



# HEALTH POLICY REVIEW

## ONGOING DEBATE ON MEDICALLY-ASSISTED DEATH IN CANADA

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## INTRODUCTION: LEGISLATIVE & HISTORICAL CONTEXT

In 2016, Canada introduced Bill C-14, the Medical Assistance in Dying (MAiD) Act, providing an end-of-life care option for a rapidly increasing number of Canadians.<sup>1</sup> MAiD includes active and passive methods, known as voluntary euthanasia, administered by a designated medical professional, and assisted suicide, the provision of medication by a medical professional to self-administer.<sup>2</sup> The House of Commons and Senate passed Bill C-14 following the Supreme Court's unanimous decision in *Carter v Canada*. This case challenged the prohibition of physician-assisted death, decreeing it an infringement on the Canadian Charter of Rights and Freedoms.

Under Bill C-14, medical and nurse practitioners providing MAiD were deemed exempt from criminal liability of homicide.<sup>2</sup> Eligible patients must be at least 18 years old and fulfill multiple criteria: possess decision-making capacity, be suffering from an incurable illness, disease, or disability in an irreversible state of decline, intolerable physical or psychological suffering, as well as a "reasonably foreseeable" natural death. This criterion involved safeguards, where requests required voluntary informed consent, two independent witnesses, a ten-day waiting period, and consent at the time of MAiD.<sup>3</sup>

Although the definitions of intolerable suffering vary, many patients request MAiD due to a loss of autonomy, independence, enjoyment, or a fear of future suffering due to their health condition.<sup>4</sup> In 2021, Bill C-7, an amendment to the MAiD Act, put forth revised eligibility criteria waiving the requirement of "reasonably foreseeable" natural death in response to public discourse suggesting an "unconstitutional exclusion" of patients who meet all other eligibility criteria.<sup>3</sup> New strengthened safeguards were implemented for such applicants. Notably, a 90-day observation period from the initial assessment and the day MAiD is provided, subject to alteration considering any imminent loss of capacity during that time.<sup>3</sup> Meanwhile, several safeguards were waived for naturally foreseeable deaths. Specifically, the ten-day waiting period and the requirement of final consent were both removed to avoid patients' suffering from fear of losing decisional capacity over the waiting period, or from refusing pain medication to preserve their ability to provide final consent.<sup>3</sup>

In March of 2024, MAiD eligibility laws stand to change further with the implementation of Bill C-39, stipulating that individuals solely suffering from a mental illness will gain eligibility.<sup>5</sup> The rapid progression from prohibiting MAiD to the widened current and foreseeable scope of legalized eligibility has sparked substantial public scrutiny and ethical debate.

## THE ARGUMENT OF AUTONOMY & RIGHTS

A 2018 qualitative case series study, while Bill C-14 was in effect, found a common sentiment about MAiD among Vancouver recipients; the vast majority concurred that their ailments compromised their quality of life through constant struggles with health function and a loss of purpose.<sup>4</sup> Patients were confident, well-informed, and unapprehensive about pursuing MAiD. In cases of great suffering and end-of-life palliative care, many supporters argue that one should have the autonomy to choose MAiD.<sup>4</sup>

Proponents often argue that MAiD gives patients autonomy when suffering from a disempowering health condition. Through decriminalizing MAiD, the Canadian government sought to affirm the autonomy and dignity of persons suffering from grievous or irremediable medical conditions to seek MAiD.<sup>2</sup> Upon discussion of eligibility expansion, many advocates in the media argue that assisted death is a matter of personal choice, and restrictive criteria against non-foreseeable death and persons with disabilities are paternalistic against those who are suffering.<sup>6</sup> In the same vein, some argue that individuals with mental illness should not be restricted from choices available to others who are suffering. In a CBC opinion piece, one such individual seeking MAiD argues that there is a disconnect between the opinions of health experts and the lived experience of individuals who have a mental illness, where all health efforts have been futile.<sup>7</sup> Therefore, excluding such individuals, while they may meet all other eligibility requirements, infringes on their autonomy.<sup>7</sup> Medically providing individuals with the support needed to die peacefully, without pain, and comfortably by their own choosing is also often seen as more dignified than unpleasant or unpredictable alternatives.<sup>6</sup> In this context, MAiD accessibility seeks to grant autonomy, empowerment, and dignity to all individuals suffering from intolerable health issues in their medical decisions.

Many also concur that access to MAiD is a matter of preserving rights. *Carter v Canada* was a catalyst, from which the Supreme Court of Canada found that laws upholding MAiD prohibition directly violated Canadians' Section 7 Charter rights to "life, liberty, and security of the person". Though MAiD prohibition laws sought to protect vulnerable persons from suicide, *Carter* argued that this law was overbroad. The Court agreed that the prohibition disproportionately denied the rights of individuals who are not vulnerable through its overbreadth.<sup>2</sup> The alterations pushed forth by Bill C-7 were prompted by *Truchon v Canada*, where the Supreme Court of Quebec ruled that restricting MAiD from people without a "reasonably foreseeable" natural death also directly violated these Charter rights by preventing people with grievous and incurable medical conditions from making decisions about their own bodily integrity.<sup>2,3,8</sup> The incoming consolidation of Bill C-39, including individuals suffering only from mental illness within the fold of eligibility, rests upon a similar justification of preserving constitutional rights. MAiD was decriminalized with carefully designed safeguards to protect Canadians' rights and safety, primarily formed by the Special Joint Committee on MAiD, a Parliamentary group handling the review and provision of MAiD laws.<sup>9</sup>

## MAiD AND PALLIATIVE CARE

While the Canadian Government considers MAiD a method of alleviating suffering, healthcare practitioners are concerned that MAiD expansion is becoming a method to relieve suffering caused by a system that lacks sufficient palliative care. The 2023 Access to Palliative Care Report in Canada describes the persistent issue that those in the early stages of their life-limiting diagnoses are often ineligible for palliative care.<sup>10</sup> Instead, half of all palliative patients lived for less than 22 days, indicating that palliative care primarily serves as end-of-life care. This inadequacy in palliative care access may decrease quality of life and increase symptom burden, which may contribute to the choice of seeking MAiD.<sup>11</sup> In a qualitative study by Pesut et al., nurses providing MAiD further discussed the tensions between a system focused on relieving suffering through MAiD and the undue suffering seemingly caused by this lack of access to specialized care.<sup>12</sup> One nurse states, “[Our] healthcare system contributes to suffering [...] but then uses that very suffering to activate access to MAiD”, which may indicate a focus on increasing MAiD access over delegating more attention towards improving patients’ access to care.<sup>12</sup>

However, it should be noted that improved access to palliative care may have a limited effect in reducing MAiD requests. A cohort study conducted by Seow et al. found that 88% of terminally ill patients, mainly with a cancer diagnosis, received more intensive and earlier palliative care, despite cancer constituting 65.6% of MAiD provisions in 2021.<sup>13</sup> Although these patients had access to earlier, more proactive, and higher quality of palliative care, their increased incidence of MAiD requests indicates that improved palliative care minutely decreases the likelihood of terminally ill patients requesting MAiD. Thus, it is argued that although access to palliative care may have modest effects in increasing patients’ quality of life, establishing MAiD availability continues to be essential to preventing undue suffering in terminally ill patients.

## THE ISSUE OF STRUCTURAL VULNERABILITY

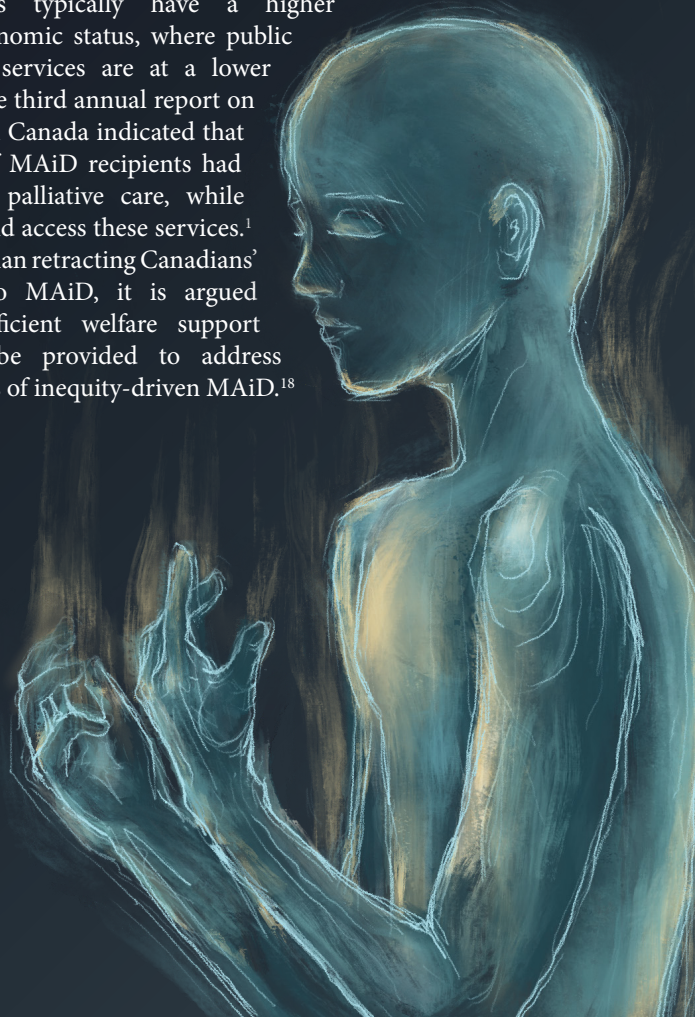
Structural vulnerabilities refer to the impacts of demographic attributes such as socioeconomic status, sex, gender, race, or ethnicity on one’s position in social hierarchies.<sup>14</sup> Public and academic discourse on MAiD remains concerned with individuals’ structural vulnerabilities to exploitation or coercion from existing social inequities.

The final report of the Expert Panel on MAiD and Mental Illness notes that reflection on such factors that “constrain decision-making, frame choices, and limit life options” is imperative.<sup>14</sup> The stigmatization of some demographic attributes may lead to instabilities in housing, employment, and social support, thereby contributing to an individual’s suffering. Structural vulnerability also indirectly contributes to suffering by reducing care accessibility, which can occur by many social determinants of health. Social variables influence illness and recovery trajectory, as resource inequities can bring about and perpetuate originate health disparities.<sup>15</sup> In a recent study involving a group of Canadians living with mental illness, researchers explored MAiD with respect to mental illness and social health determinants.<sup>15</sup> Socioeconomic disadvantages, limited mental health support, stigma, and discrimination constitute a

“social facet of suffering” that many MAiD recipients experience. Many also critiqued the availability and coverage for MAiD as opposed to more comprehensive mental health support.<sup>15</sup>

Although MAiD aims to preserve patients’ autonomy, detractors of MAiD legalization provide an alternate perspective.<sup>16</sup> The president of the Canadian Association of MAiD Assessors and Providers noted that “Our health system is woefully inadequate in serving [the Canadian] population with [social service] resources,” as outlined in a 2023 review of the Canadian MAiD program.<sup>16</sup> Ultimately, this suggests autonomy is compromised in many groups due to structural vulnerabilities. Further, released by the Parliamentary Budget Officer, the 2020 cost analysis of MAiD notes that Canada’s healthcare costs dropped by a net \$86.9 million since legalization, and predicts a drop of a net \$149 million upon eligibility expansion with Bill C-7.<sup>17</sup> With such framing, MAiD enables structural vulnerabilities and undignified living conditions by diverting pricier alternatives of expanding welfare and palliative care services. Given the coercive and pressured influence of poverty, racialization, disability, systemic healthcare imbalances, and limited social support services, it is argued that MAiD undermines autonomy in end-of-life care.<sup>6</sup> The removal of safeguards, notably in Bill C-7 and the incoming C-39, does not equalize marginalized groups as intended because they were not equal beforehand.<sup>6</sup>

It is, however, essential to note that some studies find that structural vulnerabilities are not significantly impactful in driving MAiD. In 2023, Downar et al. evaluated palliative care and structural vulnerabilities in Canada, concluding that socioeconomic deprivation does not considerably increase MAiD usage.<sup>18</sup> Though MAiD requests could be driven by poor service availability, recipients typically have a higher socioeconomic status, where public support services are at a lower need. The third annual report on MAiD in Canada indicated that 80.7% of MAiD recipients had received palliative care, while 88% could access these services.<sup>1</sup> Rather than retracting Canadians’ access to MAiD, it is argued that sufficient welfare support should be provided to address instances of inequity-driven MAiD.<sup>18</sup>





## IMPLICATIONS OF MAiD ON HEALTHCARE

With its legalization in 2016, the demand for MAiD services has increased exponentially, especially with the addition of Bill C-7, which deemed the eligibility criteria of a “reasonably foreseeable death” as unconstitutional. Healthcare professionals who provide MAiD have reported changes in the population, particularly in increasing visibility and normalization of the procedure.<sup>3</sup> However, the growing demand for MAiD services faces a looming issue concerning the number of willing MAiD providers, as MAiD is an optional “add-on” responsibility for physicians and nurse practitioners.<sup>19, 20</sup> By nature, the responsibility of being a MAiD provider is highly regulated, emotionally taxing, and laden with various potential ethical and moral quandaries.<sup>20</sup> Thus, the increase in demand for MAiD services and the number of new MAiD providers has not been proportional, as demonstrated in the 2021 federal report.<sup>19</sup> Despite a 32.4% increase in MAiD throughout 2020, there was only a 17.2% increase in providers over the same period.<sup>1,19</sup>

Accessing MAiD is a laborious process for both physicians and patients. Two independent physicians or nurses must evaluate a patient to ensure the individual meets the eligibility requirements.<sup>21</sup> Furthermore, MAiD cases are rarely straightforward, causing additional strain on MAiD practitioners who must navigate the ambiguity of a referral for a final decision.<sup>22</sup> In addition to complex cases, the legislative criteria of eligibility are vague, causing the assessment to be subject to interpretation.<sup>3</sup> Oftentimes, there are also disagreements between providers, patients, and other stakeholders involved in the process. In a qualitative study about navigating Bill C-7, assessors expressed relief when receiving relatively straightforward referrals that could be deemed eligible.<sup>3</sup> A sense of guilt and sadness was associated with deeming a patient ineligible for MAiD.<sup>3,20</sup>

Therefore, it is also crucial to examine the mental health and psychological impact of providing MAiD. A study by Dholakia et al. on the emotional impact on healthcare providers involved with MAiD reported polarizing emotions. There were positive emotions of reward and relief of providing a valuable service. At the same time, recurring themes of powerlessness, guilt, emotional exhaustion, and vicarious suffering were reported among healthcare providers.<sup>14</sup>

## CONCLUSION

Discussions of loosening MAiD eligibility requirements are steadfast into 2024, primarily concerning the current exclusion of “mature minors” and individuals suffering only from mental illness and “mature minors”—as in, minors possessing the decisional capacity to choose or reject a given treatment.<sup>5</sup> Bill C-39, which stands to include patients suffering only from mental illness within the fold of eligibility, was postponed from March of 2023. The one-year extension intends to provide additional time to prepare for safe and equitable MAiD assessment and provision guidelines.<sup>5,9</sup>

Proponents of MAiD advocate for the preservation of patient autonomy and Canadians’ Charter rights to “life, liberty and security of the person”. However, concerns regarding the contribution of inadequate palliative care access to the suffering underlying MAiD requests continue to arise among healthcare practitioners. Additionally, individuals remain concerned about issues of structural vulnerabilities among marginalized groups and coercion to MAiD. The increasing demand for MAiD services is met with the shortage of willing providers due to the unique emotional and mental burdens associated with providing MAiD. Therefore, there is a need for improved support and organizational structures to ensure the service is sustainable. Though there are several observed benefits of MAiD accessibility in healthcare, particularly protecting autonomy and rights, increasing public concerns about social vulnerability and insufficiencies in palliative care suggest a need for policy review and reform. This nuanced debate surrounding MAiD access and expansion will continue to grow as the Canadian healthcare system develops.

## THIS HEALTH POLICY REVIEW WAS ANONYMOUSLY REVIEWED BY AN ASSOCIATE PROFESSOR OF MEDICINE AT MCMASTER UNIVERSITY.

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