<sup>101</sup> Unfortunately, this provision leaves out another group of the population who also cannot receive medical assistance in dying: those who cannot swallow pills or those who are immobile.<sup>102</sup> Supporters of an expansion in the United States legislations on aid-in-dying argue it should be treated like any other medical procedure.<sup>103</sup> Patients do not typically self-administer injections; thus, the law should reflect this uniformity into aid-in-dying laws by not requiring patients to self-administer.<sup>104</sup>

As seen in Canada, there are opponents of state legislation for allowing medical assistance in dying. Opponents rest their arguments on coercion and concerns about consent.<sup>105</sup> In the United States, some medical groups oppose legislation. The AMA Council on Ethical and Judicial Affairs provides in their Code of Medical Ethics Opinion 5.7 that medically assisted dying is “incompatible with the physician’s role as healer.”<sup>106</sup> They believe it would be difficult to control

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<sup>99</sup> Weithorn, *supra* note 63, at 649.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> CLARK, *supra* note 97, at 1395.

<sup>103</sup> *Id.* at 1417.

<sup>104</sup> *Id.* at 1417.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.* at 1397.



medically assisted dying and lead to serious societal risks.<sup>107</sup> Opponents recognize the concern for autonomy and control over one’s own medical conditions, but instead conclude that the focus should then be on improving society and treatments so that patients do not want medical assistance in dying. A Disability Rights Group argued California’s law “steers people with terminal disabilities away from necessary mental health care, medical care, and disability supports, and towards death by suicide.”<sup>108</sup> Therefore, they argue that legalizing aid-in-dying laws, society is avoiding the underlying problem.

Although there are strong arguments on both sides of the debate, every state in the United States should adopt legislation to allow all fully informed, competent adults to receive medical assistance in dying. The underlying principle for health care should be patient autonomy and self-determination. MAiD in Canada reflects these values and the United States should follow in the same progressive path. In a 2020 report issued by the Oregon Public Health Division, the report found that the three most frequent concerns for those who wanted medical assistance in dying were: (1) “decreased ability to participate in activities that made life enjoyable (94%), (2) loss of autonomy (93%), and (3) loss of dignity (72%).”<sup>109</sup> The reasoning behind seeking medical assistance in dying is one of the main reasons why every state in the United States should adopt medically assisted dying legislation. The United States’ fundamental principles of freedom and autonomy should be reflected in its laws.

There is no question that like Canada, the United States needs additional support services for vulnerable populations, including the impoverished and disabled. However, empirical findings

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<sup>107</sup> *Id.*

<sup>108</sup> Don Thompson, *Disability Rights Group Sue to Overturn California’s Physician-Assisted Death Law*, KFF HEALTH NEWS, Apr. 25, 2023.

<sup>109</sup> CLARK, *supra* note 97, at 1395.

from the states revealed there have not been negative impacts on vulnerable groups.<sup>110</sup> A complete ban on medically assisted dying would hurt the groups that would benefit from the legislation the most because they could be forced to live a painful life. Additional services and medically assisted dying do not need to be mutually exclusive. Palliative care treatment can be improved along with passing laws for medically assisted dying. Palliative care can address most, but not all end-of-life suffering.<sup>111</sup> Some patients have pain that does not respond to standard treatments or are harder to alleviate than physical pain, including nausea, weakness, and loss of bodily functions.<sup>112</sup> Aside from pain, modern medicine and palliative care cannot cure “existential suffering and despair” patients can face.<sup>113</sup> The vulnerable can be protected with additional safeguards, without infringing on those who desire medically assisted dying.

In addition, those who are disabled could also benefit from an expansion of the laws. Disability advocates have emphasized the importance of respect for autonomy of persons with disabilities to counter stereotypes that those with disabilities are incapable of autonomy and decision-making.<sup>114</sup> Every state should adopt legislation that would allow physicians to administer the drugs for medically assisted dying. This would alleviate the issues for those who cannot swallow pills and for those who are immobile. Most importantly, it would allow for an extended life. Patients would no longer have to take the medication while they are still competent enough to do it themselves. Instead, patients could live longer by allowing physicians to administer the drugs. Although there is a fear that stigmatization of the impoverished and disabled could push them to seeking out medically assisted dying, a ban on medically assisted dying has vast consequences.

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<sup>110</sup> Weithorn, *supra* note 63, at 663.

<sup>111</sup> Player, *supra* note 5, at 133.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> Wright, *supra* note 67, at 168.

The consequences include forcing patients to suffer out of fear that some may be coerced into medically assisted dying. The hypothetical fear should not outweigh the clear benefits others could receive.

Arguments against medical assistance in dying based on a fear that the legislation would result in a large increase in people wanting to die can be rebutted. In a 2020 report issued by the Oregon Public Health Division, fewer than 1% of deaths resulted in medically assisted dying.<sup>115</sup> In 2020, 370 people in Oregon received medical assistance in dying and the median age was seventy-four years old.<sup>116</sup> Thus, after Oregon passed its aid-in-dying laws, the number of people that went through with the procedure was limited. In addition, the report stated, “As in previous years, most (those who received medical assistance in dying) were white (97%), well-educated (42% had at least a baccalaureate degree), and had cancer (66%).”<sup>117</sup> Most (90.2%) were enrolled in hospice and almost all (98.8%) were covered by private or public insurance.<sup>118</sup> The report indicates that medically assisted dying is largely requested by older adults who were battling cancer. The findings from other states issuing reports present a similar picture of demographics as well.<sup>119</sup>

In conclusion, states should adopt broader medically assisted dying laws as Canada has done. The United States focuses on principles of individualism, patient autonomy, and self-determination and this should be mirrored in law. Although there are important concerns with allowing medically assisted dying, the benefits of it outweigh the risks. To alleviate concerns, safeguards can be in place to ensure patients are fully informed. Competent adults should be

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<sup>115</sup> CLARK, *supra* note 97, at 1407.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> Weithorn, *supra* note 63, at 674.

<sup>119</sup> *Id.* at 675.

allowed to decide their own future and how they will die. Their dignity and personal choice are what legislation for medically assisted dying reflects. Thus, states should adopt laws to allow all competent adults to receive medical assistance in dying.

### **B. Extension of MAiD and U.S. Legislation for Advance Directives**

Under the expansion of MAiD, the last consent requirement is dropped for those whose death is reasonably foreseeable.<sup>120</sup> This waiver of final consent is referred to as “Audrey’s Amendment” and is a response to the concerns raised by Audrey Parker who received MAiD earlier than she would have wanted out of fear of losing her decision-making capacity.<sup>121</sup> Audrey Parker was battling cancer and wanted to access MAiD in 2018; however, because of the old law she needed to have decision-making capacity at the time she would receive MAiD.<sup>122</sup> Parker wanted to access MAiD after enjoying a final Christmas with her family, but because of the progression of her illness she was at risk of losing mental capacity. Instead, Parker received the procedure in November of 2018. Before her death, Parker called for a change to the legislation to protect those in the same situation as her. Parker could have lived a longer life and thus a change in the law was implemented to reflect her concerns. Supporters of this provision recall stories like Parker. They argue that by allowing this waiver of final consent, MAiD can be taken before there is a decline in capacity that would be accompanied by enduring and intolerable suffering. This law prevents individuals from ending their lives earlier than they otherwise would have to avoid losing competence.

After the implementation of this provision under MAiD, a question was left on whether advance directives could be used for medically assisted dying. In April 2021, the Canadian

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<sup>120</sup> *Canada’s Medical Assistance in Dying (MAiD) Law*, CANADA.CA (March 9, 2023).

<sup>121</sup> *Id.*

<sup>122</sup> Timothy Holland, *The Moderate Approach to Advance Requests for Medical Assistance in Dying in Advanced Dementia*, Dalhousie University (2022).

Parliament's Special Joint Committee on Medical Assistance in Dying was tasked with answering this question. The report found that Canadians support being able to make an advance request for MAiD.<sup>123</sup> The report also included testimony from doctors stating their patients with dementia have a desire for advance requests.

The report included a section dedicated to potential risks the Committee found for if advance requests for MAiD were allowed. Issues such as the difficulty in predicting the rate of decline in an individual, and the difficulty in anticipating what an individual might want in the future were at the forefront of the discussion.<sup>124</sup> It is often impossible to predict what medical circumstances a person will face one day, and it is equally impossible to predict what a person will prefer in terms of treatment when faced with illness.<sup>125</sup> Trudo Lemmens voiced his opinion that “advance consent is not true consent”<sup>126</sup> because it is not fully informed and cannot be withdrawn. Specifically, the Alzheimer’s Society argued that at the time a patient with dementia receives MAiD, their values may have changed from when they made their advance directive.<sup>127</sup> It is possible that preferences will change over time, especially as patients learn to cope with their illness.<sup>128</sup> If a patient had completed an advance directive based on earlier preferences and then lost decision-making capacity, the patient may be bound by past preferences they no longer remember or have, thus advance directives could create binding decisions.<sup>129</sup>

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<sup>123</sup> 44<sup>th</sup> Parliament, 1<sup>st</sup> Sessions, Medical Assistance in Dying in Canada: Choices for Canadians: Rep. of the Special Joint Committee on Medical Assistance in Dying (2023) (Can.).

<sup>124</sup> *Id.*

<sup>125</sup> Wright, *supra* note 67, at 167.

<sup>126</sup> *Id.*

<sup>127</sup> Kathryn Morrison, *Mature Minor Eligibility for Medical Assistance in Dying (MAiD): and Ethical Analysis* (2021) (Ph.D. thesis, University of Waterloo).

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

In interpreting advance directives, fears of abuse and coercion are at the forefront. The advance directive may not clearly indicate the patient's preferences or the physician may have difficulty in determining whether the preferences apply in the present circumstances.<sup>130</sup> This fear is enhanced when advance directives are interpreted correctly, but then not followed correctly.<sup>131</sup> Reports have indicated healthcare providers have disregarded advance directives.<sup>132</sup> One concern is that if a patient becomes incompetent it will be impossible to verify if the advance directive was made under duress.<sup>133</sup> A frequent concern is the fear that waiving express consent immediately prior to the procedure could blur the line between voluntary and involuntary MAiD and too much discretion could be left to the practitioner performing MAiD.

Problems with determining whether a patient is refusing the medication was also discussed. Dr. Lussier mentioned many patients in advance stages may resist contact and become aggressive when touched so there is a difficulty in deciding whether this would be a voluntary gesture that would result in the physician withholding the drugs.<sup>134</sup> In addition, there were arguments made that the country should focus on better support for people with dementia, palliative care, and hospice care.

The risks mentioned in the report were met with some answers on how to avoid them. For instance, opponents noted that by not allowing advance requests, the law in effect is telling those with dementia that they cannot be trusted to make their own medical decisions for their future

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<sup>130</sup> Thomas McMorrow, ARTICLE: THE WAXING AND WANING OF INFORMED CONSENT: MEDICAL ASSISTANCE IN DYING AND THE QUESTION OF ADVANCE REQUESTS, 58 Osgoode Hall L.J. 287, 299 (2021).

<sup>131</sup> Wright, *supra* note 67, at 168.

<sup>132</sup> *Id.*

<sup>133</sup> Morrison, *supra* note 126, at 24.

<sup>134</sup> 44<sup>th</sup> Parliament, 1<sup>st</sup> Sessions, Medical Assistance in Dying in Canada: Choices for Canadians: Rep. of the Special Joint Committee on Medical Assistance in Dying (2023) (Can.).

selves, and thus continues to stigmatize this group of the population.<sup>135</sup> In addressing whether a patient’s resistance to the lethal medication should result in the physician stopping treatment, the Committee concluded “while any conscious refusal or resistance should be respected, unconscious resistance could be addressed by including an advance request direction about what a clinician is to take, or not take, if there are signs of resistance.”<sup>136</sup> In addition, the Committee recommended a criteria that could be used to constitute what the patient considers to be “intolerable suffering,” such as being bedridden or not being able to eat.<sup>137</sup> This would also reassure clinicians that they were following the patient’s wishes at the time. To further reassure clinicians, the Committee recommended that patients must reaffirm their requests, so clinicians do not have to act on advance requests that were written decades prior. The Committee also noted the importance of forming resources to educate patients and protect the vulnerable population.

In its conclusion, the Committee recommended that advance requests be allowed for a diagnosis of a serious and incurable medical condition, disease, or disorder leading to incapacity.<sup>138</sup> It recommended advance directives in two instances: (1) where a person’s request has been accepted but the individual loses competence before MAiD takes place<sup>139</sup>; and (2) where a person has been diagnosed with a grievous and irremediable condition but is not yet experiencing enduring and intolerable suffering.<sup>140</sup> It recommended that the Government of Canada work with its provinces to adopt necessary safeguards for advance requests and to develop a framework for

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<sup>135</sup> Id.

<sup>136</sup> Id.

<sup>137</sup> Id.

<sup>138</sup> Id.

<sup>139</sup> Id.

<sup>140</sup> Id.

interprovincial recognition of advance requests.<sup>141</sup> The Government of Canada has tabled its response to this report until June 15, 2023.

Outside of the Special Joint Committee on Medical Assistance in Dying, support for allowing MAiD in advance directives is prevalent in Canada. Advance directives for MAiD would largely look like other types of written directive that are meant to respect autonomy after capacity has been lost.<sup>142</sup> The issue for advance directives rests on how to respect patient autonomy. Advance care planning is meant to ensure that patients’ “healthcare decision-making autonomy is respected throughout their life, even when they lack decision-making capacity.”<sup>143</sup> Proponents of advance directives for MAiD believe advance directives respect patient self-determination of their present decisions, but also their future decisions when they are no longer competent.<sup>144</sup> Supporters argue that advance directives will allow patients to decide their future medical care. On the other hand, opponents argue that patients cannot predict future suffering and thus the directives are not fully informed.<sup>145</sup> Requiring contemporaneous decisional capacity for medically assisted dying was meant to function as a final safeguard to protect the patient against mistake and abuse.<sup>146</sup> “Concerns about prediction of future suffering are accompanied by evidence that terminally ill patients’ desire to die fluctuates over time with predictor variables including depression.”<sup>147</sup>

Recommendations center around allowing patients to receive MAiD before their condition declines to the point that suffering is enduring and intolerable. Advance directives prevent suffering where MAiD had been approved but then the patient loses mental capacity. Most

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<sup>141</sup> *Id.*

<sup>142</sup> Wright, *supra* note 67, at 160.

<sup>143</sup> Morrison, *supra* note 126, at 23.

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> Wright, *supra* note 67, at 159.

<sup>147</sup> Morrison, *supra* note 126, at 23.



importantly, the recommendations prevent individuals from ending their lives earlier than they would otherwise to avoid losing competence. Regarding narrowing eligibility, some argue that safeguards to narrow cases in which advance requests for MAiD can be made, such as only in cases of irreversible unconsciousness or time limits, should be implemented.<sup>148</sup> However, this could create the risk of excluding patients with a strong desire for MAiD and leave them to suffer or end their lives prematurely, the exact scenario MAiD was created to avoid.<sup>149</sup>

In weighing the positives and negatives for allowing advance directives for MAiD, the positives weigh heavier. In the United States, every state should allow advance directives for medically assisted dying because of these benefits. Allowing advance directives would open the door to a group of the population that would otherwise want medically assisted dying, but because of their condition would lose decision-making capacity. The respect for patient autonomy is prominent. If a patient knows that they would want medically assisted dying, that is their choice and their decision to make. Advance directives encompass present and future decisions for patients. Not only do advance requests allow a patient to prevent suffering for themselves, but they also prevent suffering when medical assistance in dying has been granted, but the patient later loses decision-making capacity. Most importantly, it will deter patients from ending their lives prematurely like Audrey Parker. The purpose of advance directives for medically assisted dying is to avoid stories like Parker and that should be at the forefront of this issue. Her story is what outweighs the risks.

The risks associated with advance requests are notable. Regarding the fear that values can change over time, supporters suggest that advance directives should be continuously verified and

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<sup>148</sup> *Id.* at 26.

<sup>149</sup> *Id.* at 26.

updated while the patient still has decision-making capacity. This could potentially be satisfied by requiring a limit on the duration of the validity of the advance directive. Another safeguard that could mitigate this risk is by ensuring patients and physicians continuously discuss the options and circumstances of when a person would want to receive medical assistance in dying. Policymakers could consider implementing a monitoring system to ensure discussions are continued, although this may slow down the process of receiving medical assistance in dying.<sup>150</sup> Another safeguard could be to require a patient to provide details on what the patient qualifies as “intolerable suffering.”<sup>151</sup> Since “intolerable suffering” is subjective, a patient would have to specify. In the Special Committee’s findings, the report identified what witnesses would define as their “intolerable suffering.”<sup>152</sup> This included being bedridden, not being able to recognize family members, or not being able to eat.<sup>153</sup>

This concern goes together with the argument about involuntary refusals. Although MAiD in Canada allows the procedure to continue despite involuntary movements such as reflexes, state law should not adopt this aspect. This aspect alone comes with fears that physicians would be given too much discretion. Instead, the state legislation should ensure that movement that appears to be like a refusal of the drugs, even if the person has lost decision-making capacity, will stop the procedure, unless the patient specified involuntary movements would not stop the administration of the lethal injection. Although the Committee recommended advance directives to include what a physician should do if they are met with refusal or resistance, any refusal or resistance should immediately end the procedure in the United States.

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<sup>150</sup> Wright, *supra* note 67, at 159.

<sup>151</sup> 44<sup>th</sup> Parliament, 1<sup>st</sup> Sessions, Medical Assistance in Dying in Canada: Choices for Canadians: Rep. of the Special Joint Committee on Medical Assistance in Dying (2023) (Can.).

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

In conclusion, the states should adopt legislation to allow advance directives for MAiD. The United States should not go as far as MAiD in Canada may be going with their legislation, specifically the possibly of allowing procedures to continue despite refusal or resistance. At the forefront of this issue is patient autonomy and a patient's right to make their own medical decisions. A patient can know what type of procedures they might want in the future, and the laws should reflect their right to choose. Although the concerns are relevant, they are outweighed by the benefits advance directives could provide.

### **C. Expansion of Medically Assisted Dying for Mental Illness**

In the United States, people with only a mental illness and not a terminal illness are ineligible for medical assistance in dying. Canada's expansion of MAiD extended eligibility to those whose death is not reasonably foreseeable; thus, those whose only medical condition is a mental illness could be eligible. To qualify, the mental illness must be serious and incurable, and result in enduring and intolerable suffering that cannot be alleviated. Implementation of this has been delayed. In 2021, a two-year exclusion was put in place to allow additional time to study the impacts of MAiD on mental illness and to determine safeguards to protect those persons.<sup>154</sup> In December of 2022, the Government of Canada extended the two-year exclusion to allow additional time to design an appropriate system to address MAiD for mental illness. Thus, those with a mental illness will be eligible as of March 17, 2024.<sup>155</sup>

Supporters of this expansion of MAiD have focused primarily on patient autonomy. In 2020, the annual report on MAiD concluded the most common reason for requesting MAiD was

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<sup>154</sup> Morrison, *supra* note 126, at 26.

<sup>155</sup> *Id.*

the loss of ability to engage in meaningful activities.<sup>156</sup> Supporters argue “individuals have a protected right to make choices for themselves, no matter the timeline of their suffering.”<sup>157</sup> Since suffering and the quality of life are subjective matters, proponents state they are “best determined by the individual patient.”<sup>158</sup> Thus, by expanding MAiD’s eligibility to include those who suffer from a mental illness, the law essentially can uphold the principle of bodily autonomy by allowing patients to govern their own medical conditions and how they die.<sup>159</sup> Supporters argue the right of self-determination should weigh the heaviest in deciding a person’s medical care.<sup>160</sup> Supporters believe this is the most compassionate route to ease patients’ suffering without devaluing their life.

A key argument for expanding MAiD to those with mental illness is a matter of fairness and understanding. Supporters argue it would be unjust to allow those dying with a terminal illness to receive MAiD, but not those with mental suffering. Mental and physical suffering can create severe and significant pain, distress, and impairment in quality of life; thus, they should be treated equally.<sup>161</sup> Society has treated the symptoms of mental illness as “tolerant, transient, and sometimes the product of free will”<sup>162</sup> and as easier to treat and manage.<sup>163</sup> Society fails to recognize that the experience of a mental illness can result in physical manifestations from psychosomatic pain.<sup>164</sup> Proponents argue that psychological suffering is just as debilitating and should be just as important as physical pain.<sup>165</sup>

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<sup>156</sup> Vargo, *supra* note 94.

<sup>157</sup> *Id.*

<sup>158</sup> *Id.* at 2

<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

<sup>161</sup> *Id.* at 3.

<sup>162</sup> Tanner, *supra* note 14, at 158.

<sup>163</sup> *Id.* at 158.

<sup>164</sup> *Id.* at 161.

<sup>165</sup> *Id.* at 161.

However, even supporters have recognized the risks the expansion of MAiD can have on those with mental illnesses. There is already a stigma on mental illness, and many fear this expansion can have a negative impact on marginalized groups. Some fear that without eliminating the stigma on mental illness, those with mental illness and disabilities may feel an increased pressure of being a burden on society, especially to those who feel their lives aren't worth living, and encourage them to end their life prematurely.<sup>166</sup> Therefore, there is a fear that the expansion of MAiD will negatively impact vulnerable groups and may allow marginalized individuals suffering from loneliness and poverty to disproportionately seek and receive MAiD.<sup>167</sup>

Other concerns regarding the expansion of MAiD to those with a mental illness come from psychiatry clinicians and professionals. Health care practitioners generally believe in non-maleficence, that health care providers should do as little harm as possible, including extending life. Some health care practitioners opposed to this expansion of MAiD believe all treatments and interventions must be tried for an adequate period of time and demonstrably failed before the criteria of irremediability is met.<sup>168</sup> They argue that medically assisted dying for mental illnesses fails to appreciate “therapeutic significance of hope.”<sup>169</sup> For instance, the Canadian Psychiatric Association believes that those requesting MAiD for a mental illness should show that standard treatments have been “offered and used for a sufficient period of time”<sup>170</sup> and that “there are no other accessible, reasonable alternative treatments/interventions.”<sup>171</sup> To further their argument, they state that there is not sufficient scientific evidence that mental illness can be predicted to be

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<sup>166</sup> Vargo, *supra* note 94.

<sup>167</sup> Coelho, *supra* note 89.

<sup>168</sup> Jeffrey Kirby, *Interpreting Irremediability When a Mental Health Disorder is the Sole-qualifying Medical Condition for Maid*, CANADIAN JOURNAL OF BIOETHICS, 2023, at 85.

<sup>169</sup> Player, *supra* note 5, at 148.

<sup>170</sup> *Id.* at 85

<sup>171</sup> *Id.*

irremediable. They fear that those with a mental illness may be told that their condition is irremediable and can never improve, although that is difficult, if not impossible to predict. Those opposed believe mental health conditions could improve and MAiD will take that possibility away from those suffering.

A social justice view has also been adopted while analyzing mental illness eligibility for MAiD. This view stems from the idea that society needs to focus on the interests of those who have been and continue to be marginalized by society, thus society should support policy decisions that support these groups.<sup>172</sup> The social justice view for MAiD supports a restrictive view of the irremediability requirement because proponents want to ensure that those with a mental illness in these marginalized groups are not overrepresented in MAiD requests.<sup>173</sup> Opponents argue that a contributor to the suffering of mental illness is the failure of the healthcare system to respond to their needs in the first place.<sup>174</sup> The idea is that some mental illnesses are not actually irremediable but are not being treated effectively.<sup>175</sup> The goal is to ensure that the vulnerable populations are protected from a foreshortened life.<sup>176</sup> In contrast, another social justice view could argue that marginalized groups must be supported in order to make their own health related decisions and therefore, society should ensure these groups have support for MAiD.<sup>177</sup> By waiting for the mental health system to improve, society is then expecting those with a mental illness to continue suffering indefinitely.<sup>178</sup>

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<sup>172</sup> *Id.* at 86.

<sup>173</sup> *Id.* at 86.

<sup>174</sup> Tanner, *supra* note 14, at 164.

<sup>175</sup> *Id.* at 164.

<sup>176</sup> Kirby, *supra* note 165, at 86.

<sup>177</sup> *Id.* at 86.

<sup>178</sup> Tanner, *supra* note 14, at 164.

Every state should adopt legislation to allow those suffering from a mental illness that is incurable and results in enduring and intolerable pain and suffering to be eligible for medically assisted dying. Again, the driving force for this legislation should focus on patient autonomy and self-determination. By expanding medically assisted dying laws to allow those with a mental illness to be eligible, the laws would reflect compassion and understanding to this population. Although there is still a stigmatization surrounding mental illness, society is slowly recognizing and understanding that mental illness is as much of a sickness as physical illnesses. The law recognizes when a patient who is physically ill loses the ability to engage in meaningful activities, so the law should mirror this for mental illness as well. Suffering and quality of life are subjective matters and thus are best determined by the individual. The matter of equality across the law is important. The same “level” of suffering can be had from a physical and mental illness and the laws should treat that equally as a matter of fairness.

Although there are risks in allowing those with a mental illness to be eligible for medically assisted dying, there can be safeguards in place to mitigate these risks. On the one side of the argument, society does not want to add to the stigmatization of those with mental illness by the possibility of increasing a pressure that they are a burden on society. The idea that irreversible mental illness is difficult to predict adds another layer to the issue. On the other side of the argument, society should not want to further stigmatize this group by not allowing medically assisted dying for mental illnesses because it creates the negative connotation that their suffering is not as “bad” as those with a physical illness. To reconcile these conflicting views, safeguards such as the ones recommended from the Canadian Psychiatric Association should be implemented in United States legislation. Those requesting medical assistance in dying should show that standard treatments have been offered and that there are no other reasonable alternative treatments

or interventions. To further reconcile these issues, the patient should be required to verify with more than one physician that they are requesting medical assistance in dying for their suffering, and not because they feel they are a burden on society. Furthermore, by requiring the mental condition to be incurable and result in enduring and intolerable suffering, it could also alleviate some of the issues with vulnerable populations by ensuring that requests for medical assistance in dying is not due to loneliness or poverty.

In conclusion, every state in the United States should expand its medically assisted dying laws to allow those with a mental illness that is incurable and results in enduring and intolerable suffering that cannot be alleviated to be eligible. By doing so, the laws would be upholding the principles of patient autonomy and right to self-determination. In addition, it would be recognizing that mental illness can be just as debilitating as a physical illness, and thus could alleviate the stigmatization of mental illness by treating it the same as a physical illness. Safeguards can be implemented by requiring patients to show they were offered standard treatment or received standard treatment for a sufficient period of time and that no other reasonable alternative treatment is available.

### **III. Conclusion**

Under Canada's recent expansion of its medical assistance in dying laws, an uproar of an ethical and legal debate exploded. The legislation, MAiD, left many unanswered questions particularly regarding whether advance directives could include provisions for MAiD and whether those suffering from a mental illness would be eligible. Overall, the legislation was viewed in a positive light and has support across the country. Compared to the United States, the expansion of MAiD was largely permissive. In the United States, only ten jurisdictions allow for medical assistance in dying. Within these jurisdictions, the laws are more restrictive than those in Canada.



Every state in the United States should adopt legislation for medically assisted dying. Every state should allow all competent, fully informed adults to receive medical assistance in dying. In addition, advance directives should be allowed to include requests for medical assistance in dying, as long as safeguards are implemented to ensure the advance directive reflects the patient's true wishes. Every state should also expand eligibility to include those suffering solely from a mental illness. Safeguards should be implemented to ensure that patients suffering from a mental illness have an incurable illness that results in enduring and intolerable pain and suffering. Additionally, safeguards should ensure that standard treatment was offered or received for a sufficient period of time and there are no other alternative treatments that could alleviate the illness. Every state in the United States should move towards a more permissive approach as other jurisdictions across the world have already done.