BRIEF submitted to the Commission spéciale sur l'évolution de la Loi concernant les soins de fin de vie

Jocelyn Downie

May 24, 2021

My name is Jocelyn Downie and I'm the James S Palmer Chair in Public Policy and Law and a University Research Professor at Dalhousie University. I offer the following comments against the following backdrop of experience. First, I have been researching and writing on medical assistance in dying for a long time so I've seen the arc of progress (with all its many fits and starts). Second, I bring a perspective from outside Quebec (but having followed Quebec closely). Third, I work at the intersection of law, ethics, and policy and if ever there was an issue that needed that approach, MAiD is it. Fourth, I've been intimately involved in many of the prior processes relating to the topics that are before you as a Committee ranging from special consultant to the first Special Senate Committee on assisted dying in the early 1990's[1] to being a member of the plaintiff's legal team in *Carter*,[2] to being a member of the Royal Society of Canada Expert Panel on End of Life Decision-Making,[3] the Provincial Territorial Expert Advisory Group on Physician Assisted Dying,[4] and the Council of Canadian Academies Expert Panel on Medical Assistance in Dying[5] (specifically, the mental disorders Working Group[6]). Finally, because I led an independent process of experts exploring what the federal and Quebec governments should do in response to the *Truchon* decision and the removal of "reasonably foreseeable" and "end of life" from their respective laws and MAiD where mental disorder is the sole underlying medical condition (MD-SUMC).[7]

To prepare this brief, I first looked at the Committee's mandate. I then went to my files and pulled out all of the government committee and expert panel reports and court cases in Canada

---

[1] Special Senate Committee on Euthanasia and Assisted Suicide, Of Life and Death: Final Report (1995) https://sencanada.ca/content/sen/committee/351/euth/rep/lad-e.htm
[2] *Carter v. Canada (Attorney General)* 2015 SCC 5.
[3] Royal Society of Canada Expert Panel on End-of-Life Decision Making, End-of-Life Decision Making (2011) https://rsc-src.ca/sites/default/files/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf
[4] Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report (2015) https://novascotia.ca/dhw/publications/Provincial-Territorial-Expert-Advisory-Group-on-Physician-Assisted-Dying.pdf
[5] Council of Canadian Academies Expert Panel on Medical Assistance in Dying, Medical Assistance in Dying (2018) https://cca-reports.ca/reports/medical-assistance-in-dying/
[6] Council of Canadian Academies Expert Panel on Medical Assistance in Dying (The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition), The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition (2018) https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-Where-a-Mental-Disorder-is-the-Sole-Underlying-Medical-Condition.pdf
[7] The Halifax Group, MAiD Legislation at the Crossroads: Persons with Mental Disorders as Their Sole Underlying Medical Condition (2020) https://irpp.org/wp-content/uploads/2020/01/MAiD-Legislation-at-a-Crossroads-Persons-with-Mental-Disorders-as-Their-Sole-Underlying-Medical-Condition.pdf

that dealt with mental illness as a sole underlying medical condition and requests for MAiD made in advance of loss of decision-making capacity. And I made a Table. Who said what about the issues before this Committee. It's stark when it's on one piece of paper (see Table appended to this brief). Support for MAiD MD-SUMC and advance requests is overwhelming from the very groups that have reviewed and assessed all of the evidence and arguments and had a mandate to make policy recommendations or decisions.

So my first message is … it's time. In fact, it's past time to stop debating **whether** we should allow each of these and instead we should focus on **how** to regulate/implement them both. Especially in Quebec as you are uniquely prepared to take this step. You had your original Special Committee of the National Assembly[8] followed by a legal experts report[9] when you took your first steps along the MAiD path. Then recently you had another Expert Panel report that dug deep into the evidence and arguments about MAiD and decisional-incapacity. And, of course, the *Truchon* case. And you also had the Association des Médecins Psychiatres du Québec Committee report that dug deep into the evidence and arguments about MAiD and mental disorders. You can also draw upon the work done outside Quebec – including the Royal Society of Canada Expert Panel, the Provincial/Territorial Expert Advisory Group, the Special Joint Committee of the House and the Senate,[10] and The Halifax Group – all groups that have studied and made recommendations on the issues that are before you.

Mental disorders

Now before moving to the question of "how" to regulate and implement MAiD MD-SUMC, I'd like to make one quick point about "whether". You will hear arguments against allowing MAiD MD-SUMC. One thing that doesn't get enough attention is the extent to which these arguments were heard and roundly rejected in *Truchon v Canada (Attorney General) and Quebec (Attorney General)*.[11] Of course the plaintiffs in the *Truchon* case were not individuals with mental disorders. However, the issue of MAiD MD-SUMC was before the court because of the implications for MAiD for mental disorders of striking down the eligibility criteria of "natural death has become reasonably foreseeable" or "end of life". Justice Baudouin heard considerable evidence about the experiences in other jurisdictions with MAiD MD-SUMC and indeed most if not all of the arguments you will hear against MAiD MD-SUMC. These include the impact on suicide, suicide prevention, and suicide contagion, the relationship between suicide and MAiD , clinicians' ability to assess capacity in persons with mental disorders, the role of cognitive distortions, whether clinicians can ever say that a person's condition is irremediable, the possibility of errors, the normalization of MAiD, impact on the perceived

[8] Quebec National Assembly Select Committee on Dying with Dignity, Dying with Dignity: Report (2012) http://eoldev.law.dal.ca/wp-content/uploads/2019/11/Select-Committee-Dying-With-Dignity.pdf
[9] Committee of Legal Experts, Report of the Committee of Legal Experts on the implementation of the recommendations of the Special Commission of the National Assembly on the Question of Dying with Dignity (2013) http://eoldev.law.dal.ca/wp-content/uploads/2020/01/quebec-MAiD-report-2019.pdf
[10] Special Joint Committee on Physician-Assisted Dying, Medical Assistance in Dying: A Patient-Centred Approach (2016) https://www.parl.ca/DocumentViewer/en/42-1/PDAM/report-1
[11] *Truchon v. Canada (Attorney General) and Quebec (Attorney General)* 2019 QCCS 3792

value of the lives of vulnerable groups (including persons with mental disorders), slippery slopes, and social determinants of health and vulnerability. Justice Baudouin considered and weighed the evidence against MAiD MD-SUMC and found it wanting. I encourage you to read or reread her decision and recall that, unlike the people appearing before you or publishing their opinions, the witnesses in *Truchon* were under oath and, more importantly, were cross-examined in court.

With that, let's look at the **how**.

I imagine that you will have already generated a comprehensive list of recommendations that have been made with respect to the "how" to regulate/implement MAiD in the presence of mental disorders. Allow me to engage with some of them:

First, systems-level recommendations:

- Recommend improving and increasing access to mental health services and social supports and services (especially in rural, remote, underserved and marginalized communities) **particularly for persons with chronic, difficult to treat, mental disorders**. It is important to note that this is not a motherhood and apple pie call for increased supports and services for mental health services and social supports. Of course we would all love to see such increases. But your process is about MAiD and mental disorders and it is a very specific and small cohort of individuals with mental disorders who will be eligible for and want MAiD. So this is a very targeted call for better access. We need not remedy all of the deficiencies in the system in order to ensure adequate protections are in place re: MAiD for mental disorders.

- Recommend supporting the development of training and continuing education programs for clinicians willing to be involved in MAiD MD-SUMC. It is important to emphasize that this recommendation is not being made because this is about mental disorders *per se* – it is essential to avoid exceptionalizing mental disorders in all that you do because exceptionalizing leads to stigmatizing and discriminating. Rather, it is because this is a novel category for MAiD in Canada and so, as with all novelties, warrants training and education efforts.

- Recommend supporting the establishment of one or more consultation services for providers and assessors. The idea is a service to which clinicians can turn for prospective guidance with respect to specific challenging cases. They may be province wide and/or at the level of local hospitals (I am agnostic as to which would work better and consultation with assessors and providers would be essential for the design). But I would argue that consultation services must be independent of the oversight system (the CSFV). I would also recommend that this service be for all complex cases – in recognition of the fact that mental disorders do not have a monopoly on complexity.

- The AMPQ Committee recommended the creation of a new clinical administrative entity (to ensure appropriate access to psychiatrists and structure for prospective oversight)[12]
    - You are very lucky in Quebec to have a culture of seeing access to MAiD as a social obligation (not a responsibility resting solely on shoulders of individual clinicians). It would be great to have this formalized in an entity with the responsibility to ensure that each request is addressed within a specified timeframe. Recommend this.
    - I also think that the administrative functions proposed by the AMPQ Committee make good sense. Recommend them.
    - However, I have a concern about what they characterized as the "substantive roles".
        - I don't believe that **prospective** oversight is justifiable. First, the recommended role is limited to checking documents yet clinicians doing MD-SUMC are no more likely to not do the documents right for MAiD MD-SUMC than for other types of MAiD. Furthermore, I fear a repeat of the Morgentaler situation – a legally mandated bureaucratic requirement put in place ostensibly to protect women but the "therapeutic abortion committees" turned into an insurmountable (and indefensible barrier to access) – and led to the law being struck down.[13] It seems to me that the benefit of prospectively checking documents is outweighed by the burden of delays that can result in absolute barriers.

- I would also urge you to pay attention to MAiD in jails and recommend ensuring there is a mechanism for provision of MAiD in jails. According to the Mandela rules – the state must provide access to health care in jails that is available in community and some people will not want to leave jail for MAiD. Even more important though is to recommend that the government work on the mechanism for compassionate release from provincial jails – I have reviewed the federal approach to release and it is profoundly flawed. I'm afraid that I don't know enough about the Quebec system but I would, like the AMPQ Committee, flag this as needing special attention. Again, this recommendation would apply to MAiD for physical disorders too but it warrants special mention here and your specific attention in the context of your mandate given the disproportionately high rates of mental illness among people in jails.[14]

---

[12] Association des Médecins Psychiatres du Québec, Access to medical assistance in dying for people with mental disorders: Discussion Paper (2020) https://ampq.org/wp-content/uploads/2020/12/mpqdocreflexionammenfinal.pdf [AMPQ Report]

[13] *R v Morgentaler* [1988] 1 SCR 30.

[14] For full details on statements in this paragraph, see Adelina Iftene and Jocelyn Downie "End-of-Life Care for Federally Incarcerated Individuals in Canada" (2020) 14:1 *McGill JL & Health* 1. https://www.canlii.org/en/commentary/doc/2020CanLIIDocs551#!fragment//BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoByCgSgBpltTCIBFRQ3AT0otokLC4EbDtyp8BQkAGU8pAELcASgFEAMioBqAQQByAYRW1SYAEbRS2ONWpA. See also Jocelyn Downie, Adelina Iftene, and Megan Steeves, "Assisted Dying for prison populations: Lessons from and for abroad" *Medical Law International* (2019) https://works.bepress.com/adelina-iftene/12/

Let’s look now at some individual case-level recommendations:

- First, I would encourage you to recommend requiring that one of the assessors be a psychiatrist where a mental disorder is the reason for request or is tied up with a PD as the reason for the request. Now I must tell you that when I first heard this suggestion, I objected to it. Why exceptionalize mental disorders in this way? People weren’t suggesting requiring that assessors be specialists in MAiD for physical disorders. However, I have come to understand that this recommendation is grounded in a concern that does map onto mental disorders – these are cases in which the assessments of eligibility are inextricably linked to the different training that psychiatrists receive compared to other clinicians. The requirement is a recognition of the professional competencies required in the specific instance of MD-SUMC or where there are mental and physical comorbidities because of the interdigitation of the features being assessed for MAiD eligibility and the unique professional training and competencies of psychiatrists. Note that I am not here endorsing the recommendation that others have made that both assessors must be psychiatrists.[15] I have not been persuaded that that level of expertise in both clinicians is necessary. In assessing my recommendation, it is important to bear in mind that if the non-psychiatrist does not have the self-assessed professional competency to conduct the required assessments, they are already under a professional obligation to consult someone with the expertise or transfer the process to another clinician and we already rely on clinicians to be self-aware re: their competencies and not act outside of them.[16]

- Second, some people have suggested (directly or indirectly) that a person has to have tried treatment before being given access to MAiD.
    - One example given here in an effort to illustrate the concern motivating the requirement is a 19-year-old who shows up in ER, depressed, girlfriend just broke up with him, refuses all treatment and asks for MAiD – BUT this person won’t meet the existing eligibility criteria for MAiD[17] (e.g., advanced state of irreversible decline in capability). You don’t need to create/rely on an additional obligation to have tried treatment (or make that a condition of a finding of “incurability”) to prevent him from getting MAiD. Another example given is a person who has had a diagnosis for a couple of years, has tried a few things, hasn’t had a lot of success, and is demoralized and pessimistic about the future and refuses further treatment. Again, though, there are criteria other than a

[15] See, e.g., AMPQ Report at 41.
[16] See, e.g., College of Physicians and Surgeons of Nova Scotia, Guidance to Physicians Contemplating a Change in Clinical Scope of Practice, December 31, 2019 https://cpsns.ns.ca/resource/guidance-to-physicians-contemplating-a-change-in-clinical-scope-of-practice/
[17] Section 241.2(2) *Criminal Code*, RSC 1985, c C-46 and s.26 *An Act Respecting End-of-Life Care*, 1st Sess, 14th Leg, Quebec, 2013 (assented to June 10, 2014), RSQ c S-32.0001.

requirement to try more treatment that will preclude this person accessing MAiD.
  - I would note that, given the potential for spontaneous remission or the potential for improvement as part of the natural history of certain mental disorders, if a person is not willing to try any or recommended treatments, it may nonetheless be impossible for the clinician to form the opinion (as required by law) that their condition is incurable and their suffering irremediable because it might remit.
  - Furthermore, I would note that refusal of established treatments should be a red flag for extra caution re: decision-making capacity assessment. This doesn't justify excluding the person. But it does justify a very careful assessment of capacity. And it is likely that someone who refuses any reasonable treatment or any treatment at all for a mental disorder, will not be found capable and will therefore be ineligible for MAiD. This will, of course, not resolve all cases. But it will resolve some.
  - I would argue that you can only require that a person have tried treatment for mental disorder if you are **also** prepared to require that for physical conditions (e.g., cancer). BUT doing that flies in the face of established law,[18] reasonable interpretation of the Criminal Code MAiD provisions,[19] and *Carter* – where they expressly said that "irremediable" "does not require the patient to undertake treatments that are not acceptable to the individual."[20]
  - In sum, I believe that the concern about patients refusing treatment doesn't justify additional eligibility criteria or procedural safeguards (or indeed anything in the legislation). Rather, it justifies good education and training to alert assessors to what refusals may signify and the need to make sure the eligibility criteria are actually met but also training in how to explore refusals of treatment in a way that uncovers what is going on without imposing one's own values on the patient.

- Third, some have suggested that family involvement should be a requirement of access to MAiD.
  - I would definitely agree that the involvement of family and friends is usually very important and should usually be encouraged and facilitated. However, consistent with well-established principles and precedents in our legal system, it requires the consent of the person making the request. One need only consider requiring a patient to involve a father who sexually abused her as a child to see that involvement should not be a precondition for accessing MAiD.

---

[18] See, eg comments from Senior Counsel, Federal Department of Justice to Standing Senate Committee on Legal and Constitutional Affairs. Proceedings. 42nd Parliament, 1st session, issue no. 10, "Evidence," June 6, 2016. https://sencanada.ca/en/Content/SEN/Committee/421/lcjc/10ev-52666.

[19] Jocelyn Downie and Jennifer Chandler, "interpreting Canada's Medical Assistance in Dying Legislation" IRPP Report (2018) https://irpp.org/wp-content/uploads/2018/03/Interpreting-Canadas-Medical-Assistance-in-Dying-Legislation-MAiD.pdf

[20] *Carter* SCC at paragraph 127.

Advance requests

Some people will no doubt ask you to reject all forms of advance request for MAiD. I encourage you to reject this request for at least the following reasons:

- Your own expert committees have studied the issue and recommended that you do so (most recently the 2019 Quebec Expert Panel on the Question of Incapacity and MAiD[21]). Their research was thorough. The analysis was rigourous. And the recommendations are sound.
- Quebec public opinion supports it, e.g., a February 2021 Ipsos poll commissioned by Dying with Dignity Canada revealed that 85% of Quebeckers support advance requests.[22]

I note that these Quebec-based recommendations and opinions on “whether” to allow advance requests are aligned with views and positions taken in the rest of Canada:

- Government and expert committees (Federal Special Joint Committee[23] and Provincial-Territorial Expert Advisory Group[24])
- Canadian public opinion supports it, e.g., 79% of Canadians expressed support for advance requests in the recent federal consultation.[25]
- The recently passed Bill C-7 amending the federal *Criminal Code* permits two forms of advance request requests made after the person has been found to meet all of the eligibility criteria for MAiD (“final consent waiver” for assessed and approved) and “advance consent” for failed self-administration).[26]

In relation to the question of “when” rather than “whether” advance requests should be permitted, I would encourage you to adopt the position that advance requests should be permitted after diagnosis with serious and incurable condition. This recommendation is supported by the 2019 Quebec Expert Panel as well as the pre-C-14 Special Joint Committee of House and Senate and Provincial/Territorial Expert Advisory Group (indeed all post-*Carter* expert panels and committees tasked with making recommendations).

---

[21] Expert Panel, “L’aide médicale à mourir pour les personnes en situation d’inaptitude : le juste équilibre entre le droit à l’autodétermination, la compassion et la prudence” (2019) http://eoldev.law.dal.ca/wp-content/uploads/2020/01/quebec-MAiD-report-2019.pdf

[22] Ispos/Dying with Dignity Canada, “Support for Medical Assistance in Dying” (February 2021) https://d3n8a8pro7vhmx.cloudfront.net/dwdcanada/pages/4709/attachments/original/1614267558/DWD_Canada_MAID_Feb_2021.pdf?1614267558

[23] Special Joint Committee on Physician-Assisted Dying, *supra* note 10.

[24] Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *supra* note 4.

[25] Department of Justice Canada, “What We Heard Report: A Public Consultation on Medical Assistance in Dying (MAID)” https://www.justice.gc.ca/eng/cj-jp/ad-am/wwh-cqnae/toc-tdm.html

[26] S.241.2(3.2) and (3.5) *Criminal Code*, *supra* note 17.

Again, because I anticipate you will land on allowing advance requests made after diagnosis with a serious and incurable condition, I am not going to go into the arguments and evidence here (you can read the relevant very persuasive reports). What deserves the most of your time and energy is the consideration of the question of "how?" The usual approach taken to date is to fight over "whether"/"when" leaving no time for the how. But the devil's in the how. I encourage you to really dig into the how and develop the most nuanced and sophisticated system in the world for advance requests and MAiD. One that accurately maps philosophical justifications (for access and for protective measures) onto requirements for clinical practice.

So, on the "how", I would recommend the following:

- Immediately make an interim recommendation to the government to allow Quebeckers to make use of the federal *Criminal Code* "final consent waiver."[27] You do not need to have completed your deliberations on the broader category of advance requests to know that this is the right thing to do. You only need to know that without the final consent waiver, Quebeckers will die earlier than they would otherwise want to because they fear losing decision-making capacity and thereby their access to MAiD. Quebeckers will decline or reduce pain medications in order to retain their decision-making capacity long enough to access MAiD. Quebeckers will lose decision-making capacity waiting for arrangements for MAiD to be finalized (e.g., finding a time in their provider's schedule) and thereby be condemned to live on in a state of, by definition, intolerable suffering. There is a mechanism to avoid these harsh consequences. It has been thought through, debated in Parliament, and is already being implemented throughout the rest of Canada.[28] I hope you will encourage the government to allow Quebeckers who already meet all of the eligibility criteria for MAiD and whose natural death has become reasonably foreseeable to make arrangements for MAiD to be provided at a time in the future after they have lost decision-making capacity using the "final consent waiver" provision in the *Criminal Code*.

- Then develop a Quebec "Advance request" regime:
    - Require diagnosis with serious and incurable condition before the request is made
    - Require decision-making capacity at the time of making the advance request
    - Require being informed. This should include specifics re: trajectory taking into account all the circumstances of the person. (This is a reason to require the diagnosis – it is only then that you can be sufficiently informed).
    - Require that the document spells out what the person considers will be intolerable suffering and conditions for triggering the advance request. These should be subjectively chosen but able to be objectively determined by provider whether met. For example, if I am given a diagnosis of Alzheimer's disease, I

[27] S.241.2(3.2) *Ibid*.
[28] See e.g., British Columbia final consent waiver form https://www2.gov.bc.ca/assets/gov/health/forms/1645fil.pdf

could ask for MAiD to be provided when I am found to be stage six. Or I could say, when I have not been able to tell you the name of my spouse for two weeks straight. Or when I am unconscious. (This approach preserves the Quebec law's commitment to the subjectivity of assessments of suffering and avoids uncertainty about whether the person's conditions for suffering have been met.)

- Establish what to do if the person appears to have changed their mind – specifically, follow what the person said should happen if they appear to have changed their mind – and require as part of the informed consent process, the disclosure that this may happen.
- Establish what to do if person does not appear to be suffering – specifically, follow what the person said should happen if they do not appear to be suffering – and require as part of informed consent process, the disclosure that this may happen.
- Recognize that what is being permitted is the making of a request and acting in accordance with the request, not the creation of an obligation on the part of someone to follow a person's direction. This point, made by the Expert Panel, reflects respect for the moral agency of clinicians and recognizes the potential for moral distress associated with acting on some requests.
- Do not combine or allow any conflation of advance **requests** for MAiD with advance **directives** with respect to refusals of treatment. Avoid combinations or conflations in relation to language, forms, processes for registering, education, etc.

Parliamentary/National Assembly committees, official expert panel reports, and court cases – with mandate to make recommendations/decisions[29]

MENTAL DISORDERS	SOURCE	ADVANCE REQUESTS
No exclusion	Royal Society of Canada Expert Panel 2011	Allow
No exclusion	Quebec Select Committee on Dying with Dignity 2012	Allow when irreversibly unconscious
No exclusion	Quebec Legal Experts Group 2013	Allow
No exclusion[30]	*Carter v Canada and Quebec* 2015	N/A
No exclusion	Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying 2015	Allow after diagnosis with grievous and irremediable medical condition before suffering becomes intolerable
No exclusion	Special Joint Committee of the House and Senate 2016	Allow after diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable
No exclusion	*Truchon v Canada and Quebec* 2019	N/A
N/A	Quebec Expert Panel on the issue of incapacity 2019	Allow after diagnosis of serious and incurable disease before suffering becomes intolerable

[29] Note that the Federal Expert Panel External Panel on Options for a Legislative Response to Carter v. Canada, "Consultations on Physician Assisted Dying: Summary of Results and Key Findings – Final Report" (2015) https://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/pad.pdf and Council of Canadian Academies Expert Panel reports are not included in this table as they explicitly did not have a mandate to make recommendations.
[30] Note that it has been argued that *Carter* excluded psychiatric illness. This claim was tested in *Canada (Attorney General) v. E.F.* 2016 ABCA 155 and *Truchon* and rejected by the Alberta Court of Appeal and Quebec Superior Court respectively and neither case was appealed.

ADDENDUM on mature minors and MAiD in response to question from the Committee – some useful resources

Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report (2015) https://novascotia.ca/dhw/publications/Provincial-Territorial-Expert-Advisory-Group-on-Physician-Assisted-Dying.pdf ***[recommended allowing access to MAiD for mature minors]***

Special Joint Committee on Physician-Assisted Dying, Medical Assistance in Dying: A Patient-Centred Approach (2016) https://www.parl.ca/DocumentViewer/en/42-1/PDAM/report-1 ***[recommended allowing access to MAiD for mature minors]***

Constance MacIntosh, "*Carter*, Medical Aid in Dying, and Mature Minors" (2016) 10:1 *McGill JL & Health* S1. https://mjlhmcgill.files.wordpress.com/2017/07/mjlh_10_1_macintosh1.pdf

The Expert Panel Working Group for Mature Minors of the Council of Canadian Academies Expert Panel on Medical Assistance in Dying, "The State of Knowledge on Medical Assistance in Dying for Mature Minors" (2018) https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf

Carey DeMichelis, Randi Zlotnik Shaul, Adam Rapoport, "Medical assistance in dying at a paediatric hospital" *Journal of Medical Ethics* 45:1 (2019).