Broken to the Hope

The Right to Life, the UN Convention on the Rights of Persons with Disabilities, and Canada's Medical Assistance in Dying Act

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Abstract. The UN Convention on the Rights of Persons with Disabilities is a landmark international agreement recognizing the rights and equal status of disabled people. States Parties commit to protect the right to life of all such people and to promote their equal dignity. Canada ratified the convention in 2010. However, Canada's Medical Assistance in Dying Act, which received royal assent in 2016, allows for assisted suicide and euthanasia of those disabled people who have a grievous and irremediable medical condition. This essay contends that the act violates Canada's treaty obligations not to enact legislation inconsistent with the convention by jeopardizing the right to life of such people and placing them in a significantly unequal status within Canadian society. *National Catholic Bioethics Quarterly* 17.2 (Summer 2017): 225–233.

These juggling fiends no more believed
That palter with us in a double sense,
That keep the word of promise to our ear
And break it to our hope.

—Macbeth

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The UN Convention on the Rights of Persons with Disabilities (CRPD) is "the first comprehensive human rights treaty of the 21st century."[1] It is a landmark international agreement recognizing the rights and equal status of disabled people. States Parties (countries that accede to the CRPD) commit themselves to protect the right to life of all persons with disabilities and to promote their equal dignity. Canada ratified the CRPD in 2010, and it became effective in Canada that same year.

In June 2016, Canada's Medical Assistance in Dying Act received royal assent. The act allows for assisted suicide and euthanasia of those disabled people who have a "grievous and irremediable" medical condition. As this essay will explain, the act violates Canada's treaty obligations not to enact legislation inconsistent with the CRPD by jeopardizing the right to life of disabled people and placing them in a significantly unequal status within Canadian society.

Background of the CRPD

On December 19, 2001, the UN General Assembly created an ad hoc committee "to consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities."[2] At its second session in August 2003, the committee established a working group to prepare a draft convention. The committee began considering the draft the next year and approved a revised version in 2006 that contained an optional protocol allowing for individual complaints. The General Assembly adopted both proposals by consensus on December 13, 2006. They were open for signature on March 30, 2007, and came into force on May 3 the next year.[3]

The CRPD moves well beyond "viewing persons with disabilities as 'objects' of charity, medical treatment and social protection."[4] That said, a *deep concern* "about the disadvantaged and vulnerable situation faced by 600 million persons with disabilities around the world" remained a major motivating factor.[5] As the CRPD's preamble observes, although "discrimination against any person on the basis of

1. "Convention on the Rights of Persons with Disabilities (CRPD)" webpage, UN Division for Social Policy and Development Disability, 2017, https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html. For the text of the convention, see UN General Assembly, Resolution 61/106, "Convention on the Rights of Persons with Disabilities," December 13, 2006, https://www.un.org/ (hereafter, CRPD).

2. UN General Assembly, Resolution 56/168, "Comprehensive and Integral International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities," December 19, 2001 (hereafter, 2001 Convention), para. 1, https://www.un.org/.

3. The significance of signing is noted on the UN timeline for the treaty, in the entry for March 30, 2007: "Signature creates an obligation, in the period between signature and ratification or consent to be bound, to refrain in good faith from acts that would defeat the object and purpose of the treaty." UN Division for Social Policy and Development Disability, "Timeline of Convention Events," 2017, https://www.un.org/. See also CRPD, art. 45(1). The CRPD came into force thirty days after Deposit of the twentieth instrument of ratification, which occurred on April 3, 2008.

4. CRPD webpage, UN Division for Social Policy and Development Disability.

5. 2001 Convention, preamble.

disability is a violation of the inherent dignity and worth of the human person," disabled people "continue to face barriers in their participation as equal members of society and violations of their human rights."[6] In response, the CRPD "prohibit[s] all discrimination on the basis of disability and guarantee[s] to persons with disabilities equal and effective legal protection against discrimination on all grounds."[7] It requires States Parties to take all appropriate measures "to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse."[8]

Canada ratified the CRPD on March 11, 2010, and the convention came into force for Canada on April 12 of that year.[9] At the time of ratification, Canada made reservations to articles 12 and 33(2), but to no other provisions.[10]

The CRPD requires each State Party to submit an initial report to the UN Committee on the Rights of Persons with Disabilities within two years of adopting the CRPD and at least every four years thereafter.[11] Canada submitted its initial report on February 11, 2014,[12] almost four years after the CRPD came into force in Canada. Since the Medical Assistance in Dying Act was adopted in 2016, the report contains no reference to it. In its reply to the initial report, the Committee, seeking supplemental information, requested that Canada "inform the Committee about measures to ensure that the State party's legislation on assisted dying is in compliance with [article 10] of the Convention."[13] That article provides that "States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others."[14] Canada's Medical Assistance in Dying Act, which received royal assent

6. CRPD, preamble, items 8 and 11. Item 17 further observes that "women and girls with disabilities are often at greater risk, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation."

7. CRPD, art. 5(2).

8. Ibid., art. 16(1). See also art. 23(3).

9. See Canada, "Convention on the Rights of Persons with Disabilities: First Report of Canada," 2014, para. 1, http://www.ccdonline.ca/. Canada is considering accession to the CRPD's optional protocol. See UN Committee on the Rights of Persons with Disabilities, "List of Issues in Relation to the Initial Report of Canada: Replies of Canada to the List of Issues," March 20, 2017, para. 3, http://tbinternet.ohchr.org/.

10. See UN Treaty Collection, "Convention on the Rights of Persons with Disabilities," Status of Treaties, ch. IV, status as at July 5, 2017, https://treaties.un.org/. Given how foundational the right to life is for the exercise of other rights, any reservation to article 10 should be presumptively impermissible as "incompatible with the object and purpose of the present Convention." CRPD, art. 46(1).

11. See CRPD, art. 35(1) and (2).

12. See Canada, "First Report," para. 15.

13. UN Committee on the Rights of Persons with Disabilities, "List of Issues in Relation to the Initial Report of Canada," September 22, 2016, para. 16, http://docstore.ohchr.org/.

14. CRPD, art. 10. Concerning health care, art. 25(d) and (f) direct States Parties to "require health professionals to provide care of the same quality to persons with disabilities as to others … [and to] prevent discriminatory denial of health care or health services or food and fluids on the basis of disability."

on June 17, 2016,[15] contravenes article 10 of the CRPD and thus violates Canada's obligation under article 4(1)(d) "to refrain from engaging in any act or practice that is inconsistent with the present Convention."[16]

Canada's Medical Assistance in Dying Act

In form, the Medical Assistance in Dying Act creates exemptions from criminal liability for the provision of medical assistance in dying, which includes both directly administering a lethal drug to cause an eligible person's death and prescribing or providing it for self-administration.[17] Thus, the Medical Assistance in Dying Act legalizes not only assisted suicide but euthanasia by physicians and nurse practitioners.

The act exempts from criminal liability practitioners who provide "medical assistance in dying," pharmacists who dispense lethal drugs pursuant to such practitioners' prescriptions, and persons who do "anything for the purpose of aiding" practitioners in providing such assistance. The act also exempts any person who does "anything, at another person's explicit request," to aid that person's self-administration of such prescriptions.[18]

The act provides practitioners and persons aiding them parallel exemptions from liability for culpable homicide and for the administration of poison or other noxious thing. It also waives the rule that a patient's consent to death has no effect on the criminality of such acts.[19] Thus, since practitioners and persons who aid them are not

15. The act was adopted in response to *Carter v. Canada*, [2015] 1 SCR 331, which did not address Canada's treaty obligations under the CRPD. In the United States, Oregon, Washington, Vermont, California, and Colorado currently permit assisted suicide by statute or popular initiative. An assisted-suicide law in Washington, DC, went into effect in February 2017. In addition, Montana allows assisted suicide by judicial decree. See *Baxter v. Montana*, 2009 MT 449. Four European nations, Belgium, Luxembourg, the Netherlands, and Switzerland, openly and legally permit assisted suicide or euthanasia. See "World Laws on Assisted Suicide," Euthanasia Research and Guidance Organization, updated August 28, 2010, http://www.finalexit.org/.

16. CRPD, art. 4(1)(d). During committee debate on what became article 10 of the CRPD, Canada opposed addressing "causes of disability such as … issues that touch on bioethical debates" without further specification. CRPD Ad Hoc Committee, "Daily Summary of Discussions related to article 8: Right to Life," fourth session, August 25, 2004, https://www.un.org/. Given that the preceding discussion that afternoon covered abortion, medical experimentation, and forced treatment, "bio-ethical debates" probably did not refer to assisted suicide or euthanasia. Furthermore, given its contemporaneous opposition to Chile's proposed language—"States Parties reaffirm the inherent right to life of all [persons with disabilities] in the various stages of their life"—Canada's concern was most likely directed against including protections for the unborn. See Bret Shaffer, "The Right to Life, the Convention on the Rights of Persons with Disabilities, and Abortion," *Penn State International Law Review* 28.2 (Fall 2009): 265–287.

17. RSC, ch. C-46, sec. 241.1(a) and (b) (1985) (Can.).

18. Ibid., sec. 241(2), (3), (4), and (5). Curiously, the exemption does not apply when a pharmacist dispenses the drug to the prescribing practitioner directly. Sec. 241(5.1) also exempts health care professionals from criminal liability for providing information on "the lawful provision of medical assistance in dying."

19. See ibid., sec. 227(1), (2), and (4) and sec. 245(2)(a) and (b). The provision is drafted in general terms, not limited to the exemption from culpable homicide.

liable for these offenses when providing medical assistance in dying and since the term includes direct administration of lethal drugs, the Medical Assistance in Dying Act legalizes private persons' participation in euthanasia.[20]

All these exemptions only apply, however, when the patient has "a grievous and irremediable medical condition."[21] The act defines such a condition to include "a serious and incurable illness, disease or disability … in an advanced state of irreversible decline in capability … [where] natural death has become reasonably foreseeable, taking into account all of [the] medical circumstances, without a prognosis necessarily having been made as to the specific length of time … remaining."[22] What constitutes a "serious disability," an "advanced decline in capability," and a death that is "reasonably foreseeable" will vary with the practitioner.[23] Practitioners' discretion is practically unlimited, given that for criminal liability under the act, prosecutors must show beyond a reasonable doubt that practitioners' beliefs about any of these facts were both mistaken and unreasonable.[24]

To be "grievous and irremediable," the condition must also cause enduring suffering.[25] The requirement is satisfied, however, if the condition or any resulting decline in capability causes psychological suffering that the person finds intolerable and for which any possible remediation is unacceptable. This simply permits disabled persons to commit suicide if they find life with a disability intolerable and if a practitioner agrees that their level of incapacity is advanced and irreversible and that death is reasonably foreseeable—including death that is reasonably foreseeable only if treatment is withheld or withdrawn.[26] Thus, someone on dialysis, a ventilator, or even insulin for diabetes is potentially eligible for assistance in dying under the act.

The Medical Assistance in Dying Act offers a safeguard that requires a second practitioner to confirm in writing that the eligibility criteria are met. Knowing failure to comply is a criminal offense. In confirming such criteria, however, the second practitioner has the same broad discretion as the first, and the first must only "be

20. See ibid., sec. 227(5) and sec. 245(3). For purposes of the exemptions from culpable homicide and from the administration of poison or other noxious things, medical assistance in dying includes directly administering a lethal substance, as well as dispensing or providing it for self-administration. Medical assistance in dying is defined in sec. 241.1.

21. Ibid., sec. 241.2(1)(c).

22. Ibid., sec. 241.2(2)(a), (b), and (d).

23. The CRPD leaves the definition of persons with disabilities open, explaining that such persons "include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." CRPD, art. 1. That description is certainly broad enough to include patients with "a grievous and irremediable medical condition."

24. See RSC, ch. C-46, sec. 227(3) and sec. 241(6). Sec. 241.2(3)(a) requires practitioners to "be of the opinion that the person meets all of the criteria" laid out in the section. Sec. 241.3 adds that practitioners who knowingly disregard such criteria are criminally liable.

25. The given "illness, disease or disability or … state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable." RSC 1985, sec. 241.2(2)(c).

26. The decline in capability must be advanced and irreversible, but not necessarily progressive. See RSC, ch. C-46, sec. 241.2(2)(b).

satisfied" that he and the second are independent. Thus, for criminal liability to apply, prosecutors must prove beyond a reasonable doubt that the first practitioner "knowingly fail[ed]" to "be satisfied" that he and the second were not independent.[27] Given its extreme subjectivity, such a standard is nearly impossible for prosecutors to meet.

The act explains that such exemptions are justified as a balance "between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other."[28] However, by ratifying article 10 of the CRPD, Canada affirmed that, regardless of disability, "every human being has the inherent right to life" and pledged to "take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others."[29]

It cannot be gainsaid that the distressed eighteen-year-old, the long-term unemployed, the grieving parent, and others may also desire assistance in dying. Yet Canada denies them that wish, recognizing that "suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities."[30] Claiming that commonsense differences between a healthy adolescent and someone in advanced decline justify the distinction merely admits the fact of unequal treatment based on how quality of life is perceived.

Canada's Replies

The UN Committee received Canada's replies to its list of issues on March 3, 2017, and was scheduled to consider them with Canada's first report during its seventeenth session on April 3.[31] The replies claim that the Medical Assistance in Dying Act "includes safeguards to ensure that medical assistance is only provided in

27. See ibid., sec. 241.2(3)(e), sec. 241.3, sec. 241(3) and (6), sec. 227(2) and (3), and sec. 241.2(3) and (f). Sec. 241.2(6) specifies that such practitioners are independent if they "are not a mentor to the other practitioner or responsible for supervising their work; do not know or believe that they are a beneficiary under the will of the person making the [medical assistance in dying] request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death … or do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity."

28. Medical Assistance in Dying Act, 2016 SC, ch. 3, preamble, http://www.parl.ca/Content/Bills/421/Government/C-14/C-14_4/C-14_4.PDF.

29. CRPD, art. 10. See also Medical Assistance in Dying Act, preamble: "It is important to affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled."

30. Medical Assistance in Dying Act, preamble.

31. Canada claimed that, under the act, "patients must be given the opportunity to withdraw their request immediately before medical assistance in dying is provided." UN Committee on the Rights of Persons with Disabilities, "Replies of Canada to the List of Issues," para. 28. This is potentially misleading. The act defines medical assistance in dying to include, in part, the prescribing or providing of a lethal substance for self-administration. RSC, ch. C-46, sec. 241.1(b). Nothing in the act, however, requires that patients be given such opportunity immediately before they self-administer the drug. See also UN Committee on the Rights of Persons with Disabilities, "Committee on the Rights of Persons with

response to a truly voluntary request that reflects the wishes of the patient and that is not made as a result of external pressure or coercion."[32] On examination, however, the claimed "robust safeguards"[33] fall far short of ensuring genuine choice.

Unlike comparable legislation in the United States, the Medical Assistance in Dying Act does not require practitioners to refer patients for psychological or psychiatric evaluation if they suspect clinical depression or other mental disorders that can impair judgment.[34] Given that many people seeking suicide suffer from clinical depression and often lose the urge to end their lives when the condition is treated, the absence of such a requirement undermines the claim that Canada is protecting true choice.[35]

The act repeats many of the flaws found in its US counterparts, however.[36] For example, once a prescription is written and the lethal drug is dispensed, the prescribing practitioner's duty to the patient under the act ends. He is not obliged to reevaluate the patient's competence before the drug is taken, even though weeks or months may pass and a decline in capacity may occur.[37] Nor is he obliged to be present when the drug is taken[38] (and, in the United States, the practitioner is seldom present).[39] The act is more a safe haven from liability for practitioners who follow

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Disabilities Holds Its Seventeenth Session in Geneva from March 20 to April 12," news release, March 16, 2017, http://www.ohchr.org/.

32. UN Committee on the Rights of Persons with Disabilities, "Replies of Canada to the List of Issues," para. 28.

33. Medical Assistance in Dying Act, preamble.

34. The few American jurisdictions that permit assisted suicide have patterned them after legislation first adopted by Oregon in 1994 and then by Washington State in 2008. "If in the opinion of the attending … or … consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life … shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment." Or. Rev. Stat. § 127.825 (2015). The Revised Code of Washington is almost identical to the Oregon statute; see Wash. Rev. Code § 70.245.060 (2009).

35. "Research indicates … that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." *Washington v. Glucksberg*, 521 US 702, 730–731 (1997).

36. See Stephen L. Mikochik, "Unwelcome Guests: Disabled People and the New Eugenics," *University of St. Thomas Law Journal* 13 (Fall 2016): 94–98.

37. In 2016, Oregon reported a median of fifty-six days between the first oral request for assisted suicide and death, with a range of 15 to 539 days. Oregon Health Authority, "Oregon Death with Dignity Act: Data Summary 2016," February 10, 2017, 11, http://www.oregon.gov/. Similarly, in 2015, Washington State reported a lapse of twenty-five weeks or more between the first oral request and death for thirty-two patients. Washington State Department of Health, "2015 Death with Dignity Act Report: Executive Summary," 2016, 8, http://www.doh.wa.gov/.

38. Even when a patient requests euthanasia, the physician's presence is not required, since someone else aiding the physician can administer the drug. See RSC, ch. C-46, sec. 227 (5), sec. 241(3), and sec. 245(3).

39. Based on Oregon's annual reports for 2001 to 2016, prescribing physicians were present when 163 of 1,057 patients (15 percent) ingested the lethal drugs. Oregon Health Authority, "Data Summary 2016," 10. Similarly, in Washington for 2009 to 2015, prescribing

its checklist than an assurance that death is actually the result of competent choice.[40] Furthermore, persons who are financially interested in the patient's death may be the only witnesses present when the lethal drug is taken, since the act fails to require that an objective observer be present at the person's death. This is an open invitation for patient abuse, since no one will know if the patient resisted.[41]

Finally, any administrative oversight of the safeguards is ultimately discretionary. Canada's health minister can exempt "on any terms that may be specified, a class of persons" who receive "a written request for medical assistance in dying" or who dispense "a substance in connection with the provision of … [such] assistance" from providing information "relating to requests for and the provision of … [such] assistance" that the minister "considers necessary … for the purpose of monitoring … [that] assistance." Practitioners and pharmacists cannot be held criminally liable for failing to comply with regulations from which they are exempted.[42]

Though the safeguards fail in other respects,[43] it is unnecessary to provide an exhaustive list since, even if it is scrupulous in safeguarding choice, the Medical Assistance in Dying Act protects only the choice of disabled persons, those with "grievous and irremediable" conditions.[44] This does not enhance their dignity but discounts their worth, since persons are simply not made equal by making them dead.

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physicians were present when 31 of 651 patients (5 percent) ingested the lethal drugs. Data from Washington State Department of Health, Death with Dignity annual reports for 2009 through 2015, at "Death with Dignity Data," WADOH, accessed June 15, 2017, http://www.doh.wa.gov/.

40. See RSC, ch. C-46, sec. 241.2(3).

41. See Margaret K. Dore, "Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice," *Vermont Bar Journal* 36.4 (Winter 2011). Secobarbital is the drug most often prescribed in Oregon and Washington for assistance in suicide. See Oregon Health Authority, "Data Summary 2016," 10; and Washington State Department of Health, "2015 Executive Summary," 8. The drug is soluble in water and alcohol and can be mixed into a reluctant patient's drink. See "Seconal Sodium," RxList, accessed June 15, 2017, http://www.rxlist.com/.

42. RSC, ch. C-46, sec. 241.31.

43. For example, although persons must make a written request for medical assistance in dying at least ten clear days (excluding the day the request is made) before such assistance is given, the first practitioner can shorten that time if he and the second practitioner believe that "the loss of … [such person's] capacity to provide informed consent … is imminent." Ibid., sec. 241.2(3) (g). This raises the prospect of failing patients being pressured to agree. Practitioners can also shorten the time if they believe death is imminent. Ibid., sec. 241.2(3) (b) and (i). This provision appears to be tailored to persons receiving assisted nutrition and hydration or other life support, so that they can receive assistance in dying as soon as such support is withdrawn. Compare to CRPD, art. 25(f), which requires States Parties to "prevent discriminatory denial of … food and fluids on the basis of disability."

44. A report submitted to the Committee on the Rights of Persons with Disabilities by the Canadian Civil Society Parallel Report Group, which comprises sixteen disability rights organizations, identified serious problems with the act's post-enactment implementation. For example, "at present, there is no coordinated record keeping supporting federal oversight of the practice [under the act]." The report concluded that "without data to track

Lost Opportunity

When the Committee adopted its concluding observations on April 10, 2017, it expressed concern about Canada's "adoption of legislation that provides for medical assistance in dying, including on the grounds of disability."[45] The Committee stopped short, however, of declaring that the Medical Assistance in Dying Act "contradicts the object and purpose of the Convention … and prevents the State party from fully implementing and addressing all human rights of persons with disabilities."[46]

Canada's Medical Assistance in Dying Act is incompatible with disabled persons' right to life under article 10 of the CRPD, and in its concluding observations on Canada's initial report, the Committee should have stated that emphatically as a principle topic of concern.[47] Given the fundamental importance of that right, the Committee's failure to declare such legislation inconsistent with article 10 compromises the very foundation of the CRPD and renders its assurance of equality "only a promise to the ear to be broken to the hope."[48]

requests and the reasoning for their denial or granting, it is impossible to know the extent to which 'negative perceptions of the quality of life' of disabled persons factor in calculations of eligibility." Canadian Civil Society Parallel Report Group, "Parallel Report for Canada," UN Committee on the Rights of Persons with Disabilities, February 27, 2017, 15, http://www.tbinternet.ohchr.org/.

45. UN Committee on the Rights of Persons with Disabilities, "Concluding Observations on the Initial Report of Canada," April 10, 2017, para. 23, http://www.tbinternet.ohchr.org/. The Committee was "also concerned about the absence of regulations for monitoring medical assistance in dying, the absence of data to assess compliance with the procedural safeguards regarding such assistance, and the lack of sufficient support to facilitate civil society engagement with and monitoring of this practice."

46. Ibid., para. 7. In contrast, the Committee was willing to reach this conclusion regarding Canada's continued reservation to art. 12 of the CRPD, preserving its substitute decision-making practices.

47. See UN Committee on the Rights of Persons with Disabilities, "Working Methods Adopted at Its Fifth Session (11–15 April 2011)," April 15, 2011, paras. 13–14, http://www.tbinternet.ohchr.org/; and CRPD, art. 36(1). A clear declaration by the Committee could serve to deter other States Parties from enacting similar assisted-suicide legislation.

48. "Unless this Court is willing to say that citizenship of the United States means at least this much to the citizen, then our heritage of constitutional privileges and immunities is only a promise to the ear to be broken to the hope, a teasing illusion like a munificent bequest in a pauper's will." *Edwards v. California*, 314 U.S. 160, 186 (1941).