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[Aller au sommaire du numéro](#)

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Résumé de l'article

Une personne compétente peut-elle refuser des soins afin de rendre son décès naturel raisonnablement prévisible pour être admissible à l'aide médicale à mourir (AMM)? Prenons l'exemple d'un patient compétent atteint d'une paralysie du côté gauche à la suite d'un accident vasculaire cérébral droit qui ne devrait pas mourir avant de nombreuses années ; normalement, la cause de son décès ne serait pas prévisible. Cependant, il refuse de se retourner régulièrement, de sorte que son médecin peut prédire que des plaies de pression se développeront, entraînant une infection pour laquelle il refusera le traitement et mourra par conséquent. Est-il maintenant admissible à l'AMM? Prenons l'exemple d'un patient compétent atteint d'une sténose spinale (affection non mortelle) qui refuse de manger (mais pas de boire pour ne pas perdre sa capacité à cause de la déshydratation). Par conséquent, son médecin peut prédire la mort par famine. Est-elle maintenant admissible à l'AMM? Pour répondre à ces questions, nous devons répondre à trois sous-questions : 1) les patients compétents ont-ils le droit de refuser des soins ; 2) les prestataires de soins de santé ont-ils l'obligation de respecter ces refus ; et 3) les décès résultant de refus de soins sont-ils naturels aux fins de déterminer si un patient est admissible à l'AMM? Si un patient compétent a le droit de refuser certains soins particuliers et que les prestataires de soins de santé ont l'obligation de respecter ce refus, et si le décès qui résulterait du refus de ces soins est naturel, alors ce refus de soins est une voie légale vers le AMM. Toutefois, si le patient compétent n'a pas le droit de refuser certains soins particuliers, ou si les prestataires de soins de santé n'ont pas l'obligation de respecter ce refus, ou si le décès qui résulterait du refus de ces soins n'est pas naturel, alors ce refus de soins ne constitue pas une voie légale vers le AMM. Dans cet article, nous explorons ce terrain juridique complexe avec les implications éthiques les plus profondes : l'accès à l'AMM.



ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Refusing Care as a Legal Pathway to Medical Assistance in Dying

Jocelyn Downie¹, Matthew J. Bowes²

Résumé

Une personne compétente peut-elle refuser des soins afin de rendre son décès naturel raisonnablement prévisible pour être admissible à l'aide médicale à mourir (AMM)? Prenons l'exemple d'un patient compétent atteint d'une paralysie du côté gauche à la suite d'un accident vasculaire cérébral droit qui ne devrait pas mourir avant de nombreuses années ; normalement, la cause de son décès ne serait pas prévisible. Cependant, il refuse de se retourner régulièrement, de sorte que son médecin peut prédire que des plaies de pression se développeront, entraînant une infection pour laquelle il refusera le traitement et mourra par conséquent. Est-il maintenant admissible à l'AMM? Prenons l'exemple d'un patient compétent atteint d'une sténose spinale (affection non mortelle) qui refuse de manger (mais pas de boire pour ne pas perdre sa capacité à cause de la déshydratation). Par conséquent, son médecin peut prédire la mort par famine. Est-elle maintenant admissible à l'AMM? Pour répondre à ces questions, nous devons répondre à trois sous-questions : 1) les patients compétents ont-ils le droit de refuser des soins ; 2) les prestataires de soins de santé ont-ils l'obligation de respecter ces refus ; et 3) les décès résultant du refus de soins sont-ils naturels aux fins de déterminer si un patient est admissible à l'AMM? Si un patient compétent a le droit de refuser certains soins particuliers et que les prestataires de soins de santé ont l'obligation de respecter ce refus, et si le décès qui résulterait du refus de ces soins est naturel, alors ce refus de soins est une voie légale vers le AMM. Toutefois, si le patient compétent n'a pas le droit de refuser certains soins particuliers, ou si les prestataires de soins de santé n'ont pas l'obligation de respecter ce refus, ou si le décès qui résulterait du refus de ces soins n'est pas naturel, alors ce refus de soins ne constitue pas une voie légale vers le AMM. Dans cet article, nous explorons ce terrain juridique complexe avec les implications éthiques les plus profondes : l'accès à l'AMM.

Mots-clés

assistance à mourir, aide médicale à mourir, AMM, arrêt volontaire de manger et de boire, AVMB, raisonnablement prévisible, mort naturelle

Abstract

Can a competent individual refuse care in order to make their natural death reasonably foreseeable in order to qualify for medical assistance in dying (MAiD)? Consider a competent patient with left-side paralysis following a right brain stroke who is not expected to die for many years; normally his cause of death would not be predictable. However, he refuses regular turning, so his physician can predict that pressure ulcers will develop, leading to infection for which he will refuse treatment and consequently die. Is he now eligible for MAiD? Consider a competent patient with spinal stenosis (a non-fatal condition) who refuses food (but not liquids in order not to lose capacity from dehydration). Consequently, her physician can predict death from starvation. Is she now eligible for MAiD? Answering these questions requires that we answer three sub-questions: 1) do competent patients have the right to refuse care?; 2) do healthcare providers have a duty to respect such refusals?; and 3) are deaths resulting from refusals of care natural for the purposes of determining whether a patient is eligible for MAiD? If a competent patient has the right to refuse some particular care, and healthcare providers have a duty to respect that refusal, and if the death that would result from the refusal of that care is natural, then that refusal of care is a legal pathway to MAiD. However, if the competent patient does not have the right to refuse some particular care, or if healthcare providers do not have a duty to respect that refusal, or if the death that would result from the refusal of that care is not natural, then that refusal of care is not a legal pathway to MAiD. In this paper, we explore this complex legal terrain with the most profound of ethical implications – access to MAiD.

Keywords

assisted dying, medical aid in dying, MAiD, voluntary stopping eating and drinking, VSED, reasonably foreseeable, natural death

Mr. Smith is a 55-year-old man with quadriplegia as a result of a stroke five years ago. He experiences extreme neuropathic pain that cannot be controlled without profound sedation. He recently asked his physician about medical assistance in dying (MAiD). He was assessed and told that he does not meet the eligibility criteria for medical assistance in dying. Mr. Smith experiences enduring and intolerable suffering that cannot be alleviated by any means acceptable to him and he is in an advanced state of decline in physical capability. He has been told that he has an incurable condition but that, as he could live on for decades, his natural death has not yet become reasonably foreseeable. Desperate, he refuses consent to being turned, knowing that this will result in pressure sores that will get infected, and he refuses consent to antibiotics for any resulting infection, knowing that this will lead to his death. He then claims that, as a result of these refusals, his natural death has become reasonably foreseeable and so he is eligible for MAiD. (fictional case)

Introduction

One of the most talked-about criteria for eligibility for medical assistance in dying (MAiD) in Canada is s.241.2(2)(d) of the *Criminal Code of Canada* [1]:

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

...

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

The phrase “reasonably foreseeable” has received most of the attention directed at this subsection of the federal legislation,¹ largely because it has been taken to exclude a number of individuals who would have qualified for MAiD under the Supreme Court of Canada (SCC) decision in *Carter v. Canada* [8]. In that decision, the SCC declared the prohibition on MAiD to be unconstitutional insofar as it prohibits access to MAiD for “a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes

¹ Indeed, this was at the centre of the firestorm during the process of Bill C-14's passage through Parliament in the Spring of 2016. See, for example [2-5]. It is also the subject of two Charter challenges currently before the courts [6-7].

enduring suffering that is intolerable to the individual in the circumstances of his or her condition.” [8, para 127]. Bill C-14 (which brought in the MAiD provisions of the *Criminal Code*) narrowed access by adding, among other things, the requirement that the person’s “natural death has become reasonably foreseeable.” [9] As a result, individuals experiencing enduring and intolerable suffering are being denied access on the grounds that their natural death has not become reasonably foreseeable. In response, they are exploring three pathways to access MAiD: first, arguing in court that the provision breaches their *Charter* rights [7]; second, advocating for interpretations of “reasonably foreseeable” that are broader than those being used in their denials;² and third, taking steps to make their deaths “reasonably foreseeable” even on a narrow interpretation of the phrase.³

In this paper, we explore this third potential pathway to access MAiD, i.e., competent patients refusing care so that their death will become reasonably foreseeable on any of the leading interpretations of that phrase (if the patient is likely to remain steadfast in their refusal), as it will be predictable **that**, **when**, and **how** the person will die [10,12]. In these cases, the word “natural” requires attention. Does the very thing that makes their death “reasonably foreseeable” (refusal of care) also render their death not “natural” (but rather “accident,” “suicide,” or “homicide)? Section 241.2(2)(d) of the *Criminal Code* contains two conditions, both necessary for eligibility; as one eligibility door opens, does the other one shut?

Consider the following set of illustrative fictional examples of the conundrum of “natural death” in the context of MAiD. In each, as a result of steps taken by a competent patient, death has become reasonably foreseeable — but would the manner of death be “natural”?

1. A competent patient with Huntington’s disease (a neurodegenerative condition not expected to result in the patient’s death for many years) develops pneumonia that is treatable but, without treatment, will likely result in her death. The patient refuses treatment, so her physician can say that her death is likely to be as a result of pneumonia.
2. A competent patient was rendered ventilator-dependent three years ago by an unusually severe case of Guillain-Barré syndrome. Facing the prospect of permanent ventilator dependence and an anticipated survival of more than ten years, she requests the ventilatory support be discontinued. Her physician can predict death as a result of the support being discontinued.
3. A competent patient was in a car accident and, as a result, in the hospital attached to a ventilator for a year. Facing the prospect of permanent ventilator dependence, the patient requests the ventilatory support be discontinued. His physician can predict death as a result of the support being discontinued.
4. A competent patient with multiple sclerosis who is dependent on a percutaneous endoscopic gastrostomy (feeding tube) tube for nutrition asks that artificial nutrition be stopped (but doesn’t stop liquids in order not to lose capacity from dehydration). Consequently, her physician can predict death from starvation.
5. A competent patient with left-side paralysis following a right brain stroke is not expected to die for many years; normally his cause of death would not be predictable. However, he refuses regular turning, so his physician can predict that pressure ulcers will develop, leading to infection for which he will refuse treatment and consequently die.
6. A competent patient with quadriplegia following a diving accident three years ago is not expected to die for many years; normally his cause of death would not be predictable. However, he refuses regular turning, so his physician can predict that pressure ulcers will develop, leading to infection for which he will refuse treatment and consequently die.
7. A competent patient with spinal stenosis (a non-fatal condition) refuses food (but not liquids in order not to lose capacity from dehydration). Consequently, her physician can predict death from starvation.

These examples display the key variables to watch for throughout the following analysis: the origin of the underlying condition (i.e., disease or disability, accident, intentional injury by self or other); the nature of the underlying condition (i.e., fatal vs. chronic condition); the type of care (e.g., ventilator, antibiotics, turning, artificial or oral hydration or nutrition); and the goal of the care (e.g., preventative, curative, palliative).⁴

There will be patients among those in the examples provided above who will not be eligible for MAiD without refusing care and for whom palliative care will be either unavailable, ineffective, or undesired or by whom MAiD will be preferred. It is therefore important to ask: can competent individuals refuse care to make their natural death reasonably foreseeable in order to qualify for MAiD? Answering this question requires that we answer three sub-questions: 1) do competent patients have the right to refuse care?; 2) do healthcare providers have a duty to respect such refusals?; and 3) are deaths resulting from refusals of care not natural for the purposes of determining whether a patient is eligible for MAiD? If a competent patient has the right to refuse some particular care, and healthcare providers have a duty to respect that refusal, and the death that would result from the refusal of that care is natural, then that refusal of care is a legal pathway to MAiD. However, if the competent patient does not have the right to refuse some particular care, or healthcare providers do not have a duty to respect that refusal, or the death that would result from the refusal of that care is not natural, then that refusal of care is not a legal pathway to MAiD.

² For example, arguing that “reasonably foreseeable” does not mean “death expected within 12 months” or denying that there is a temporal proximity condition [10].
³ Individuals might also request deep and continuous sedation and refuse artificial hydration and nutrition as a path to death when found to be ineligible for MAiD or if they object to MAiD but wish a hastened death. This path to death is analyzed in full in [11].

⁴ We are assuming here that the withholding or withdrawal of treatment would not cause death in less time than it would take for a patient to avail themselves of MAiD.

Do competent patients have the right to refuse care?⁵

It is very clear that competent adult⁶ patients have a common law right to refuse any or all medical treatment (including artificial nutrition and hydration) even where the consequence of the refusal is death. As Justice Smith noted in *Carter*: “[...] the law in Canada is that: (a) Patients are not required to submit to medical interventions (including artificial provision of nutrition and hydration), even where their refusal of or withdrawal from treatment will hasten their deaths, and physicians must respect their patients’ wishes about refusal of or withdrawal from treatment.” [15] It is also clear that competent adult patients have a common law right to refuse oral hydration and nutrition. In *Carter v. Canada (Attorney General)*, Justice Smith noted that “[h]e [Mr. Copley for British Columbia] submits that ‘the able bodied and the disabled can equally commit suicide by refusing to eat or drink or by refusing provision of artificial nutrition or hydration.’” [15, para 1067] Justice Smith did not take issue with this characterization of refusing oral or artificial hydration or nutrition as suicide (and the SCC in the *Carter* appeal did not take issue with her acceptance of the characterization). Similarly, in *Bentley v. Maplewood Seniors Care Society*, Justice Greyell noted that “adults have a common law right to consent or refuse consent to personal care services [including oral hydration and nutrition].” [16, para 84]

It is also clear that the right to refuse extends to individuals beyond those with a fatal condition to those with chronic conditions to those who are healthy (whether able-bodied or with a disability) [15]. While there is no case law directly on point, it can be argued that the right to refuse extends to preventive care if it involves touching the patient. The SCC has clearly grounded its decisions regarding treatment in the individual’s constitutional right to bodily integrity. The right to bodily integrity would equally ground the position that patients have a right to refuse preventive care. This was recognized recently by Justice Greyell in *Bentley* when he stated:

I am not aware of any statute in British Columbia that sets out a legislated standard for informed consent for personal care or basic care. However, there is common law authority for the proposition that it is necessary to obtain consent before providing personal care or basic care. Indeed, intentional non-consensual touching can amount to the tort of battery (Malette at 327; *Norberg v. Wynrib*, [1992 CanLII 65 \(SCC\)](#), [1992] 2 S.C.R. 226 at 246). Although most cases relating to consent rights have been decided in the context of a right to consent or refuse consent for health care treatment, the principles on which that right is based is the general right to personal autonomy and bodily integrity.

For instance, in *Ciarliariello v. Schacter*, [1993 CanLII 138 \(SCC\)](#), [1993] 2 S.C.R. 119 at 135 Cory J. said for the Court: “Everyone has the right to decide what is to be done to one’s own body.” Similarly, in *Fleming* at 312 Robins J.A. observed that “[t]he common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection.” These statements recognizing the common law right to be free from non-consensual touching or care of one’s body must encompass the right to consent or refuse consent to personal care or basic care. [16, para 46]

Thus it can be concluded that competent adults have a common law right to refuse care no matter the origin of the underlying condition (disease or disability, accident, intention or self-induced injury), the nature of the underlying condition (fatal or chronic), the type of care (e.g., ventilator, antibiotics, turning, artificial or oral hydration and nutrition), the goal of the intervention (preventative, curative, or palliative) and whether the person is able-bodied or has a disability but is otherwise healthy.

Do healthcare providers have a duty to respect refusals of care?

Criminal and civil law

Healthcare providers have a legal duty to respect competent adult patients’ refusals of care. They are required by both criminal and civil law to respect such refusals. To touch a person in the course of delivering care against the patient’s wishes would constitute battery⁷ or assault [1, s.265]. Healthcare providers risk criminal and civil liability if they provide treatment or preventive medical care (including artificial hydration and nutrition) or force oral hydration or nutrition against a competent adult’s wishes, regardless of whether the person has a fatal or chronic conditions or is healthy (whether able-bodied or with a disability).

It should be noted here that it has been suggested that healthcare providers have a duty to provide care because of the *Criminal Code* duty to provide the necessities of life.⁸ However, patients in the circumstances under discussion are capable of removing themselves from the care of the physician, so this provision of the *Criminal Code* would arguably not be triggered.

⁵ Parts of the next two sections are drawn from [13].

⁶ This is not to say that mature minors do not have this right. Rather, this paper is focused on MAiD and under Canadian legislation only adults are eligible. We therefore limit our analysis to adults to avoid the unnecessary complications of the uncertainty surrounding the mature minor rule in Canadian common law. For an explanation of mature minors and end-of-life decision-making, see [14].

⁷ The SCC has clearly endorsed the view that the common law concept of bodily integrity requires that healthcare providers not touch patients without their consent. Starting or continuing treatment is touching and, if done against a patient’s wishes, is considered tortious battery [17].

⁸ “(1) Everyone is under a legal duty (a) as a parent, foster parent, guardian or head of a family, to provide necessities of life for a child under the age of sixteen years; (b) to provide necessities of life to their spouse or common-law partner; and (c) to provide necessities of life to a person under his charge if that person (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and (ii) is unable to provide himself with necessities of life” [1, s.215].

Furthermore, failure to provide the necessities of life is only an offence under the *Criminal Code* if there is no lawful excuse,⁹ and one could argue that the patient's refusal of the care is a lawful excuse and therefore there would be no offence.

Provincial/territorial consent legislation

Some provincial/territorial consent legislation includes elements relevant to the analysis: the requirement of consent to treatment and personal care or personal assistance services (which could include assistance with eating and drinking) and the definitions of these terms.¹⁰ However, the statutes either codify the common law or are silent and therefore leave the common law position undisturbed. Thus, healthcare providers have a duty to respect competent adult patients' refusals of care no matter the origin of the underlying condition (disease or disability, accident, intention or self-induced injury), the nature of the underlying condition (fatal or chronic), the type of care (e.g., ventilator, antibiotics, turning, artificial or oral hydration and nutrition), the goal of the intervention (preventative, curative, or palliative), and whether the person is able-bodied or has a disability but is otherwise healthy.¹¹ Hence, inasmuch as there is provincial/territorial legislation on point, healthcare providers have a statutory obligation to respect all competent adult patients' refusals of care (including preventive care and oral and artificial hydration and nutrition).¹²

Are deaths resulting from refusals of care “natural deaths” for the purpose of determining whether an individual is eligible for MAiD?

The final question that must be addressed is whether a death following a refusal of care is “natural” (as opposed to the other possible classifications: “accident,” “suicide,” “homicide,” “undetermined,” or “other”). There are a variety of potential sources for guidance regarding the meaning of “natural death” in the Canadian MAiD legislation: 1) the MAiD provisions of the *Criminal Code*; 2) the *Criminal Code* beyond the MAiD provisions; 3) case law interpreting relevant part(s) of the *Criminal Code*; 4) College of Physicians and Surgeons' decisions interpreting relevant part(s) of the *Criminal Code*; and 5) legislation, guidelines, and established practices in relation to the completion of medical certificates of death. We consider each in turn.

The MAiD provisions within the *Criminal Code*

The MAiD provisions within the *Criminal Code* use the phrase “natural death” but do not include a definition of the phrase.

The *Criminal Code* beyond the MAiD provisions

The phrase “natural death” only appears once in the *Criminal Code* – in the provisions with respect to MAiD. No definition for the phrase is provided anywhere in the *Criminal Code*.

Case law

There has been only one case in which the meaning of “natural death” has been mentioned in the context of the federal MAiD legislation. In *A.B. v Canada (Attorney General)*, Justice Perell wrote:

In referring to a “natural death” the language denotes that the death is one arising from causes associated with natural causes; i.e., the language reveals that the foreseeability of the death must be connected to natural causes, which is to say about causes associated with the functioning or malfunctioning of the human body. These are matters at the core if not the whole corpus of medical knowledge and better known to doctors than to judges. The language reveals that the natural death need not be connected to a particular terminal disease or condition and rather is connected to all of a particular person's medical circumstances [20, para 81].¹³

There is nothing in the decision to tell us what “associated with” means and it is not clear when, if ever, natural causes brought on as a result of a person's choices (e.g., refusal of care) would constitute “causes associated with natural causes.” In addition, the case did not involve a refusal of care and so these comments could be considered *obiter dicta*. Finally, deference is shown here to the views of physicians on the issue (and such views will be discussed in detail later in this paper).

⁹ “(2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if (a) with respect to a duty imposed by paragraph (1)(a) or (b), (i) the person to whom the duty is owed is in destitute or necessitous circumstances, or (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently” [1, s.215].

¹⁰ Newfoundland and Labrador, New Brunswick, Manitoba, Saskatchewan, Alberta, Northwest Territories, and Nunavut do not have relevant legislation and so are governed by the common law as explained above. For a full review of the provincial/territorial law regarding refusals of treatment, see [18].

¹¹ Nova Scotia, Prince Edward Island, Quebec, Ontario, British Columbia, and Yukon have relevant legislation but none of the statutes displace the common law right to refuse care. Rather, they reinforce the duty to respect refusals of care [18].

¹² It must be noted that, in some provinces (e.g., British Columbia), patients who are involuntary confined under mental health legislation but who have decision-making capacity can nonetheless be treated for their mental disorder against their will. However, “[t]reatment for purposes unrelated to the person's mental disorder is subject to the generally applicable laws regarding consent to treatment.” [19]

¹³ Therefore, this exception to the general rule does not displace the conclusions drawn in this section.

There have been a few cases in which “natural death” has been discussed (outside of the context of the federal MAiD legislation). In *Nancy B.*, Justice Dufour reflected on whether withholding or withdrawing potentially life-sustaining treatment results in a “natural death” rather than “suicide.”

[Sections 222 to 241](#) of the [Criminal Code](#) deal with different forms of homicide. What I have just reviewed is sufficient to conclude that the person who will have to stop Nancy B.’s respiratory support treatment in order to allow nature to take its course, will not in any manner commit the crimes prohibited by these sections. The same goes for [s. 241](#), aiding suicide.

I would however add that homicide and suicide are not natural deaths, whereas in the present case, if the plaintiff’s death takes place after the respiratory support treatment is stopped at her request, it would be the result of nature taking its course [21, para 61].

While Justice Dufour did not explicitly consider whether the refusal of artificial nutrition and hydration would constitute suicide, he did state, albeit in the context of considering a different point under the *Civil Code of Québec*, that placing someone on a respirator was “a technique of the same nature as that of feeding a patient. One cannot therefore make distinctions between artificial feeding and other essential life-sustaining techniques.” [21] The logic of this passage suggests that if he had turned his mind to it, he would have concluded that the refusal of artificial nutrition and hydration also does not constitute suicide.

It is important to note, however, that the conclusion may be narrower than the entire range of cases captured by the right to refuse care described above and the examples set out at the beginning of this paper. That is, it may only apply in circumstances in which the death can be characterized as “letting nature take its course.” This case arguably stands for the proposition that death following a refusal of life-sustaining treatment (including artificial nutrition and hydration) is “natural” if the resulting death can be characterized as “letting nature take its course” (whatever that may mean). While this is, of course, only the decision of a single judge in the Quebec Superior Court, it has been widely and approvingly cited (including, e.g., in *Carter*) without any exception being taken to these conclusions.

Turning to the issue of refusing oral hydration and nutrition, there is some evidence that this might be considered suicide: in *British Columbia (Attorney General) v. Astaforoff*, Justice Bouck held that dying via a self-imposed hunger strike was equivalent to suicide [22]. It must be noted, however, that this case took place many years ago and in the context of a prison rather than a hospital. It is also a case of someone who could but chose not to eat as opposed to someone who relied on being fed by another person and refused that assistance – which is perhaps a closer analogy to *Nancy B.*

Further complicating matters, there is also some evidence that refusing either oral or artificial hydration and nutrition might be considered suicide: in *Carter*, Justice Smith noted that “[h]e [Mr. Copley for the Attorney General of British Columbia] submits that ‘the able bodied and the disabled can equally commit **suicide** by refusing to eat or drink or by refusing provision of artificial nutrition or hydration’.” [22, para 1067] Justice Smith did not take issue with this characterization of refusing oral or artificial hydration or nutrition as **suicide** (and the SCC in the *Carter* appeal did not take issue with her acceptance of the characterization). However, the Attorney General of BC and Justice Smith may well not have contemplated the implications of their statements for end of life care outside the context of the issue of whether to strike down the *Criminal Code* prohibitions on MAiD. Calling the refusal of oral and artificial hydration and nutrition “suicide” (rather than simply saying that they are legal) [8,15] suggests that wherever a patient dies as a consequence of the withholding or withdrawal of oral or artificial hydration and nutrition, their death should be treated as “suicide.” Which, of course, in practice, it is not.

Ultimately, a review of the cases discussing manner of death – directly or indirectly and with or without attention or awareness of the broader implications of the statements being made – does not provide sufficient clarity to conclusively evaluate the legality of this paper’s set of possible pathways to MAiD. It seems like refusals of life-sustaining treatment are not suicide, regardless of the cause of the underlying condition precipitating the request for MAiD (i.e., scenarios 1,2,3,5, and 6). However, competing conclusions have been drawn about whether refusals of artificial nutrition and hydration are suicide (“no” where it is “nature taking its course” in *Nancy B.*, but “yes” in *Carter*). Finally, at first glance, it seems like refusals of oral nutrition and hydration are suicide (in *Astaforoff* and *Carter*). However, *Astaforoff* was a case in the prison context and *Carter* was a case about the legality of a prohibition on assisted dying (which does not include the withholding and withdrawal of nutrition and hydration). It is simply not clear from a review of the case law what a court would conclude about artificial and especially oral hydration and nutrition (i.e., scenarios 4 and 7).

It therefore seems wise – and consistent with the only case to consider the meaning of “natural death” in the context of the federal MAiD legislation – to turn to medical sources and authorities that address the determination of the manner of death directly.

Colleges of Physicians and Surgeons

No College of Physicians and Surgeons has provided guidance on this issue to their members through MAiD Standards or Guidelines. However, there has been one complaint made to a College and the College’s response is directly on point [23]. In June 2016 and again in December 2016, Dr. Ellen Wiebe assessed a patient with advanced multiple sclerosis who was requesting MAiD. Dr. Wiebe found that her natural death was not yet reasonably foreseeable. At the end of February 2017, the patient stopped eating and drinking and fourteen days later, Dr. Wiebe concluded that her natural death was now

reasonably foreseeable and provided her with MAiD. The chief medical officer and coroner for British Columbia wrote to the BC College of Physicians and Surgeons to raise questions about whether this instance of MAiD was legal – was the patient's natural death reasonably foreseeable given that “her decision to decline treatment arguably contributed to the serious nature of her disease and her act of voluntarily stopping eating and drinking precipitated her advanced state of decline.” [24] An Inquiry Committee for the BC College found that the patient met the criteria for MAiD “despite the fact that her refusal of medical treatment, food, and water undoubtedly hastened her death and contributed to its ‘reasonable foreseeability.’” [24] Based on this, it is reasonable to conclude that at least one College of Physicians and Surgeons is of the view that deaths that would result from a refusal of care (including treatment, food, and water) are “natural” for the purposes of determining eligibility for MAiD (for scenarios 1-7).

Medical certificates of death

Federal guidelines regarding medical certificates of death

In April 2017, the federal government published “Federal guidelines: reporting of deaths in cases of medical assistance in dying (April 2017).” [25] The purpose was to “address the completion of the Medical Certificate of Death where a patient has received medical assistance in dying, to facilitate the identification of cases of medically assisted deaths and to encourage consistency in approaches across provinces and territories.” [25] However, the government also recognized that “death reporting and investigation is the responsibility of individual provinces and territories. Also, some provinces and territories have already adopted their own approaches to death certification for medically assisted deaths. That is why the federal guidelines are non-binding and respect provincial and territorial oversight for reporting deaths.”

The federal guidelines indicate that “[m]anner of death [for MAiD] should be certified as natural if such an option exists.” Unfortunately, this does not explicitly help resolve the questions raised by this paper, as the guidelines address only how to certify the manner of death for deaths after MAiD has occurred, but not how to certify the manner of death in the absence of MAiD. It is this second fact that is relevant to whether someone qualifies for MAiD in the first place. However, it could be argued that an implication can be drawn from the guidelines. That is, it could be argued that a refusal of care is as natural a manner of death as the lethal injection or ingestion associated with MAiD. If MAiD is to be classified as “natural,” regardless of any of the variables outlined at the start of this paper, then arguably so too should be refusals of care. On this argument, all of the scenarios outlined at the beginning of this paper should be classified as “natural.”¹⁴

Counter to this, it might be argued that “natural death” is defined with different goals in the context of medical certificates of death than eligibility for MAiD. For medical certificates of death, MAiD is defined as “natural” so as not to skew the national mortality data and lead to mistakes being made about, for example, public health initiatives. For example, if it were recorded as suicide, we would see a significant increase in suicide deaths and so might redirect public funding to suicide prevention where that would be an inappropriate response to the phenomenon. Eligibility for MAiD has no such mortality data and public health spending implications. On this argument, the federal guidelines give us no direction regarding the scenarios.

Statistics Canada – Canadian Coroner and Medical Examiner Database: Annual Report

The Canadian Coroner and Medical Examiner Database Annual Report, 2006 to 2008 [26] defines natural death as “[a]ll deaths where a disease initiates the chain of events ending in death” and suicide as “[a]ll deaths where a self-inflicted injury initiates the chain of events ending in death where the decedent intends to cause their own death.” Accident is defined as “[a]ll deaths where an injury initiates the chain of events ending in death and there is no element of intent in the circumstances leading to the injury. Undetermined deaths are defined as “[a]ll deaths where investigation is unable to attribute one of the previous manners are characterized as undetermined. Note that in such circumstances, the cause of death may be known.”

If one were to apply these definitions to the scenarios outlined at the beginning of this paper and to our central question, the following conclusions might be drawn:

- Where a patient has pneumonia not precipitated by an accident or self-inflicted injury, refuses antibiotics and is going to die of pneumonia, then the death should be classified as natural. However, if the pneumonia was precipitated by an accident or self-inflicted injury, then the death should be classified as an accident or suicide respectively.
- Where a patient requiring turning in order to avoid pressure ulcers (the requirement for turning precipitated by a disease), refuses turning and as a result gets pressure ulcers, which then get infected and the patient then refuses antibiotics and is going to die from the infection, then the death should be classified as natural. However, if the requirement for turning was precipitated by an accident or self-inflicted injury, then the death should be classified as an accident or suicide respectively.
- Where, a patient requires artificial hydration or nutrition (the requirement for artificial nutrition and hydration precipitated by a disease), refuses that artificial hydration or nutrition, and is going to die of starvation or dehydration, then the death should be classified as natural. However, if the requirement for artificial hydration or nutrition was precipitated by an accident or self-inflicted injury, then the death should be classified as an accident or suicide respectively.
- Where a patient refuses oral hydration or nutrition and is therefore going to die of starvation or dehydration, then the death should be classified as suicide or “undetermined” (depending on whether starvation or dehydration is considered a “self-inflicted injury”).

¹⁴ It should be noted here that, as will become clear later in the paper, these guidelines dissociate the classification of death from the disease or injury that set in motion a chain of pathophysiologic derangements that end in death (the traditional approach taken by coroners and medical examiners to classification of death).

Instructions regarding completion of medical certificate of death forms

Some provincial/territorial governments provide instructions for completing medical certificates of death, not specific to MAiD. Ontario's instructions state: "Is the death due to non-natural causes (such as accident, homicide, or suicide)? For example, an injury (e.g., hip fracture) that precedes a terminal medical event (e.g., pneumonia) is considered to be non-natural, and therefore a coroner must be notified to determine if the death may be attributable to the initial injury." [27]¹⁵ British Columbia's instructions lead to the same conclusion [28]. This suggests that if a death follows a refusal of care (whether preventative, curative, or palliative and whether artificial or oral hydration or nutrition) responding to a medical condition attributable to an initial injury caused by an accident, then the death should be determined to be accidental rather than natural. However, if a death follows a refusal of care (whether preventative, curative, or palliative, whether artificial or oral hydration or nutrition) responding to a medical condition attributable to a disease or naturally occurring disability, then the death should be determined to be natural. This seems consistent with the definition of "natural" found in the Canadian Coroner and Medical Examiner Database Annual Report discussed above.

Interestingly, in Alberta, a death resulting from MAiD is to be classified as "'unclassified' which is neither 'natural' nor 'suicide' but indicates a drug poisoning." [29] In Yukon, MAiD is dealt with by inserting "MAiD" rather than ticking any of the boxes for manner of death (accident, suicide, homicide, undetermined): "[m]edical assistance in dying (or MAiD) must be reported (hand written) on the form in Section 29 as the manner of death." [30] In Manitoba [31] and British Columbia [28], the cause of death is the underlying disease and the manner of death is to be natural.

Unfortunately, the available provincial/territorial instructions do not explicitly help resolve the questions raised by this paper. First, they reveal a lack of one consistent approach across the country. Second, they address only how to certify the manner of death for deaths after MAiD has occurred, but not whether someone qualifies for MAiD in the first place. That said, a very important lesson can be drawn from them, i.e., in the context of MAiD and for the specific purposes of MAiD, provincial/territorial authorities can issue instructions and make it clear what they believe constitutes "natural death".

The traditional approach to classification of death by coroners or medical examiners

The individuals with the greatest experience with, and understanding of, the classification of death are coroners and medical examiners. How then do they classify death? And is there any consensus among these groups as to how the manner of deaths should be classified that could provide insight into the questions posed in this paper? In effect, what can we draw from "first principles"?

The meaning of the word "natural" varies with context but, in the community of coroners and medical examiners, the word has a specific technical meaning. Amongst coroners and medical examiners, the cause of death is the disease or injury that sets into motion a chain of pathophysiologic derangements that end in death. The manner of death for any death where the chain of derangements was set into motion by a disease is natural. Deaths where the chain was set into motion by an injury are classified according to the circumstances of that injury, e.g., the manner is accidental where the injury was unintentional or suicide where the injury was inflicted in a deliberate attempt at self-harm. The chain of pathophysiologic derangements itself is called the mechanism of death.

When the death is in close temporal proximity to the onset of disease or the time of the injury, the analysis is usually straightforward. The problematic cases (from the point of view of classification) are those where the onset is distant in time, and this is usually a consequence of the large number of physiologic derangements that may dominate the person's terminal course, and thus their treatment decisions. Consider the person who suffers a spinal cord injury from a gunshot wound: such a person may be expected to live a long time, and may well suffer repeated bouts of urinary tract infection, sepsis from pressure sores, and bronchopneumonia. Although this person's death from sepsis years after the injury may not prompt a treating physician to think of trauma as the proximate cause (and therefore the manner as natural), in the minds of coroners and medical examiners, it is logical to construct that person's death as a late complication of a gunshot wound (hence manner as non-natural), since but for the gunshot wound, that person would not have been paraplegic, and would not have suffered from sepsis from a urinary tract infection. Physicians and others may refer to sepsis and pressure sores as "natural" consequences of paraplegia, meaning that these are logical or expected consequences of the underlying pathology. This may be so, but it does not make these deaths "natural" from the point of view of coroners and medical examiners.

Let us now apply these standard practices of coroners and medical examiners to the novel question of whether a death following a refusal of care should be considered a "natural" death. On the logic of the specific technical meaning of "natural death" in the community of coroners and medical examiners, if the patient refuses care that is necessary due to an accident (scenarios 3 and 6), then the manner of death is not natural – even if the mechanism is, for example, an infection. If the patient refuses care that is necessary due to a disease, then the manner of death is natural (scenarios 1, 2, 4, and 5).

What about a death following refusal of oral nutrition and hydration? The need for oral nutrition and hydration does not flow from a disease, disability, injury, accident, or violence. This need is a simple consequence of normal human physiology. There is no causal chain of pathophysiologic derangements resulting in a dependence on oral nutrition and hydration that one can then refuse. However, perhaps one could rely upon the long-established tradition that deaths due to complications of therapy

¹⁵ Note: according to these instructions, "natural causes" is manner of death and not a cause of death.

for a disease or injury ought to be classified as due to the disease or injury that caused the patient to seek the therapy. Death due to refusal of oral nutrition and hydration might be classified as due to the disease or injury that caused the patient to refuse the oral nutrition and hydration. If so, the manner of death following a refusal of oral nutrition and hydration in response to a disease would be “natural” (scenario 7). Similarly, the manner of death following a refusal of oral nutrition and hydration in response to an injury caused by an accident would be “accident.”

Conclusion

It has been observed that there are no national standards for the classification of death [32]. This situation, a consequence of the division of powers, has introduced great variability in the practice of death classification generally, not just in the context of MAiD. It is thus unsurprising that a search of the medical literature reveals numerous examples of studies demonstrating significant variability in the classification of the manner of death by various professionals (e.g., attending physicians, coroners and medical examiners) in response to scenarios [33].

The need for clear guidance

Because Canadian MAiD legislation requires that the reasonably foreseeable death must be a “natural death,” the law must be clear about whether the deaths that would follow respect for refusals of care constitute “natural death.” Specifically, whether the following reasonably foreseeable deaths are “natural” (vs. “accident” or “suicide”):

- a patient with a treatable pneumonia refuses antibiotics
- a paralyzed patient refuses life-sustaining ventilator support
- a patient refuses turning, which leads to pressure ulcers, which leads to treatable infection, for which the patient refuses antibiotics
- a patient refuses artificial nutrition, which leads to starvation
- a patient refuses oral nutrition, which leads to starvation

If the reasonably foreseeable death would be a “natural death,” then the individual meets the eligibility criterion of s.241.2(2)(d) of the *Criminal Code* once it is reasonable to conclude that they will not change their mind about the refusal of care. In addition, healthcare providers do not risk liability for aiding or abetting suicide by disclosing or facilitating the exercise of that refusal pathway to MAiD [13,34].

Taking into account all the sources of authority examined in this paper, we can conclude that, in some cases, the law is clear. A reasonably foreseeable death is natural if:

- it flows from the refusal of medical interventions such as ventilators or antibiotics (but not including artificial hydration and nutrition);
- the reasonably foreseeable death would be “nature taking its course;” **and**
- disease (rather than accident or injury whether inflicted by self or other) precipitated the need for the care that is being refused.

It is critically important that this clarity be acknowledged and disseminated so that individuals who could legally refuse care as a path to MAiD are not denied access due to a misguided fear of criminal liability on the part of health care providers or institutions.

Unfortunately, in some cases the law is not as clear. It is not as clear whether the following reasonably foreseeable deaths would be natural:

- deaths that would flow from the refusal of artificial or oral hydration and nutrition;
- deaths that would flow from the refusal of preventive care;
- deaths that would not be the result of “nature taking its course;” and
- deaths that would flow from the refusal of care where accident or injury (whether inflicted by self or other) precipitated the need for the care being refused.

It is critically important that the law regarding these cases be clarified so that individuals who could legally refuse care as a path to MAiD are not denied access due to a reasonable fear of criminal liability on the part of health care providers or institutions and that individuals who could not legally refuse care as a path to MAiD are not given access to MAiD due to a misunderstanding of the law on the part of MAiD assessors and providers.

Proposed clarification

In order to harmonize the various aspects of the case law, provincial/territorial consent legislation, and the *Criminal Code*, the definition of “suicide” for the purposes of s.241(1) of the *Criminal Code* should be clarified. In order for patients and providers to know for certain which, if any, of the examples outlined at the beginning of this paper constitute “natural death” and so can function as a path to MAiD, a clear definition of “natural death” for the purposes of s.241.2(2)(d) should be established. Such clarification can come from Parliament (through an amendment to s.241.2 of the *Criminal Code*) or from the courts (through a case turning on the definition).

Given that individuals have a right to refuse treatment, preventive care, and artificial and oral hydration and given that physicians have a duty to respect refusals (and may be liable for assault or battery if they touch patients without their consent), the *Criminal Code* should be amended/interpreted to make it clear that, in the context of s.241.2(2)(3), a reasonably

foreseeable death from a refusal of treatment or preventive care or artificial and oral nutrition or hydration would be “natural” if an underlying medical condition (regardless of whether caused by disease or naturally-occurring disability, accident, or intentional injury by self or other) precipitated the refusal.

In the meantime, the federal government should revise the “Federal guidelines: reporting of deaths in cases of medical assistance in dying (April 2017)” [25] to make it clear when refusing care renders a patient’s death not “natural.” Provinces and territories should, in turn, harmonize their vital statistics instructions regarding medical certification of death with these federal guidelines. Where they have a mandate to do so, chief coroners/medical examiners should issue instructions for the completion of medical certificates of death by coroners/medical examiners/physicians/nurse practitioners to harmonize their approach to medical certification of death with the federal guidelines. Colleges of Physicians and Surgeons as well as Colleges of Nurses should direct physicians/nurse practitioners to follow the instructions provided by the authorities in their province/territory and, if none, the federal guidelines. These instructions should be included in their professional standards regarding medically assisted dying, as they are in Nova Scotia.

Any of these entities, as well as the Canadian Association of MAiD Assessors and Providers, need not wait for the federal government to act. They could reasonably offer guidance immediately to those they regulate or serve.

Clarifying documents could state either of the following:

1. *Template text consistent with the traditional approach to the classification of death and Statistics Canada database*

If a person refused care – including preventive, curative, and palliative health care (including artificial and oral nutrition and hydration and nutrition) – and died as a result of the withholding or withdrawal of that care, we would consider their death to be natural if the care was necessary due to a disease or naturally-occurring disability. We would not consider it to be natural if the patient refused care that was necessary due to an accident or intentional injury by self or other, even if the mechanism of death would be, for example, an infection.

OR

2. *Template text consistent with inference from the federal guidelines regarding medical certificates of death in cases of MAiD*

If a person refused any type of care – including preventive, curative, and palliative health care (including artificial and oral nutrition and hydration and nutrition) – and died as a result of the withholding/withdrawal of that care, we would consider their death to be natural if an underlying medical condition (regardless of whether cause by disease or naturally-occurring disability, accident, or intentional injury by self or other) precipitated the refusal.

A person’s natural death has become reasonably foreseeable when they have refused care without which they will die and it is reasonable to conclude that they will not deviate from that refusal.

The latter of these two options is preferable for at least two reasons. First, because it is grounded in guidelines drafted after the passage of the federal MAiD legislation and specifically for the purpose of providing guidance in the context of MAiD. Second, because it avoids the indefensible position that a person’s access to MAiD would depend on the ethically irrelevant and arbitrary fact of whether the cause of their underlying medical condition causing enduring, intolerable, and irremediable suffering was an accident or a naturally occurring disease, disability, or disorder (e.g., a person who is quadriplegic due to a stroke would have different rights than a person who is quadriplegic due to a motorcycle accident).

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References

1. [Criminal Code of Canada](#). RSC 1985, c C46.
2. Senate, Proceedings of the Standing Senate Committee on Legal and Constitutional Affairs, 42nd Parl, 1st Sess, Issue No 10, Evidence (6 June 2016) ([Peter Hogg](#)).
3. House of Commons, Standing Committee on Justice and Human Rights, 42nd Parl, 1st Sess, Evidence, No 13 (4 May 2016) at 2045 ([Jocelyn Downie](#)).
4. Senate, Proceedings of the Standing Senate Committee on Legal and Constitutional Affairs, 42nd Parl, 1st Sess, Issue No 9, Evidence (10 May 2016) ([Dr. Douglas Grant](#), [Dr. Joel Kirsh](#)).
5. House of Commons, Standing Committee on Justice and Human Rights, 42nd Parl, 1st Sess, Evidence, No 13 (4 May 2016) ([Dr. Jeff Blackmer](#)).
6. [Lamb v Canada \(Attorney General\), Vancouver, SCBC, S-165851](#) (notice of civil claim), filed 27 June 2016.
7. Jean Truchon and Nicole Gladu v Attorney General (Canada) and Attorney General (Quebec), Montreal, CQ (Civ Div) ([notice of Application to Proceed for Declaratory Relief](#)), 13 Jun 2017.
8. [Carter v. Canada \(Attorney General\)](#), 2015 SCC 5, [2015] 1 SCR 331.
9. [Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts \(medical assistance in dying\)](#). 1st Sess, 42nd Parl, 2015 (assented 17 Jun 2016).
10. Downie J, Scallion K. [Foreseeably unclear: the meaning of the 'reasonably foreseeable' criterion for access to medical assistance in dying in Canada](#). *Dalhousie Law Journal*. 2018;41:1-23.
11. Downie J, Liu R. [The legal status of deep and continuous palliative sedation without artificial nutrition and hydration](#). *McGill Journal of Law and Health*. 2018;12(1):29-66.
12. Downie J, Chandler J. [Interpreting Canada's medical assistance in dying legislation](#). IRPP Report. Mar 2018.
13. Downie J. [An alternative to medical assistance in dying? the legal status of voluntary stopping eating and drinking \(VSED\)](#). *Canadian Journal of Bioethics/Revue Canadienne de Bioéthique*. 2018;1(2):48-58.
14. MacIntosh C. [Carter, assisted death, and mature minors](#). *McGill Journal of Law and Health*. 2016;10(1):1-33.
15. [Carter v Canada \(Attorney General\)](#). 2012 BCSC 886, 287 CCC (3d) 1; 261 CRR (2d) 1
16. [Bentley v. Maplewood Seniors Care Society](#). 2014 BCSC 1321.
17. [Ciarlariello v Schacter](#). 1993 2 SCR 119.
18. Mader S, Apold V. VSED as an alternative to MAiD: a Canadian legal analysis. (unpublished); on file with the authors.
19. 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](#). Ottawa: Council of Canadian Academies; 2018.
20. [AB v Canada \(Attorney General\)](#). 2017 ONSC 3759.
21. [Nancy B v Hotel-Dieu de Quebec](#). 1992 86 DLR (4th) 385, RJQ 361 (QCSC).
22. [British Columbia \(Attorney General\) v. Astaforoff](#). 1983 6 WWR 322.
23. Downie J. [Has stopping eating and drinking become a path to assisted dying?](#) Policy Options. 23 Mar 2018.
24. College of Physicians and Surgeons of British Columbia. [Final disposition report of the inquiry committee](#). 13 Feb 2018 (quoting letter from Dr. Jatinder Baidwan).
25. Government of Canada. [Guideline for death certificates](#); 26 Apr 2017.
26. Statistics Canada. [Canadian Coroner and Medical Examiner Database: Annual Report, 2006 to 2008](#). 82-214-X, 9 Feb 2012.
27. Ontario Office of the Registrar General. [Handbook on medical certification of death: prepared for: registered nurses \(extended class\)](#). Ministry of Consumer and Business Services, Government of Ontario; 2010.
28. BC Vital Statistics Agency. [Medical certification of death and stillbirth: a handbook for physicians, nurse practitioners and coroners](#). Government of British Columbia; 2017.
29. Office of the Chief Medical Examiner. [Death investigation process](#). Government of Alberta; 2019.
30. Demers S. [Protocol for completion of death registration in medical assistance in dying](#). Registrar Vital Statistics, Director Insured Health and Hearing Services, Government of Yukon. 1 Sept 2016.
31. Winnipeg Regional Health Authority. [Manitoba medical assistance in dying overview for health-care providers](#). WRHA. Sept 2018.
32. Kelsall D, Bowes M. [No standards: medicolegal investigation of deaths](#). *CMAJ*. 2016;188(3):169.
33. McGivern L, Shulman L, Carney J, Shapiro S, Bundock E. [Death certification errors and the effect on mortality statistics](#). *Public Health Reports*. 2017;132(6):669-675.
34. Downie J. [Can nurse practitioners mention MAiD to patients?](#) *Impact Ethics*. 3 Jul 2018.