

“Medical Assistance in Dying” (Euthanasia and Assisted Suicide) in Canada: A Case Raises Questions About Its Use in Patients with Disability and Mental Illness

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Legislative Background: The Development of Medical Assistance in Dying Law in Canada

In 2016, Canada created an exception to the criminal law’s prohibition of euthanasia and assisted suicide. The law, which termed the practice “Medical Assistance in Dying” (MAiD), came about in response to a 2015 Supreme Court decision (*Carter v. Canada AG* 2015) which invalidated Canada’s absolute prohibition. The Supreme Court ruled that this absolute prohibition was an unjustifiable restriction of patients’ right to life, liberty and security of the person, a right protected under the Canadian constitutional Charter of Rights and Freedoms. It suspended its declaration of invalidity of the absolute prohibition and gave parliament at the time one year to come up with legislation to change the law in line with some specific parameters it put forward in its judgment.

The 2016 federal law kept the criminal prohibition in place but carved out an exception that allowed physicians or nurse practitioners to provide MAiD, either by injection or by providing a lethal medication that patients can take themselves. An important characteristic of the 2016 law was that the person’s natural death had to be “reasonably foreseeable.” As a result, MAiD was restricted to a broad end-of-life context. The law also introduced some other safeguards, including an assessment by a second physician, the signing of a consent form in the presence of two witnesses and a reflection period of 10 days between the demand and the execution of the request — a period which could be shortened if a patient was likely to lose consciousness or to die earlier. The law further imposed post-factum reporting to a federal agency.

To be eligible, patients had to be 18 years old, have a grievous and irremediable medical condition that causes unbearable suffering and provide informed consent. One of the controversial components of the law was the detailed definition of what a “grievous and irremediable” medical condition is. The Supreme Court had made a general statement in the *Carter* decision that capable patients like the plaintiff in the case (a person with terminal illness at an advanced stage — ALS) should have a right to have MAiD when suffering intolerably from a “grievous and irremediable”

condition. It had, however, not given any definition of these concepts, which it referred to as “parameters” the law should respect. The law adopted by the federal Parliament defined that a patient has a “grievous and irremediable medical condition” when all the following criteria are fulfilled: 1) a serious illness, disease or disability; 2) an advanced state of decline that cannot be reversed; 3) unbearable physical or mental suffering that cannot be relieved under conditions that patients consider acceptable; and 4) natural death is reasonably foreseeable.

From the moment that the law was adopted, the “reasonably foreseeable natural death” criterion, a safeguard aimed at protecting people with potentially years or decades of life left against premature death, was interpreted very broadly. As a result, in several provinces, people with a life expectancy of 1 or 2 years, or even more, were already considered eligible for MAiD if all other criteria were fulfilled. Those arguing for a broad interpretation found support in an Ontario judgement (*A.B. v Canada* 2017), which interpreted the law as providing much professional discretion in the interpretation of “reasonably foreseeable death.” The judge in this case ruled that a person’s death did not need to be imminent to qualify for MAiD. It only had to be predictable, according to the ruling, that a patient would likely die within the foreseeable future from natural causes.

This broad interpretation of “reasonably foreseeable death” notwithstanding, some felt that this criterion, not mentioned in the *Carter* decision, made the law still too restrictive and went to court to challenge the “reasonably foreseeable death” criterion as a violation of their constitutional rights. In September 2019, a Quebec superior court sided with two plaintiffs (*Truchon v Canada* 2019) who had been deemed not eligible for MAiD because their death had been considered not “reasonably foreseeable.” It is worth noting that this case occurred in Quebec, where a provincial law also limited MAiD to people who are at the “end of life.” Physicians in the province interpreted the federal requirement of “reasonably foreseeable death” in line with this provincial “end of life” criterion and thus narrower than in other provinces (*McMorrow, Wiebe, Liyanage et al.* 2020). The plaintiffs would likely have had access to MAiD in other provinces.

The Quebec court declared both the federal and provincial access criteria discriminatory towards people who have a disease or disability but who are not close to their natural death, and also an unjustifiable restriction of their right to life, liberty and security of the person. The federal Attorney General failed to appeal that decision, a decision likely influenced by political consideration — the decision not to appeal was made during an election period, claims for broad

access to MAiD had been very popular in Quebec and voters in the province were key for electoral success. There were, however, strong reasons to appeal the decision, considering the peculiar application of the concept of discrimination by the judge, and problematic statements about the evidence (Lemmens and Jacobs 2019).

In response, the government introduced in 2020 a bill that broadened access to MAiD outside the end-of-life context and further abolished several other safeguards of the 2016 law. The bill originally excluded MAiD for sole reasons of mental health, but Canadian Parliament adopted an amendment introduced by senator (and psychiatrist) Stanley Kutcher, which removes this exclusion of mental health under a so-called sunset provision. Under the sunset provision as finally adopted, mental health will be a basis for MAiD by March 2023. In the meantime, the government must explore whether additional safeguards for mental health are required. Just prior to calling an election, it has set up an advisory committee for this very purpose. The Chair of this advisory committee, as well as many other experts on the advisory committee have already explicitly endorsed in public statements and reports broad access to MAiD for mental illness. Several are also associated with Dying with Dignity, an advocacy organization that has lobbied for broad access to MAiD.

The new law, adopted in the spring of 2021, introduces a two-track system for MAiD (Canada Justice 2021). For people whose natural death is “reasonably foreseeable,” some of the previous safeguards were abolished. For example, there is no longer a required reflection period. People can thus in theory request MAiD, receive approval, and have their life ended on the same day. The rationale provided for abolishing this reflection period has been that people who come to the decision to request MAiD have undergone a long process of reflection. But note that the reflection period could already be shortened under the original law. The need for reconfirmation of consent is also abolished, which means that some form of advance request for MAiD has now been introduced. A person who is approved for MAiD but loses consciousness before the procedure is performed can still have their life ended by MAiD. The requirement of having two independent witnesses for a written MAiD request has been reduced to one and this witness can now under the new law be a paid health care provider.

For people whose death is not “reasonably foreseeable,” the law introduced a 90-day assessment period, which can be shortened if the assessors are of the opinion that they were able to conduct an appropriate assessment and the person requesting MAiD is about to lose capacity.

One of the two required evaluators of the MAiD request must also have expertise in the condition that causes the patient's suffering. The law further introduced some additional, albeit limited, informed consent requirements for this second-track system outside the end-of-life context. Information must be provided about all mental health, disability and palliative care services. Patients must be offered consultations with appropriate experts. And health care providers must discuss with the patients all reasonable and available options and agree that the patient "seriously considered" these options. As some of us have pointed out, this stops short of requesting that all reasonable options have been made available and tried out first (Lemmens, Shariff and Herx 2021).

In the few other MAiD regimes that allow MAiD outside the end-of-life context, physicians must agree that there are no other reasonable options. Canada's system is uniquely failing to impose this most basic requirement, which in my view undermines the role of the medical profession in determining the standard of care (Lemmens, Shariff and Herx 2021). It is not clear yet whether additional requirements will be imposed in the context of requests for MAiD for sole reasons of mental health.

For those whose death is not "reasonably foreseeable," the other access criteria remain in place. People need to suffer intolerably from a serious illness, disease or disability, and have irreversible decline of capability. The criterion of "intolerable suffering" is interpreted very subjectively in the Canadian context. While a MAiD assessor could theoretically at least still conclude that they do not *believe* that the patient is truthful in their statement about intolerable suffering, it seems unlikely that will practically happen.

What this concretely means is that by definition, the people who can request MAiD outside the end-of-life context are persons with a disability (i.e., people who have an illness, disease or disability which is associated with irreversible decline of capability, which corresponds to the definition of disability). They just have to claim that their disability makes them suffer unbearably. Canadian law has thus now introduced MAiD for everyone who has an illness who is approaching their natural death, but people with disabilities are the only ones who can ask for MAiD even when they are not dying. This has been criticized as depriving people with disabilities from equal protection against premature death (Kaiser, Grant, Lemmens and Sheehy 2021), including by United Nations Human Rights Experts (Quinn, Mahler and Deschutter 2021). As mentioned before, in two years mental health will explicitly be included as a basis for access to MAiD, and it is not clear yet if additional procedures or criteria will be introduced.

The Alan Nichols Case

This short background information is important to understand the narrative account written up by three family members (brothers and sister-in-law) of 62-year-old Alan Nichols, a man with physical frailty due to past health issues and a cognitive disability, but who was not diagnosed with a terminal illness. In 2019, Mr. Nichols died by MAiD in a British Columbia hospital, about a month after hospitalization. The RCMP (federal police force) transported him to the hospital on June 16, 2027, after a “wellness check” which had been solicited by a family member who was worried about his wellbeing. At admission, he was diagnosed as suicidal and dehydrated. He was treated briefly (two days) with an anti-depressant.

As the account reveals (see below), in the days and weeks following his hospitalization, Alan Nichols’ family tried to obtain information about his treatment and his recovery, but there were problems with communication between the treating staff and the brothers and sister-in-law. Four days before the procedure, they learned that he had requested MAiD and that the procedure would take place on July 26, 2019, a month after his hospitalization.

They tried to convince the hospital, treating staff and Alan Nichols to postpone the procedure and to explore various social and health care options. They also wanted to be given an opportunity to discuss other options of social and health care support with him in person.

In their view, Alan did not fulfill the access criteria that existed at the time under the Canadian MAiD law. His natural death was in their opinion not “reasonably foreseeable,” which was an explicit access criterion. They also raised questions about his capacity for decision-making. In addition, communication with Alan was difficult since he refused to use his cochlear implant hearing system and communications were therefore taking place through notes on an erasable board. Note that they only had an opportunity to discuss with him the MAiD request the day before the procedure took place.

The family’s account and the Health Authorities response to their complaint are reproduced below for further discussion and to raise awareness about some of the challenges that already existed under the 2016 Canadian MAiD law.

They also provide a good background to reflect on the challenges of providing MAiD to people suffering from mental illness more generally. This issue is now the topic of serious debate in Canada, since the government has set up an advisory committee to make recommendations

about how MAiD for mental health reasons can be introduced, as required by the 2021 law with its sunset provision. As mentioned before, mental illness will normally be accepted as a sole basis for MAiD requests as of March 2023.

The case is also relevant for the official review of the MAiD practice in Canada, which is currently taking place as required under the 2016 law. As part of this review process the government commissioned several reports of the Council of Canadian Academies (CCA) on the topic of MAiD, including on MAiD for people whose sole underlying condition is a mental disorder. These CCA reports, written by an extensive group of experts, did not provide any recommendations, but focused on providing the “evidence” of the practice of other jurisdictions in relation to three controversial areas of MAiD: MAiD for people whose sole underlying condition is a mental disorder; MAiD based on advance requests; and MAiD for mature minors. They were submitted to the government in December 2018, to be used by parliament in the official parliamentary review of the MAiD practice (CCA 2018).

Following the release of these official CCA reports in 2018, two different groups with past members of the CCA expert panels on MAiD have issued reports with specific recommendations for MAiD in the context of mental illness following the CCA. One report recommended broad access to MAiD for mental illness (Halifax Group 2020) and made specific recommendations about how to do so. It emphasized that there should be no assessment of the quality of the decision for MAiD (i.e., whether it is a good decision) but that the focus should be on the process of decision making, to make sure a decision was “well thought out” and “not impulsive.” The other report was written in response to the first report and made recommendations against providing access to MAiD for mental disorders (Expert Advisory Group on MAiD 2020). The key recommendation was that the law should recognize that “irremediability” and “irreversible decline” cannot be determined a priori in relation to mental illness. It also made two general recommendations in relation to MAiD outside the end-of-life context: 1. That a non-ambivalence criterion should be required for MAiD in situations when death is not reasonably foreseeable; and 2. That a “lack of reasonable alternative criterion” should be introduced in those circumstances.

A joint parliamentary committee (which is now dismantled because of upcoming elections) recently started the official review of Canada’s MAiD practice, unfortunately after parliament already expanded MAiD with its new law. During hearings of this committee, some experts and parliamentary members (including Stanley Kutcher) already suggested that cases such as Alan

Nichols are not relevant for this review since they are “anecdotal.” Some maintained that in addition to official data and peer-reviewed analyses of such data, only cases that have gone to court and have been submitted to adversarial procedures are to be taken seriously. But anyone somewhat familiar with the evidentiary and financial challenges patients face in obtaining accountability for medical mishaps in court or through professional disciplinary procedures will appreciate the problematic nature of these claims. While we do have to realize that the narrative below is primarily based on the family’s account, an official response is reproduced below, which corroborates at least several components of their account.

The case illustrates in what circumstances MAiD has been provided in Canada even before the introduction of mental illness as a basis for MAiD; and what some of the challenges are that we were already facing before an expansion of the law outside the end-of-life context.

Key issues raised by this case include:

- Alan Nichols was diagnosed as suicidal, only four weeks prior to receiving MAiD. He was treated with anti-depressants for two days after hospitalization. The Health Authority states in its letter that the psychiatrist declared that his request for MAiD was unrelated to mental illness. We must presume the psychiatrist and MAiD assessors also considered it unrelated to his cognitive disability. Further, there were, according to the official response, no problems with capacity for decision-making. The account of the family raises questions in that regard. One key question is whether the time frame between admission and termination of life would have been sufficient to explore and address potential underlying mental health issues.
- Alan Nichols appeared to be overall frail, because of a complex history of disease, including a stroke several years earlier, but he was not terminally ill. He also, according to family members, had a cognitive disability. The health authorities’ response confirms that he was not diagnosed with a fatal or terminal illness. They emphasize in their letter the flexibility permitted under the law (which restricted MAiD at that time to “reasonably foreseeable natural death”). Persons with disabilities and disability advocacy organizations have expressed serious concern about how health care providers and MAiD assessors may be influenced in their

assessments by ableist presumptions about the quality of life of persons with disabilities and about what it means to be dependent on others. The following statement by the health authorities is in that context worth noting, since it appears to validate these concerns: “Each patient's circumstances are unique, and life expectancy depends on several factors such as the nature of the illness, and the impacts [*sic*] of other medical conditions and health-related factors such as frailty, and dependency on others for activities of daily living.” In other words, even the fact of being dependent on others is explicitly put forward as part of the reason why inferences can be made that a person is on a “trajectory towards death.” The Health Authorities pretend also that physicians and nurse practitioners “have the necessary expertise to effectively judge” whether a person is on a trajectory towards death. In Belgium and the Netherlands, two liberal euthanasia regimes, there has been a significant increase in the last decade of cases of people receiving euthanasia without immediate life-threatening condition but being overall frail. In Belgium, the Federal Review Commission introduced the concept of “polypathology,” i.e., a combination of medical issues associated with frailty, generally associated with old age, to provide a medical basis for these euthanasia requests (Lemmens 2018; Raus, Vanderhaegen and Sterckx 2021). This has been seriously criticized, in my view appropriately, as an expansion of euthanasia through a medicalization of old age. The Nichols case suggests that even before the expansion of the law outside the end-of-life context, Canada had already embarked on MAiD for people who are generally frail and dependent on others but who are not terminally ill. Physicians and health authorities in Canada have done so based on a broad interpretation of the criterion of “reasonably foreseeable natural death.”

- It seems remarkable that people can be brought to hospital under legal provisions that allow for their hospitalization for reasons of risk to their health and receive MAiD merely four weeks after hospital admission, and this without a clearly identifiable terminal illness. Note that under the new law, which allows MAiD also for people whose death is not “reasonably foreseeable,” a 90-day assessment period has been introduced. During this period, according to the new law, various options must be

explored and alternatives must be offered to patients. This remains in my view an insufficient safeguard against premature death. It is particularly weak as a safeguard because the law doesn't even require that health care providers must agree that all reasonable options have been tried first. Health care providers simply have to verify that the patient "seriously considered" other options, whatever that means. They do not even have to ensure that they are all made available, but simply have to present what is available. But regardless of the flaws of this 90-day assessment period with additional consent requirements, it constitutes at least recognition of the fact that assessing people who are not dying for eligibility for health-care provider termination of life and exploring potential alternatives are to be done with particular scrutiny and care, and that it inevitably requires time. What we see here with Alan Nichols case is that people who are overall frail, dependent on others, can be identified as being "on a trajectory towards death" and have their lives terminated by health care providers in Canada, even without a 90-day assessment period and more careful scrutiny of alternatives. For them, even the 10-day reflection period, which existed under the previous law, has been abolished.

- According to the family, Alan had obtained approval for MAiD and was going to receive it originally without the family even being informed about it. They indicate that the procedure was only postponed when the nurse practitioner who was going to perform MAiD refused to perform the procedure, according to the family because she felt several issues were not addressed (no physician present, no family contacted, no directive about what to do with his body after death). It is only after the procedure was refused the first time that family members received information about the pending ending of life through MAiD. This was four days prior to the procedure. From the account provided, it appears that the family had in the past been closely involved in the care of Alan Nichols. The Health Authority invokes privacy law to defend the late notice, since in their view Alan was not interested in getting his family informed. But wouldn't it be crucial, particularly when we are dealing with a vulnerable, fragile individual with cognitive disability, to explore all options of support, including family

support, as part of the development of a treatment plan? Here we seem to be dealing with a family who had always been involved in his care.

- According to the family, and as confirmed in the response by the Health Authority, Alan Nichols refused to use his cochlear implant. The only means of communication was through an erasable board. This does not mean that communication with him was impossible, but it does raise questions about the quality of the communicative process through which it was established that Alan Nichols was capable of decision-making, well informed and not submitted to pressures that might have undermined or at least affected his voluntariness. One of the key concerns that have been put forward in this context is that undue pressure or misunderstanding may impact on the decision-making process.
- The case also reveals the hurdles family members faced in order to obtain information, including information about the details of the MAiD approval. One must ask whether it would not be crucial, in most circumstances, that family members are able to obtain detailed information about the basis for MAiD. Health information privacy is too often invoked to shield the health record from scrutiny by family members, who may often be the only ones willing to seek accountability for problematic practices.
- It is noteworthy that, according to the family members' account, the stated cause of death on the death certificate is "MAiD because of stroke." The family indicated that he had been living with stroke for several years and had recovered from it. In some provinces MAiD would even not have been mentioned. A remarkable part of the regulation of MAiD in Canada is how some provincial regulations (Ontario's, for example) explicitly require that physicians do not identify MAiD as the cause of death on death certificates. They do have to make a separate MAiD declaration, but they must state as the "cause of death" on the official death certificate the medical condition which lies at the basis of the request for MAiD. The reason originally invoked was that death by MAiD could be stigmatizing and that privacy of the decision

to have MAiD justified this peculiar rule. It seems extraordinary, however, that we now have introduced in some provinces in Canada an official rule that obliges physicians to make a false declaration on death certificates. Even if that would be considered not too far removed from the truth in situations where someone is close to their death due to cancer, it seems extraordinary that physicians basically would have to invent a cause in a situation like that of Alan Nichols. Imagine also what this will mean if the same rule is applied outside the end-of-life context under the new law. Will we now see on death certificates a non-life threatening disability as the official cause of death?

A final note on how the legal organization of MAiD may restrict what family members can do if they feel that the life of their loved one was inappropriately terminated. The family members of Alan Nichols told me they contacted the RCMP (federal police) to file a complaint about what happened. It was the RCMP, after all, which brought Alan Nichols to the hospital following a wellness check. The response by the RCMP was that since this was a case of MAiD, there was no reason for the RCMP to investigate. Even though the MAiD law has kept the general prohibition on assisted suicide intact, and obviously continues to prohibit intentional killing of a person outside the context of MAiD, the mere fact of framing something officially as death by MAiD makes it unlikely that there will be any criminal investigation. One must wonder if this is desirable as a matter of policy.

References:

A.B. v. Canada (Attorney General), 2017 ONSC 3759. Court File No.: AD-001/17. eol.law.dal.ca/wp-content/uploads/2017/06/20170619152447518.pdf.

canada.justice.gc.ca. Medical Assistance in Dying. 2021. <https://canada.justice.gc.ca/eng/cj-jp/ad-am/text.html>

Carter v. Canada (Attorney General), 2015 SCC 5 (CanLII), [2015] 1 SCR 331, <https://canlii.ca/t/gg5z4>.

Expert Advisory Group on Medical Assistance in Dying. Canada at a Crossroads: Recommendations on Medical Assistance in Dying and Persons with a Mental Disorder. An Evidence-based Critique of the Halifax Group IRPP Report. EAG 2020a. <https://static1.squarespace.com/>.

Halifax Group. MAiD Legislation at a Crossroads: Persons with Mental Disorders as Their Sole Underlying Medical Condition. IRPP 2020. <https://irpp.org/research-studies/>.

Kaiser A, Grant I, Lemmens T, Sheehy E. MAID bill is an affront to equality. Toronto Star 2021.

Lemmens T. Charter Scrutiny of Canada's Medical Assistance in Dying Law and the Shifting Landscape of Belgian and Dutch Euthanasia Practice (2018) Supreme Court Law Review (2nd) 85: 453-544.

Lemmens T, Jacobs L. The latest medical assistance in dying decision needs to be appealed: Here's why. The Conversation 2019. <https://theconversation.com/>.

Lemmens T, Shariff M, Herx L. How Bill C-7 will sacrifice the medical profession's Standard of Care. Options 2021. <https://policyoptions.irpp.org/magazines/february-2021/>.

McMorrow T, Wiebe E, Liyanage R, Tremblay-Huet S, Kelly M. Interpreting Eligibility Under the Medical Assistance in Dying Law: The Experiences of Physicians and Nurse Practitioners. McGill Journal of Law and Health (2020) 14(1): 51-108

Quinn G, Mahler G, Deschutter O. Mandates of the Special Rapporteur on the rights of persons with disabilities; the Independent Expert on the enjoyment of all human rights by older persons; and the Special Rapporteur on extreme poverty », Ref. OL CAN 2/2021, (3 February 2021). <https://t.co/CGNlgjsYFw?amp=1>

Raus K, Vanderhaegen B, Sterckx S. Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice" J Med & Philosophy (2021) 46: 80-107

Truchon c. Procureur général du Canada, 2019 QCCS 3792 (CanLII), <https://canlii.ca/t/j4f8t>.

Attached below are:

1. A narrative description by the family members of Alan Nichols;
2. A letter of complaint by family members; and
3. A letter by the health authority responding to the complaint by the family members.
(Names of the health care providers involved have been anonymized.)

ATTACHMENT 1:

A narrative description by the family members of Alan Nichols

**Summarized account of events surrounding the death of Alan G. Nichols, from June 16
2019 to July 26 2019**

Document prepared by Gary, Trish and Wayne Nichols

Dated: 17 September 2019

June 16 – RCMP left a telephone message on Wayne Nichols (Alan’s brother) answering service they were admitting Alan to Emergency at the X Hospital by for his own health and safety after gaining entrance from Alan’s neighbor YYY who called to ask for a Wellness Check.

June 16 – Alan didn’t want to be admitted and was reluctant to get into the ambulance. He told Gary (Alan’s brother) later that day in Emergency when Gary went to see Alan, “If you’re not here to bust me out, then you might as well leave”. Alan made it clear to Gary then he wanted out of the hospital and did not want to be there. Gary heeded the message from RCMP saying Alan would be safer at X HOSPITAL.

June 17, 2019 – Gary went to Emergency to see Alan again. Unbeknown to our family, they transferred Alan to the Psychiatric Unit. Gary walked over to that wing of the hospital to see Alan. They told Gary there, that Alan said he did not want to see any visitors.

June 18, 2019 – Gary spoke with XY of Psychiatry Unit to discuss the family concerns about Alan and feared he could no longer go home and live unassisted anymore and that family had tried and failed to receive guardianship up to this point and hoped that temporary guardianship could be granted at this time to the family with the assistance of X HOSPITAL and BC Health. Gary left contact information etc. and XY said he would be in touch. Gary then went back to X Hospital Administration Office and spoke with Z to also leave his contact information them as well. He shared his concerns with her, and she stated the Psychiatric Unit works independently from X HOSPITAL and that X HOSPITAL Administration would not be able to help us or do much of anything else, unless Alan was transferred to one of the hospital units.

No contact from either XY or Z in administration was ever received after these conversations until Gary sent the following emails.

June 21 – Unbeknown to our family, once again, they transferred Alan to the PATH unit on the 5th Floor of the X Hospital.

June 25 – Gary emailed XZ to try to find out what was going on with Alan but there was no reply.

June 27 – Gary emailed XZ again asking for updated status of Alan. He said he would be calling him directly the following day if he hadn’t received a reply from him.

June 27 – XZ responded by email and let Gary know that Alan had been transferred from Psychiatry to the PATH Unit at X HOSPITAL the week prior, on June 21st. He apologized in this email for not having passed on the info to Gary sooner regarding this. Alan was now under the care of Dr. Y and that he could call the PATH unit at X HOSPITAL for more information.

Gary contacted Dr. Y at the PATH unit right away and Dr. Y asked Gary to call her back on Monday to give her a chance to talk with Ms T, Alan's social worker, to get an update on Alan's status. Monday was a July 1st statutory holiday, so Gary called Tuesday July 2nd.

July 2 – Gary called the PATH Unit to talk to Dr. Y and the receptionist told Gary that Dr. Y was away for the next few weeks on holidays. Gary asked if there were anyone else that could tell him how Alan was doing. The receptionist located one of the nurses to take the call. That nurse told Gary Alan was doing ok and that he would have to call back in a couple of weeks, when Dr. Y got back from her holidays.

Gary called from his office during this next 2 weeks and was only able to speak once to Ms T (Alan's social worker) who said Alan was eating, walking, talking, visiting with others on the ward. She would have Dr. Y contact Gary upon her return from holidays to give him more information.

July 19 – Unbeknown to our family, once again, Alan had been prepared to receive the MAID procedure, but it was stopped by Ms P, the person who administers the lethal injections. She had shown up at X HOSPITAL this day (the needle site was already put in Alan's left arm for the administration of injections). She would not proceed as the hospital did not have required criteria and protocols in place for MAID.

July 22 – Dr. Y called Gary at work in Edmonton, as a courtesy she said, to notify the family of Alan's intent to have assisted death within the next four days, scheduled for the upcoming Friday, July 26, 2019.

Trish (Alan's sister-in-law) called Dr. Y back the same afternoon from home when she learned of this news. Shocked and in disbelief, she now had several questions, concerns and suspicions as to what was going on and had actually transpired during Alan's stay at the Chilliwack Hospital, where he had been admitted for medical reasons and there on the intention of being kept safe or causing any further harm to himself. Trish told Dr. Y the family felt strongly that this was not assisted dying in Alan's case, but rather an assisted suicide and the family could not support that choice and wanted this stopped. Alan clearly did not have any terminal illness or disease, nor was he in any pain. He had been depressed over the years and showed signs of poor choices stemming from outer conditions which he had no control over, and that perhaps he was angry about many too many changes happening, that he had been admitted for his own safety. Dr. Y said it was Alan's "legal right" to have assisted death, that is not necessarily what she wanted for him, but she gave him the forms, he applied and it was approved and there was nothing she or anyone but Alan could do to stop it. Trish told Dr. Y that her and Gary were making arrangements to drive to Chilliwack and would try to convince Alan to stop or at the very least postpone this until the family could seek legal counsel.

July 23 – Gary and Trish (we) were frantically trying to reach Wayne (who was across country on a planned holiday) and out of cell phone receptivity. We called the PATH unit to wish Alan a happy 62nd birthday. The receptionist said they would get the message to Alan and that they themselves were celebrating his 62nd with a cake and the staff on Unit 5!

July 24 – We arrived at X HOSPITAL after driving 12 ½ hours from Edmonton, only to be told by staff that Alan did not want to see us that evening and to come back the following day after 10:00 a.m.

July 25 – We returned at 10:00 a.m. and were able to walk into Alan’s room. He was happy to see us. Alan’s social worker, Ms T came and introduced herself and sat in the room with us to answer some questions and assist with the visit. We asked to meet with Dr. Y as well, but she, once again, was unavailable until the next morning, before the procedure. Ms T assured us though, that Dr. Y would indeed pay a visit to Alan on the morning of his impending death. **ALL communication with Alan** was done by writing on a white board with felt pen. He should have been wearing his cochlear hearing device. We spent this final day with Alan imploring him to reconsider the alternatives. He ate all meals and snacks with much joy, he walked around the unit with his walker, walking faster than I could keep up with him. We shared lots of laughter and reminisced about family times. We asked, implored Alan to try assisted living rather than assisted dying and begged him to stop this procedure and work towards a better solution. “No.”, he said. “Not going to happen. Too late.” We start asking Alan the dreaded end of life questions. What were his wishes? He stated: “Don’t worry about any thing like that. I took care of it all. It’s all in the will.” He became very agitated, and in a burst of anger he shouted, “it took them three days to do my will. Just wait and see... Canada’s going to pay for butchering me! They’re not going to be happy.” We were stunned. He lowered his voice saying, “he didn’t trust anyone in the hospital and that it was better to keep quiet, and sometimes it was better not to say anything”. He couldn’t hear anyone speak, had so much difficulty in seeing anything, would not take care of his basic needs, was admitted to the hospital to address fatigue, depression and lack of proper nutrition, and yet somehow the staff had managed to bring in lawyers to have his will done, celebrate a his birthday, but no medical staff to help with any of his muscle weakness, eye sight correction, or help him wear his cochlear device? How was this possible? He was not of sound mind and body. He was admitted for an unsound body and then transferred to psychiatry for an unsound mind. He had been depressed and suicidal, and angry thinking things were falling apart, yet he was deemed competent to complete a will and sign his own death application? We were devastated to say the least and begged anyone who would listen, if there were any way to stop this fiasco, or at least postponing it temporarily, so our family could seek legal consult. What was the hurry? Now that family was involved, seeing what had gone on in the X Hospital for the duration of Alan’s stay, and told we could not do one single thing about it? We began to see the misuse of this application and how could this happen with Alan who had been placed in the care of the Health Unit at the X Hospital, with doctors and staff, knowing of Alan’s brain surgeries and previous admissions. We asked Ms T if we could be present for procedure. She asked Alan on the whiteboard and he then asked Ms T: “I don’t know? Is it ok that they are here? I mean who would want to watch it? I didn’t know this was going to be a social event.” He looked at Ms T and said: “If you think it’s a good idea, then ok.” We wondered why would Alan have to ask his social worker if it was OK for anything, especially this? Was he afraid that allowing someone to be present might interfere with the procedure?

July 26 – We had a 7:30 breakfast with Alan. He didn’t care that we were there that morning. They tried to put the site shunt in his right arm, but that nurse could not find a good enough vein. Alan was non-communicative. I could see he was moving uncomfortably in his chair and he was not very happy. He wouldn’t even look or acknowledge our printed messages begging

him on the whiteboard. He then became very agitated and shouted: “It’s too late. This is my moment. This is supposed to be about me. You aren’t going to take this away from me”. Ms T, the social worker joined me outside of Alan’s room. I confessed how confused and twisted up we were inside that this was happening. How did things get this far? This didn’t make sense. Things just weren’t adding up. Alan was angry with the world. We had seen this before, but through support and rehabilitation, we saw him recover and get back on track. Could she please, PLEASE do something to stop this. It appeared to us that Alan had been fast tracked to have assistance to die, requesting a suicide. We hadn’t even met yet with Dr. Y to talk to her about our concerns. We wanted this stopped. Another nurse came back to try to insert the site into Alan’s arm. Gary came outside the room and joined Ms T and me. We mentioned that Alan’s other brother, Wayne, was in Newfoundland on a cross-Canada trip and was not able to make it in time. That is when we first laid eyes on Dr. Y. Wayne had met Dr. Y a few years before when Alan was admitted. (She had made Alan aware then of Bill C-14 and provided him the paperwork. He never did apply.) We had so many questions and concerns to share with her. She advised us that she was Alan’s doctor and was representing him in this. Though she herself had told Wayne that Alan would not qualify for assisted death two years prior, she now said she was not part of the assessment and did not have a say in that decision. She said we cannot legally stop people from making bad choices and we should not judge Alan for this. This is what Alan wants to do, it is his decision and he has been assessed by four doctors and given the legal right to assisted dying. She pointed out that his health would be deteriorating, yet we told her his health is better than when he had been admitted two years ago. Everyone’s health deteriorates as we age. She said she had done everything she knew of to convince Alan to consider assisted living but to no avail. She said, each time Alan would say he’d rather die. I reminded her he had two brain tumor surgeries he’d survived, two emergency hospital admittances since 2011 for related illnesses and this non-emergency admittance for health and safety reasons. She asked me: “What would you have us do Trish?” I told her they had Alan for 40 days and look at their end results. I asked her to give our family the same amount or even less, 38 days, to see if we could convince Alan to at least TRY an assisted living situation, or placing someone in his residence, bringing him home with us even, or place him in a secure facility if they were so concerned he would harm himself. I said what if we sat with Alan for 38 days, here in his room or maybe in the comfort of his own home etc. Dr. Y went into see Alan in his room. She wrote on the whiteboard to Alan:

“Your family tells me they would like to try and re-build their relationship with you.”

Alan went into a rage. The attending nursing staff, and Dr. Y all began placating Alan to calm him down. He was screaming and shouting his anger at the top of his lungs, losing his breath! “No! he screamed! “This is my moment! They can’t stop this...it’s too late! You are supposed to be my doctor, not Gary’s doctor! They aren’t even my blood relatives! They don’t even have the same blood as me (is that someone who is speaking rationally and accurately? Does that sound like someone who is right minded and competently sane? No! Gary is indeed Alan’s blood brother, as is Wayne). He continued to shout louder, “If you can’t do this, then put me in a hospital where they will!” The staff rushed to calm him once again. Dr Y slowly and methodically printed and tapped out the following statement on the whiteboard:

“Alan, I k-n-o-w they are not lying.”

It must be noted here that this is when we learned on the previous Friday, July 19th that Alan had been prepared to receive the MAID procedure, but it was stopped by Ms. P Helgeson, the person who administers the lethal injections. OUR FAMILY FEELS THAT THIS WAS A HUGE RED FLAG AND THAT AN INDEPENDENT PARTY SHOULD HAVE BEEN BROUGHT IN IF HE WASN'T SPEAKING TO HIS FAMILY. THE HOSPITAL COULDN'T EVEN GET THE PROCEDURE RIGHT!

We sat with Alan, held his hand, and witnessed the lethal injections that Ms. P pushed into the IV site which stopped our brother's heart at 10:05 a.m. July 26, 2019.

We were told by Ms T, the social worker, that she thought Alan's remains were going to be sent to Henderson's Funeral Home, and she "thought" Alan wants cremation but not sure what he wanted done with his remains. She was present during the making of Alan's will and aware of the contents and suggested we contact PPP and PPPs, Public Notaries. We were able to meet with PPP 3 hours after Alan's death. Gary asked for a copy of the will. S [of PPP] told him, "No, you don't get a copy of the will. As of this moment, all of Alan's personal property, including bank accounts etc. would be executed through probate, citing ABC as the lawyers and as he flipped through the file quickly he told us that he had personally not done up the will, but that someone from his office did, and that he though, in fact, was listed as Alan's executor. We were shocked that neither brother or any family member or friend of Alan's was not listed as executor.

Thank you for taking this time to read our account of events. We cannot begin to speak to you of the anguish we are suffering as a result of this wrongful act of assisted death (suicide) being "granted" to our brother Alan, at the very hands of people we had always trusted and classified as professionals looking out for the well being of people in our community. Especially, one so vulnerable, as our brother Alan.

ATTACHMENT 2:

**A letter of complaint by family members to the Patient Care Quality
Officer**

September 9, 2019

Patient Care Quality Officer Att: XXXX

The Nichols Family is requesting an investigation to be opened in the assisted suicide of our brother Alan G. Nichols, on July 26, 2019 at the X Hospital, in Y, BC.

We sincerely do not believe Alan met the legal threshold for assisted dying, nor do we feel that Alan was competent to make this decision. Our family was not informed, consulted with or included in any or at all during the assessments made on Alan. We had made several attempts (and will provide telephone logs and email correspondence upon request) to the various units Alan was being transferred amongst at X Hospital to learn more of Alan's condition. We were told we would receive updates (by both TTT and Dr. Y) on his condition during his stay, those very professionals who were to be providing care to Alan. Alan's physical and mental states were not properly addressed during the care he received at the X Hospital. He was not provided with his cochlear hearing device (so all communication had to be hand written and erased on white boards), proper vision care for his failing eyesight (very difficult for Alan to see or read any small print), nor did he receive any physiotherapy or exercise regimen to help support his weakened muscles during his stay. We were told the following day, after Alan was admitted to emergency by RCMP, that Alan had been transferred to the psychiatric unit and he did not want to see anyone. We respected that and relied on the medical staff to keep us informed as they had in all of Alan's previous admissions. It needs to be noted here, that Alan DID NOT check himself into the X Hospital on Sunday, June 16, 2019. He was brought to the emergency ward of X Hospital by the RCMP. The RCMP were called to Alan's condo unit, by neighbour AA, who had concerns that she had not seen him for a few days and that he may have fallen or perhaps may need medical assistance (she helps to keep an eye on Alan as his immediate family all live out of town). The RCMP used her key for entry and they did indeed find Alan weak, dehydrated and confused. They left a message on Wayne Nichols phone, that it would be in the best interests of Alan's personal safety to admit him to X Hospital, by ambulance, where he would be safe and could do no further harm to himself. We find this to be most disturbing, as in this act of compassion intended to keep Alan safe and our family relieved, it would ultimately lead to the death of our brother Alan. Dr. Y provided the necessary documentation to help Alan apply for assisted dying and arranged for the various doctors who performed required assessments for approval for M.A.I.D. At Alan's request (according to Dr. Y), she did not contact our family. It is at this point we feel Alan's medical health, mental well-being, and safety had been put in a compromising position. We have provided care for Alan in his living years (Wayne took Alan weekly grocery shopping and banking) and we should have been alerted, after numerous requests for updates and information, on his progress and his application for assisted suicide. We would have questioned the care he was receiving, made arrangements to remove him from the supposed "care" of the X Hospital or exercised options that could have kept Alan safe from harming himself (whether that be to hire someone to sit with him as one would sit on suicide watch or place him in a facility that would promote his well being rather than continue to provide him a means to end his life.) While the doctors continued to assess, direct, and care for Alan behind closed doors, our family made calls and then began sending emails and communications asking of Alan's progress etc. We never received a response from any X Hospital doctors assessing Alan, or on his case. Dr. Y called 4 days prior to his scheduled death. It is our understanding that Dr Y left for vacation after Alan received the approval for assisted death. It is also our understanding that there is even a mandatory 10 day waiting period after the approval, before arrangements for assisted death can be made. This would have given our family time to work with Alan and/or consult another professionally medical team, second opinions, seek power of attorney or file for guardianship at the very least. As soon as we were aware, we asked to have this procedure stopped, feeling this was a very fast-tracked, unscrupulous and irreprehensible permission slip for legal suicide.

If the doctors approved Alan's M.A.I.D. application because of damage from his brain surgery 50 years earlier and result of loss of hearing, how can the psychiatrist and psychologist say then that he is of sound mind? Even while we were there, he had several outbursts, and we questioned his soundness of body and mind. Was he told a will must be drawn up as protocol perhaps, in order to have the assisted suicide approved? He most likely would have done that only as a mandatory requirement to proceed with the assisted suicide. Alan did not have a will when he went into the hospital. We have since learned his will was done while in hospital care, on July 12, 2019. We feel that he may have been coerced into drawing up a will, in the mental and physical state he was in, without any family present. That the will was not a voluntary action at all but perhaps a requirement in order to proceed with assistance to die. He didn't make a trip to the lawyers voluntarily. He never got out of the hospital. How can that even be legal to do up a will with Alan's obvious case of instability? We received one update only from Alan's "team" from social worker, Andrea, in all the weeks of his stay there, who had reported to Gary that Alan was eating, walking with his walker, doing much better and had even spent time socializing in the tv and kitchen areas of the unit. He was responding well to the assistance he was receiving. She assured Gary that Alan was well, and that is directly misleading our family into thinking he was being appropriately cared for. She did not make mention that an assisted suicide had been approved and in progress (though she was aware of it at the time she spoke with Gary and had been personally working with Alan and we would discover later that Andrea was even present during the drawing up of his will with the Notaries of [T and T]). Andrea told Gary that Dr. Y was on vacation and when she returned from vacation in a few weeks, she could provide more information about Alan's progress and condition. We had no reason to think that the staff was preparing for an unknown assisted suicide that very week. They withheld vital information our family needed. One call was made to our family from Health Authorities X at the X Hospital. It was upon Dr. Y's return, on July 22nd that she called Gary at work to tell him of the impending scheduled injections and that Alan had been "ACCEPTED" for death by injection. We scrambled to get to XXX from Edmonton to stop this!

As far as our family was concerned, we thought Alan was in the right place to receive the care that he was admitted for. Gary was told by Dr. Y herself when he finally was able to make initial contact with her on Friday June 28th, to call her back on Monday, so she could speak to Andrea and receive an accurate update. When Gary called Tuesday (Monday was a statutory holiday, so he thought best to call the next day) and when he did, the receptionist told him Dr. Y was on vacation. Why would Dr. Y have asked Gary to call back after that weekend, knowing she would be leaving for holidays?

On Friday, July 19, 2019, (unbeknown to our family) Alan was being prepared to have the procedure for assisted death but it was stopped by YY (and we feel it appears it did not meet the required 10 day waiting period for assistance protocol?) YY is reportedly the only person in the Lower Mainland that has legal permission to perform these fatal injections. She had shown up at X HOSPITAL that day, (the needle site was already put in Alan's left arm for the administration of injections) and, at the last moment, YY decided that due to the following criteria:

1. A doctor was not present (Alan's Dr. Y was on vacation)

2. Concern if Alan's final requests legally documented in a will, and,
3. That no member of Alan's family had been notified, and so therefore, YY refused to proceed. The assisted suicide was postponed until the X HOSPITAL met all protocol and criteria in accordance with Ms. P's concerns.

It is for these reasons we ask that an investigation be opened to address our questions, to provide to us a copy of the application for MAID and all legal documentation and witnesses with Alan's signature(s), a copy of the last will and testament of Alan go to his only surviving brothers Wayne and Gary, and to hold accountable the X HOSPITAL and all associated staff that assisted with the suicide of our brother Alan. We will not rest until we know and see the substantial evidence, beyond a doubt, that Alan was put to death with a sound mind and body to make this decision and without the chance for family involvement. Because he was deemed sound mind and body, he was given "permission" to end his life, yet not of sound mind and body to return home and make the better choices outside of the closed hospital doors for himself. It appears that a team of legal and medical professionals were put in place, behind the backs of the family who was already respecting his living wishes, and then granted Alan his dying wish, based on whatever information he had told the doctors. Physically and mentally he was improving during his hospital stay. He could have lived a longer and healthier lifestyle. We are grateful that the current team of doctors and M.A.I.D. were not available when Alan had his brain surgeries and cochlear transplant, as Alan would have lost out on 50 years of living.

Our family has been honoring Alan's requests to live independently. We asked the doctors for several years to give our family some sort of guardianship to help with Alan's care, and we were denied, and Alan would not try assisted living. Wayne Nichols, Alan's oldest brother took him shopping weekly for the past several years for groceries and to the bank to pay bills etc. We feel Alan should have stayed in psychiatric care longer than the 5 days upon his fateful admittance to the Emergency Ward at X HOSPITAL. Alan was admitted for his own medical safety, according to the RCMP, on June 16th, 2019 and because his doctors denied family to be involved, our brother was not safe, and is now dead. We believe that the Medical Certification of Death (Document Control No.21056426) is inaccurate as it states Alan's immediate cause was M.A.I.D but because of CVA (medical term for stroke). It is our family's observation that Alan had not been admitted since his CVA years prior and that his body was active and working. How could this be considered a consequence of stroke? This had been the best period of physical and emotional time for Alan. He had done better since his stroke every week! Alan was upset (and displayed anger) that his brother Wayne, who looked in on him each week, was leaving for a cross Canada trip, his neighbor that looked in on him would be moving this summer and that Safeway's (where he did his weekly shopping) had closed its doors. All these familiar things to give him comforts were changing. That is unsettling for anyone, but especially for Alan who relied on these basics for survival. Not even the assurance from both Gary and Wayne who were already planning the ways in which to assist him during this time, was able to console Alan. These are the reasons Alan stopped taking care of himself and had to be admitted. Is this competent thinking? Is this the way a "sound mind and body" responds to crisis? By not eating or drinking? Absolutely not! This is exactly what Alan needed help with! Not an approved suicide as an answer to his dilemma! They did not do a CATT Scan or neurological tests, nor did he receive any medical care during his time on the Path Unit to assist with the very things that were depressing him, his hearing, his eyesight and his lack

of body muscle. He could have been in a rehabilitation centre, but certainly not given permission to be given injections to kill him. The death certificate also states a seizure disorder. He hadn't taken medication for that since 2006...13 years without medication and no reported seizures in the past ten years. Also stated in Part II of Death Certification for other underlying conditions...Osteocytoma - age 12??- his surgical removal of two brain tumors. 50 years ago? As a reason for his frailty? To list that as underlying 'condition contributing to his death' is absurd! Those surgeries gave Alan 50 years of life! They didn't contribute to his death! Alan's poor choices and the doctors are the only ones who ultimately contributed to Alan's suicidal assistance on July 26, 2019. Shouldn't the names of the doctors then also be listed as causes and significant contributors to Alan's death? The death certificate needs to be amended, the doctors and support staff on this case all need to be held accountable, and though Alan signed the documents, how much mental stress and duress was Alan experiencing after being admitted to emergency, transferred to the psychiatric ward, bounced over to the PATH Unit in the X Hospital, fed and regularly nourished increasing his spirits (he was chatting and visiting with other patients on the ward!!), and then ultimately a decision made to assist him to his death because he felt he didn't have a "place" to go in this world if they released him. And all this happening to him, and no-one responding to our countless calls and emails about his progress! Is this what we are doing with all mentally challenged individuals being admitted for their own safety? Offering them a chance to end their life, if they feel they can't meet the challenges? Alan's physical health improved since his admittance; his mental health had deteriorated.

Our family is prepared to substantiate (and provide support documentation upon request) that Alan was indeed depressed, paranoid, suspicious and suicidal. He was not capable of making good choices or certainly end of life decisions for himself. It should be noted that Alan did not have a medical illness that could indicate how long his natural life would be. He had improved over the course of the past two years and we are still reeling from the shock that Alan, who was not living in pain, had a home, money provided to him as beneficiary from the death of our parents, family tending to assist him was also still physically able to tend to most of his needs, with the exception to grocery shopping and banking, yet somehow, he was considered and approved (PERMITTED) to end his unhappiness. We have researched and been reading about the stories of several victims of Bill C-14. There are bed-ridden, hospitalized patients ravaged with cancer and/or terminal illnesses in unfathomable pain, who have applied for assistance, and have been DENIED permission to end their suffering. How cruel is that? How in heavens name can the Medical Services in the Province of BC and the federal government of Canada explain a capable human being be approved of this, when one so terminally sick, dying, in sheer agony and bed-ridden be denied their assistance to death? We believe in Bill C-14 for the spirit in which it was intended. To especially help end the physical suffering of a terminally ill patients, but not as an answer or a means to help assist a suicide due to mental challenges of an able human being making some very poor choices for himself. Applying for assisted suicide would prove to be our brothers' final poor choice. We feel the other poor choice to encourage this procedure, made on Alan's behalf, would be the unjustifiable choice of the doctors involved, those who poorly chose to grant permission for Alan to end his life in this fashion, without consulting any member of the family for medical background. This is just simply unforgiveable.

Attached is an account of events for the time Alan G. Nichols spent in the supposed care and “custody” of the X Hospital, and its’ staff. We are hoping that our voices are heard, and that other families are made aware that when anyone admits a family member to the hospital, even our trusting police officers, that the hospital can take it upon themselves to do as they please as long as their patient signs the documents. This is completely unacceptable and leaves room for errors. We have given the doctors permission to determine when to end someone’s life, who isn’t on life support at all or dying from a terminal illness. The right to a legal suicide? Is that what Bill C-14 was designed for? The public needs to be aware of what can happen when your emotional depressed or suicidal loved one enters a hospital, stating patient confidentiality as a reason for not informing loving family members about what is going on behind closed doors.

Thank you for taking time to read our letter. We look forward to hearing your response.

Sincerely,
The Nichols Family

Gary & Trish Nichols

ATTACHMENT 3:

Letter by the health authority responding to the complaint by the family

December 30, 2019

Mr. ..N... [address omitted]

Dear Mr. Nichols..... ,

Thank you for contacting the [x] Health Patient Care Quality Office (PCQO). We appreciate the opportunity to review the concerns you had regarding the passing of your brother, Mr. Alan Nichols, at the [X Hospital] on July 26, 2019, under the Medical Assistance in Dying (MAiD) provision.

On behalf of X Health Authority, I extend to you and your family our most sincere condolences for your loss. It is clear that your brother was a much-loved member of your family and his passing has greatly affected those around him.

During your conversation with our office on August 15, 2019, you expressed the following concerns about Alan's passing at the hospital.

- You do not believe that Alan met the legal requirements for MAiD as he was not expected to have a natural death in the immediate future and did not have an irreversible medical condition;
- He was brought to the X Hospital by the police for safekeeping, but later died under the hospital's care;
- The hospital did not notify his family of any plans to administer MAiD and refused to share any information about this citing privacy concerns;
- You were adamant that Alan did not meet the legal requirements outlined in Bill C-14 and that the hospital made a mistake that resulted in his death.

Our office also received an email from your brother Mr. Gary Nichols on October 8, 2019, where he shared concerns similar to yours and had a list of questions about Alan's passing.

Understandably, the loss of your brother has been very difficult for you and your family. I would like to reassure you that your concerns were taken very seriously, and sent for review to:

- Dr. X, Medical Director for Medical Assistance in Dying, X Health Authority
- Dr. Y, Physician, X Hospital
- Dr. Z, Local Department Head, Psychiatry, Y Hospital
- Ms. XX, Program Leader, Medical Assistance in Dying, X Health Authority
- Ms. YY, Social Worker, X Health Authority

We appreciate the opportunity to respond to the concerns shared by your family. For your ease, we have noted your concerns below in bold with our responses directly below:

1. **How did the X Hospital allow for Alan to be euthanized when he did not meet the criteria for Bill-C14? It appears that the MAiD team in BC did not follow the criteria and protocol of Bill C14 as Alan's physical health had improved throughout 2018 and 2019 and the end of his natural life was not known. Alan also suffered from severe depression from time to time as well as mental illness.**

Dr. X provided the following information about this concern. All MAiD assessors and providers involved in Alan's case were trained and continue to be apprised of the legal and clinical developments with MAiD in Canada.

The Federal Government has provided a legislative background and the Department of Justice published the Glossary to Bill C-14 that explains the bill and may be helpful for those interested in the legal details.

The law does not require patients to be dying from a fatal illness or be terminally ill to be eligible for MAiD. In referring to eligibility, the law uses flexible language including that '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 they have remaining'. This allows those who are on a trajectory toward death in a wide range of circumstances to choose a peaceful death instead of having to endure a long or painful one.

In the 2017 Superior Court of Ontario case of *A.B. vs Canada*, it was written that Bill C-14 '...purposefully provided flexibility to medical practitioners to use their expertise, to take into account all of the circumstances of a person's medical condition and what they deem most appropriate or define as reasonably foreseeable.'

In his consultation report, the MAiD assessor documented the medical circumstances of Alan, as well as the intolerable suffering that Alan reported. The legal requirements of Bill C-14 were met from the perspective of this assessor and the 'flexibility' in the legal language provides support for this practitioner who deemed Alan to have natural death in the foreseeable future.

Though Alan had a history of depression, his request for MAiD was not based on this or any other mental health condition.

2. **Two years ago Dr. Y gave Alan a MAiD application and Alan never submitted the application. Why would someone from the Hospital give him another MAiD application during his stay at the X Hospital this time? Alan was admitted by RCMP and did not want to be there. Alan was upset and therefore vulnerable.**

MAiD is meant to be accessible to Canadians and residents who meet the requirements outlined in Bill C-14. When a patient requests MAiD, doctors, and other medical professionals can provide them with information about the procedure. According to Alan's medical record, he requested information about MAiD on June 17, 2019 and was provided with reading materials on the procedure.

3. **The X Hospital was not treating Alan for any medical conditions during his stay that we are aware of. His vitals as indicated by his hospital chart the last day he was alive were excellent. On July 25, 2019, we noticed that the hospital was feeding Alan, but concerned that they were not providing him with any physio and/or physical activity.**

According to his medical records, Alan was brought to the X Hospital Emergency Department on June 16, 2019, by ambulance after a neighbor contacted the RCMP to conduct a wellness check. During his assessment, he was found to be upset about being taken from his home and also expressed suicidal thoughts to the emergency room physician. He was admitted under the *Mental Health Act* for his own safety and subsequently transferred to the medical unit as his physical health issues warranted more attention. The records indicate that he was prescribed

antidepressants on June 16 and he took these for two days. He was not given any PRN (as needed) psychotropic medication during this admission. Dr. X has noted that the medications offered or administered to Alan had no bearing on his MAiD request or assessments.

Within 24 hours of his admission, he had calmed down significantly and was no longer upset, agitated and showed no signs or symptoms of depression. On June 28, 2019, a psychiatric evaluation found that he was competent to make his own decisions, including his request for MAiD. He was also able to mobilize independently with the aid of a walker and did not require any physiotherapy to help with his mobility.

After he formally requested MAiD by completing the request form on June 25, 2019, the hospital care team followed the guidelines for his assessments to determine eligibility. He chose to remain in the hospital during this process.

4. Why was his family not informed of his MAiD request and application being approved, I do not believe patient confidentiality is an excuse the physicians should have used. Alan's family had always cared and supported him.

We understand that Alan's decision to apply for MAiD was difficult for you and your family. It is normal for family members to want to be involved and engaged when a loved one requests services like MAiD.

Since his admission to the hospital, he was very clear and consistent in requesting that the staff did not inform his family of his decision about MAiD. The maintenance of our patient's confidentiality and their request for privacy is paramount and mandated to the delivery of all patient care. As Alan was considered capable, it was the hospital's responsibility to honor his wishes about communicating with his family.

Recognizing the importance of having family involvement and support during this process, the care team encouraged him to reconsider his decision. The social worker suggested that he compose a letter to inform his family about his end of life wishes. He declined the option to do this.

We acknowledge that it can be difficult for loved ones when they feel left out of a patient's decision to pursue MAiD. We can imagine your anguish about not being there for Alan as he made this difficult decision and we are deeply sorry.

5. During his stay in the Hospital from June 17, 2019, to July 22, 2019, the Chilliwack General Hospital staff and Dr. Y misled us by saying Alan was doing fine, they indicated he was eating, walking on the Path Unit floor and making visits to the TV room. During this time the Hospital knew Alan was being examined and reviewed for MAiD, but misled our family as we were unaware of Alan's intentions to end his life.

Alan clearly and consistently requested that his family members were not be informed about his decision regarding MAiD. Dr. Y and the staff of the X Hospital were mandated to respect his wishes.

A review of the records does indicate that Dr. Y informed the family of your brother's decision on July 22, 2019 after she had discussed this with him and he provided consent for her to do so.

- 6. During his stay in the hospital Alan would not approve visits from his brothers, his neighbours his aunt and cousin, that should have been a concern right there, did Dr. Y do nothing to follow up on the reasons for Alan not allowing visitors?**

We understand from Dr. Y that there were several discussions between her, the MAiD physicians and psychiatrists and Alan about his reasons for not wanting his family informed or involved. Social Work talked to him about this, and he expressed his concern that his family would

not approve of his decision to have MAiD and would try to intervene. He also expressed that he did not want many visitors while in the hospital as he did not have many visitors while he was living at his home. His explanations seemed reasonable to the care team and he was deemed capable to make decisions.

- 7. Why did Alan's Social Worker request Alan to make out a Will which has nothing to do with Bill C-14. Also you would think the hospital would have contacted Alan's family to see if Alan already had an existing Will Who was responsible for Alan's Will, Alan or the Social Worker? Because Alan had Cochlear implants why did the Social Worker not contact his family to bring his Cochlear hearing aid to the hospital.**

As part of their role in end of life care, Social Work engaged Alan in supportive counseling prompted by his wish to leave his estate to the Bill Gates Foundation. He indicated that he did not have a will. The social worker advised him that his wishes may not be honoured in the absence of a will. The social worker did not request that he complete a Will. He decided to make a will so that his final wishes would be honoured.

The care team was aware of his hearing impairment; however, he preferred to use a whiteboard to communicate with them. He did not wish for his family to be involved and did not provide consent for the team to contact his family. There was one occasion when his brother Gary called the unit requesting an update and the social worker informed Alan of this. He provided consent at that time to contact Gary to advise him that he was okay.

- 8. We would like proof that the BC MAID team did testing to assure of Alan's natural life expectancy, the death certificate indicated antecedent causes being CVA, seizure disorder and frailty. Alan maybe had one stroke back in "2017" but his vitals were great in July 2019. It's been a few years since Alan's last seizure and won't comment on frailty.**

Dr. X provided the following information regarding this concern: In addition to the legal requirements outlined in our response to question 1, the current state of persons requesting MAiD does not have to be imminently terminal nor does there need to be a specified prognosis of the timeline to the expected death. Each patient's circumstances are unique, and life expectancy depends on several factors such as the nature of the illness, and the impacts of other medical conditions and health-related factors such as frailty, and dependency on others for activities of daily living.

Physicians and Nurse Practitioners have the necessary expertise to evaluate each person's unique circumstances and can effectively judge when a person is on a trajectory toward death.

Mr. Nichols, we are again very sorry for your loss and acknowledge the profound impact your brother's passing has had on your family. While I appreciate that these answers may not be what you were looking for, I hope that they provide you some assurance that the MAiD provision was administered appropriately.

If you are not satisfied with this response, you may wish to consider contacting the Patient Care Quality Review Board. The Review Board is independent of the health authority and can be reached toll-free at [0-000.000.000]. For more information on the Review Board, please visit xxxxxxxxxx.

We thank you again for sharing your concerns with us. Our goal is to continually learn from the experiences of patients and families so that we can improve our systems and the quality of services we provide.

Respectfully,

[Signature]

Patient Care Quality Officer

October 21, 2021