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Irish Parliamentary Joint Committee on Assisted Dying

I thank the Committee for the invitation. I am a professor of law at the University of Toronto. I have been an expert witness for the Canadian government in two cases related to Canada's assisted dying law, and I was a member of the Council of Canadian Academies MAID Expert Panel. My work emphasizes the human rights dimensions and the professional regulatory challenges of MAID practice.

I supported the Canadian law when it focused on an already broad end-of-life context. I considered it a proper response to the Supreme Court *Carter* decision, which confirmed the role of the criminal law in protecting life but declared an 'absolute prohibition' of assisted dying unconstitutional. Parliament first carved out so-called 'MAID' as an exemption to the criminal code prohibition in the end-of-life context. But under pressure of advocates for broad access, MAID practice quickly went beyond the end-of-life context; and the government used a lower court decision to push through an expansion of the law to make it, de facto, available for disabled persons who are not dying; this notwithstanding opposition of about all disability organizations, Indigenous organizations, and law, medicine, and ethics experts; including 3 United Nations Special Rapporteurs and Experts on human rights, who warned that Canada's law discriminatory deprived disabled persons of the same protection that non-disabled persons continue to receive.

I am troubled by the normalization, even trivialization, of ending-of-life as a quasi-universal therapy for suffering in Canada's MAID law and practice. In 7 years, Canada has become the country with the highest number of euthanasia-deaths, more than 10,000 per year. Two Canadian provinces already bypass the percentage of euthanasia deaths of the Netherlands & Belgium, which legalized euthanasia in 2002. In Quebec, more than 7% now die by MAiD. The 2021 expansion of the law, which facilitates an early death of persons with disability, including soon also mental disability, will result in further increase.

Advocates see this as a confirmation of the inherent benefits of legalization. They focus on concerns about access, rather than protection. For market-capitalists, high numbers confirm consumer need. But HCP and state-funded ending-of-life is not a standard consumer good. It occurs in a challenging health care context, characterized by vulnerability, ambiguity; in the context of complex HCP-patient relations, a medical system with limitations and wait-times for needed care, pressures on caregivers and family members, growing rates of poverty, discrimination, Indigenous trauma, and so on. This context has been ignored by advocates for MAID. Or worse: some invoke it now as an acceptable remedy for gaps in care and social injustice; or they suggest it creates 'opportunities' for social reform.

Official data and case reports confirm that many Canadian lives were ended not because people wanted to die and ease the dying process. More than 35% considered being a burden on care-

givers and loved ones a source of their unbearable suffering. 57% indicated inadequate pain control (or concern), whereas inadequate pain relief should be rare with good care. 54% felt they lost dignity, an experience influenced by societal messaging and all-too-often 'confirmed' in the healthcare setting by ableist perceptions of the quality of disabled lives. About 1 in 5 indicated loneliness, and 3% even existential suffering.

The committee received more details about why we had this escalation. Overall, there has been a focus in the law, professional regulations, and practice, on the need for access to, rather than protection against premature death, reflecting a ill-informed perception of MAID as a constitutional right. This is reflected in the law and practice.

First: vague access criteria have been interpreted excessively broadly. Other jurisdictions have a terminal illness diagnosis with 6-months survival prognosis, offering at least some protection against premature death. Existing safeguards were abolished, and the law has already been expanded.

Second: Canada allows, and largely has physicians and nurse practitioners directly ending lives. This is associated with higher uptake than assisted suicide regimes..

Third: MAID is explicitly not treated as a last resort. Contrary to the few other liberal regimes (Belgium and the Netherlands), HCPs must not agree that no other options are left. There is no obligation to make sure care or support is made available and tried first. This has turned death into first-line therapy for often only remotely disease related suffering.

The emerging rhetoric and practice had rippling effects in the health care system and society at large, where we have witnessed a glorification of dying by MAID, with even congratulatory references to increased organ donations and cost-savings.

Individual case reports further illustrate the troubling normalization of offering death to patients with chronic illness and disability, often in a context of troubling social injustice.

I urge the committee to read and watch some of the detailed investigative reports: of Kiano Vafeian (23) who has diabetes and resulting vision loss, who was only saved because his mother discovered he had an appointment for MAID and launched a public letter writing campaign. Or of Rosina Kamis (41), who did not want to die, but was isolated and lonely, and struggling with poverty and chronic illness.

They and many others represent the price we pay for the aggressive promotion of MAID and should raise a red flag for other jurisdictions exploring legalization of the practice.