



# **ETHICAL ISSUES IN EUTHANASIA AND ASSISTED SUICIDE IN CANADA**

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**CARDUS**



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## Executive Summary

“Medical assistance in dying” (MAiD) has rapidly altered the landscape of healthcare in Canada. Presented as a means to end suffering, enable autonomy, and fuel Canadians’ choices in health matters, euthanasia and assisted suicide, referred to in Canada as MAiD, have been assimilated into Canadian healthcare with relative ease. However, the implementation and evolution of MAiD from its inception until now reveal significant ethical problems.

These ethical problems consist of gaps in equity and care, rapid and unnecessary expansion, a misconstrued sense of what suffering is and how it may be addressed, and a shift in understanding what Canadian healthcare is and how it ought to be delivered.

This report provides an overview of the current situation of euthanasia and assisted suicide in Canada and highlights some of the major ethical problems that exist within it. We examine what MAiD is, how it has been legislated into healthcare, and the populations for which its expansion has been proposed. We also argue that MAiD is distracting from the real and pressing need for a national palliative care infrastructure to address the healthcare needs of suffering Canadians.

We hope that this paper contributes to the public discussion by alerting Canadians to ethical issues that exist in relation to MAiD and the care disparities that exist for suffering and dying Canadians. We do so with the hope that better legislation will be written and practice guidelines and policies will be modified to address these ethical issues and care disparities.

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## Introduction

The introduction of euthanasia and assisted suicide in Canada, referred to as “medical assistance in dying” (MAiD) in legislation, has rapidly evolved into a situation of unprecedented availability of death on demand. This has impacted the healthcare system and has introduced serious ethical issues, which this paper explores.

*The introduction of euthanasia and assisted suicide as MAiD into healthcare contradicts the very purpose of healthcare, which is to support well-being, particularly in those who are experiencing suffering.*

The prohibition of euthanasia and assisted suicide under sections 14 and 241(b) of the *Criminal Code* was struck down as unconstitutional by the Supreme Court in *Carter v Canada* in February 2015.<sup>1</sup> The federal government then passed Bill C-14 in June 2016, establishing MAiD as a legally permissible service, under certain conditions, within Canadian healthcare. These conditions included having a “grievous and irremediable medical condition” and where “natural death has become reasonably foreseeable.”<sup>2</sup> In 2021, following the *Truchon* case discussed later in this paper, the government expanded MAiD through Bill C-7, which removed the “reasonably foreseeable” death requirement.<sup>3</sup>

The laws established two methods of MAiD: clinician-administered (euthanasia), in which the clinician “directly administers a substance that causes death,” and self-administered (assisted death or assisted suicide), in which the clinician “provides or prescribes” lethal drugs used by the patient, themselves.<sup>4</sup>

The introduction of euthanasia and assisted suicide as MAiD into healthcare contradicts the very purpose of healthcare, which is to support well-being, particularly in those who are experiencing suffering. Instead, euthanasia and assisted suicide end the life of the patient. The ideological framework undergirding MAiD is ethically fraught, moreover. It perpetuates the narrative that some people’s lives are not worth living in direct correlation to the degree to which they are suffering. This is a new and concerning approach to healthcare.

With such a narrative, the lives of Canadians may be at risk if their suffering becomes perceived as too great to bear or provide care for—even by those who are part of the healthcare professions. And as detailed in this paper, there is ongoing pressure from some to expand MAiD still further: expansion is being proposed for advance

1 *Carter v Canada (Attorney General)*, [2015] 1 SCR 331.

2 Bill C-14, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*, 1st Sess, 42nd Parl, 2016, <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>.

3 Bill C-7, *An Act to Amend the Criminal Code (Medical Assistance in Dying)*, 2nd Sess, 43rd Parl, 2021, <https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent>.

4 Health Canada, “Medical Assistance in Dying: Overview,” Government of Canada, last modified June 30, 2023, <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>.

requests, for those suffering from mental illness as a sole diagnosis, and for children deemed capable of consent, often referred to as “mature minors.”<sup>5</sup>

Euthanasia and assisted suicide have been introduced without adequate coordinated and strategic efforts to target care measures that could provide effective alternatives, such as improving the well-being of those suffering who need support and care. For instance, while MAiD legislation and practice continue to be expanded, there remains a lack of advancement of government-funded national infrastructure to improve access to high-quality palliative care that is available early in serious illness through to end of life. Access to palliative care has not been adequately improved since the legislation of MAiD into the Canadian healthcare system, particularly given the rate at which MAiD expands, both in practice and in legislation.<sup>6</sup>

The adoption of euthanasia and assisted suicide in the Canadian healthcare system is also related to the widespread use of bioethical frameworks in mainstream healthcare and education systems that drive models of efficiency and pragmatism, and the consequent lack of person-centred ethical frameworks. The dominant bioethics models in Canada align with autonomy-forward approaches to healthcare that view ethical issues from the standpoint of autonomy, suffering, and rights.<sup>7</sup> Many proponents of MAiD who hold these views have defended and advanced MAiD legislation and practice by arguing that healthcare should include eliminating suffering by eliminating the person experiencing the suffering.

Importantly, these frameworks are often bereft of a consistent appreciation for dependency, which is an inherent feature of being human and is heightened in situations of vulnerability.<sup>8</sup> For instance, many requests for MAiD have been made and granted on the basis of the patient’s desire to die due to the inability to function autonomously.<sup>9</sup>

Contrary to these views, and according to person-centred ethical frameworks, the purpose of healthcare should be to support well-being, particularly of those experiencing suffering. The introduction of euthanasia and assisted suicide as MAiD

5 Council of Canadian Academies, “Medical Assistance in Dying,” December 12, 2018, <https://cca-reports.ca/reports/medical-assistance-in-dying/>.

6 Canadian Society of Palliative Care Physicians, “CSPCP Submission to Special Joint Committee on Medical Assistance in Dying,” April 2022, <https://archive.cspcp.ca/wp-content/uploads/2022/05/CSPCP-submission-to-Special-Joint-parliamentary-committee-on-expanding-MAiD-Apr-26.pdf>.

7 University of Toronto Joint Centre for Bioethics: Task Force on Physician Assisted Death, “After *Carter v. Canada*: Physician Assisted Death in Canada—Report and Recommendation,” December 14, 2015, <https://jcb.utoronto.ca/wp-content/uploads/2021/03/JCB-PAD-TaskForce-Report-2015.pdf>; C. Lamb, “The Moral Pandemic of MAiD,” *Convivium*, August 11, 2020, <https://www.convivium.ca/articles/the-moral-pandemic-of-maid/>.

8 J. Herring, *Law and the Relational Self* (Cambridge: Cambridge University Press, 2019), <https://doi.org/10.1017/9781108348171>; Lamb, “Moral Pandemic of MAiD”; C. Lamb, “Voice, Vulnerability, and Dependency of the Child: Guiding Concepts for Shared-Decision Making,” *American Journal of Bioethics* 22, no. 6 (2022): 34–36. <https://doi.org/10.1080/15265161.2022.2063445>.

9 Health Canada, “Third Annual Report on Medical Assistance in Dying in Canada: 2021,” Government of Canada, 2022, <https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html>.

into healthcare contradicts this purpose because it ends the life of the patient. Care could still be provided to support persons with autonomous decline, if dependency was understood and valued as part of being human.

Instead of advancing an excellent system of palliative and holistic care in which suffering is alleviated through optimizing high-quality and effective healthcare, proponents of euthanasia and assisted suicide in Canada are advancing the ending of life as though it is an appropriate means to address suffering. This has been done with such rapidity that there has been no comprehensive public process to pause and critically examine the ethical status of this program and its effects on Canadians. Rather, proponents of euthanasia and assisted suicide are looking to expand access to the mentally ill, and there are now calls to incorporate infanticide.<sup>10</sup> As will be further detailed, MAiD on the sole basis of mental illness was scheduled to become legal in March 2023 but has been delayed until March 2024.

The gravity of the situation, and the impending expansions, should compel us all to take stock of the evidence and consider what exactly this movement now consists of and where it is going. This paper contributes to this reflection by first focusing on three concepts within the framework that supports euthanasia and assisted suicide: autonomy, suffering, and a rights-based approach to healthcare access. We then address the impact of MAiD on ethical healthcare, and in the third section, we discuss forthcoming ethical dangers with expanding MAiD.

## **Autonomy: An Absolutist Approach**

First and perhaps foremost in the conceptual framework undergirding support for euthanasia and assisted suicide in Canada is the concept of autonomy. As the authors of the 2022 “Report of the *Lancet* Commission on the Value of Death: Bringing Death Back into Life” attest, dying has become over-medicalized, obscuring its natural place within the human experience.<sup>11</sup> Dying and death are increasingly touted as medical events, in which autonomy—valued as independence and materialized as choice over care options—typically determines decision-making. Overall, Canadian healthcare and society alike are largely experienced within an autonomy-absolutist ethos, which is ableist and puts autonomy before all else, assuming that there is something deficient in being dependent.

The Supreme Court’s decision in *Carter v Canada* provided traction for such an autonomy-absolutist approach to dying and death. *Carter* stipulated that the sections of the *Criminal Code* that criminalized assisted suicide and euthanasia infringed on Canadians’ right to life, liberty, and security of the person under section 7 of the *Charter of Rights and Freedoms*, by forcing people who are dependent to suffer

10 C. Cullen and A. Zabjek, “Federal Minister Says She’s ‘Shocked’ by Suggestion of Assisted Death for Some Babies,” *CBC News*, October 22, 2022, <https://www.cbc.ca/news/politics/assisted-dying-carla-qualtrough-1.6625412>.

11 L. Sallnow et al., “Report of the *Lancet* Commission on the Value of Death: Bringing Death Back into Life,” *The Lancet* 399, no. 10327 (January 31, 2022): 837–84, [https://doi.org/10.1016/S0140-6736\(21\)02314-X](https://doi.org/10.1016/S0140-6736(21)02314-X).

unnecessarily. In many ways, the decision reached in *Carter* made the point that if some Canadians are so disabled by their condition as to limit their autonomous actions, then, in the name of freedom, they should be able to request that someone else end their lives.<sup>12</sup> This approach privileges autonomy as a state of well-being that does not require reliance on others.

While suffering can be very difficult to bear, society's response should be to counter rather than confirm autonomy-absolutist and ableist assumptions. Suffering Canadians should be met with compassionate care, including palliative care. Compassionate care is that which respects people experiencing suffering, in the midst of their pain, works with them to decrease and manage their suffering, and offers solidarity and meaning for their lives, instead of killing them, and thus aligns with a person-centred approach to bioethics.<sup>13</sup>

Further, the ethical challenge with an autonomy-absolutist approach is that it creates difficulties, if not impasses, in providing care that is dependency-oriented. Dependency is an aspect of being human that acknowledges our intrinsic need for others, which can be enhanced in situations where there is increased vulnerability. The reality is that all Canadians at some point in their lives are dependent on others. We all begin life in this way, and many of us experience periods of time, or the last years of our life, in this way also. This reality does not diminish our dignity as humans.

One area in which dependency features well is in the context of palliative and hospice care. Palliative care involves holistic care, provided by a healthcare team and ideally with community support. Palliative care views dying and death as a natural part of life and values the patient as a partaker in this shared human experience.<sup>14</sup> Autonomy and independence are not requisite for palliative care. Rather, palliative care is provided within a context of interpersonalism, vulnerability, and dependency.

To move forward in valuing death in healthcare contexts, we need to value dependency. Re-valuing death starts with acknowledging vulnerability and dependency across the lifespan and within all facets of healthcare. Care can then be envisioned to support patients with differing abilities but with equal fundamental dignity and worth.

## **A Misconstrued Sense of Suffering**

A second concept in the framework fuelling the uptake of euthanasia and assisted suicide is the idea that Canadians should not be made to suffer unduly or

12 *Canadian Charter of Rights and Freedoms*, part 1 of the *Constitution Act*, 1982.

13 E. Sgreccia, *Personalist Bioethics: Foundations and Applications*, trans. J.A. Di Camillo and M.J. Miller (Philadelphia: National Catholic Bioethics Centre, 2012).

14 World Health Organization, *Integrating Palliative Care and Symptom Relief into Paediatrics: A WHO Guide for Health Care Planners, Implementers and Managers* (Geneva: World Health Organization, 2018), <https://apps.who.int/iris/bitstream/handle/10665/274561/9789241514453-eng.pdf?ua=1>; Canadian Hospice Palliative Care Association, "Fact Sheet: Hospice Palliative Care in Canada," 2020, <https://www.chpca.ca/wp-content/uploads/2020/03/CHPCA-FactSheet-D.pdf>.



unbearably. Much of this suffering, however, is due to the lack of care and supports for well-being. This raises the question: why aren't we first addressing this care gap, instead of establishing and expanding euthanasia and assisted suicide through the MAiD regime?

Since its inception in 2016, over 30,000 Canadians have had their lives ended by euthanasia and assisted suicide.<sup>15</sup> If suffering people have to wait weeks or months to receive medical treatment but can access MAiD within days, euthanasia and assisted suicide then become increasingly viewed as efficient mechanisms for ending human suffering. Making euthanasia and assisted suicide as MAiD available without providing real alternatives to address suffering is now posing a threat to the lives of Canadians.

## A Rights-Based Approach to Access

The third dominant value in the framework motivating euthanasia and assisted suicide is the notion that access to healthcare in Canada is a right. While ensuring access to health services is laid out in the *Canada Health Act*,<sup>16</sup> the notion that MAiD is healthcare and something that should be regularly accessible demonstrates a misconstrued understanding of healthcare and a subsequent lack of appreciation for suffering, dying, and death. It arises from the notion that there are some instances in which life is not worth living.

The lack of equitable access to essential palliative care in Canada also exacerbates this viewpoint. Providing for a “right” to euthanasia obscures the right that Canadians should have to compassionate care and palliative care. Access to pediatric palliative care is one example of this equity imbalance. Despite being a high-income country, Canada still experiences significant gaps in providing equitable specialized pediatric palliative care.<sup>17</sup> Despite the fact that access to pediatric palliative care and hospice care has significantly improved over the past decades, significant disparities to access persist, particularly within rural and remote communities and among Indigenous children.<sup>18</sup> This reveals the lack of available specialized pediatric palliative care for vulnerable Canadian children as a marked health inequity.

15 Health Canada, “Third Annual Report”; S. Kirkey, “Canada’s Expanding MAiD Program Leading to a Crisis in Supply of ‘Willing’ Doctors,” *National Post*, October 27, 2022, <https://nationalpost.com/news/canada/medically-assisted-death-canada-losing-maid-providers>.

16 *Canada Health Act*, RSC, 1985, c C-6, 1

17 World Health Organization, “Palliative Care,” August 5, 2020, <https://www.who.int/news-room/fact-sheets/detail/palliative-care>; K. Widger et al., “Pediatric Palliative Care in Canada in 2012: A Cross-sectional Descriptive Study,” *CMAJ Open* 4, no. 4 (2016): E562–68, <https://doi.org/10.9778/cmajo.20160054>.

18 Canadian Hospice Palliative Care Association, “Fact Sheet”; K. Widger et al., “Pediatric Palliative Care in Canada in 2012: A Cross-sectional Descriptive Study,” *CMAJ Open* 4, no. 4 (2016): E566, <https://doi.org/10.9778/cmajo.20160054>; J.M.G. Bally, N.R. Smith, and M. Burles, “Pediatric Palliative and Hospice Care in Canada,” in *Hospice Palliative Home Care and Bereavement Support*, ed. L. Holtslander, S. Peacock, and J. Bally (Cham: Springer, 2019), 253–69, [https://doi.org/10.1007/978-3-030-19535-9\\_19](https://doi.org/10.1007/978-3-030-19535-9_19).

Moreover, the calls for infanticide on the basis of disability made by those in favour of expanding MAiD could only heighten the degree to which this disparity exists.<sup>19</sup> Without a healthcare infrastructure that provides palliative and holistic supports for infants with life-limiting illnesses and potentially short lives, such calls are irresponsible. At worse, such calls signify eugenics, given that the call for infanticide has been made on the basis of disability and severe syndromes.

## The Impact of MAiD on Ethical Healthcare

Having discussed the concepts undergirding support for MAiD, we now turn to the impact of euthanasia and assisted suicide on Canadian healthcare. Importantly, the federal legislative framework on MAiD in Canada expressly notes that nothing in it “compels an individual to provide or assist in providing” euthanasia and assisted suicide.<sup>20</sup> But with healthcare providers as the primary facilitators of MAiD, there are consequences for healthcare ethics.

### Compromising the Morality of Healthcare Communities

Healthcare communities are moral communities.<sup>21</sup> Healthcare providers are moral agents who have a responsibility to make moral decisions that will benefit their patients, themselves, and their professions.<sup>22</sup> They do this in part by maintaining ethical professional standards for their patients, the public, themselves, and the profession. Simply, healthcare professionals and professions ought to stand out as ethical and moral exemplars.

One problem with legislating euthanasia and assisted suicide into healthcare is that healthcare professionals and providers are already viewed as moral exemplars in society. When moral exemplars start enacting euthanasia, this can either drastically alter patient and public perceptions against euthanasia or align patient and public perceptions in favour of it.

Perhaps even more troubling is the fact that when healthcare professionals become supportive of euthanasia, this perspective could push patients towards euthanasia if the patients are already in a vulnerable state of mind, health, or way of being

19 Cullen and Zabjek, “Federal Minister Says She’s ‘Shocked’”; Collège des Médecins du Québec, “Brief—Recommendations on Expanded Access to Medical Assistance in Dying: Special Joint Committee on Medical Assistance in Dying,” May 9, 2022, <https://www.ourcommons.ca/Content/Committee/441/AMAD/Brief/BR11762505/br-external/CollegeDesMedecinsDuQuebec-10616958-e.pdf>.

20 *Criminal Code*, RSC, 1985, c C-46, S.241.2 (9).

21 Canadian Nurses Association, “Code of Ethics for Registered Nurses,” 2017, <https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics>; Canadian Medical Association, “CMA Code of Ethics and Professionalism,” 2018, <https://policybase.cma.ca/viewer?file=%2Fmedia%2FPolicyPDF%2FPD19-03.pdf>.

22 C. Lamb and B. Pesut, “Conscience and Conscientious Objection in Nursing: A Personalist Approach to Bioethics,” *Nursing Ethics* 28, no. 7–8 (2021): 1319–1328.

when healthcare professionals suggest MAiD as a “care” option. Moreover, cases have occurred in Canada where some are making requests for MAiD on the basis of their social suffering (homelessness or poverty) rather than on an underlying medical condition. Yet, despite such a reason being outside the bounds of the current MAiD regulations, some Canadians have had healthcare providers approve requests to end their lives for this reason.<sup>23</sup>

These instances in which Canadians are being killed due to social suffering are also problematic because these cases are not making a difference in the way that proponents view the restrictions on MAiD. That is, some proponents of euthanasia and assisted suicide in Canada see these cases merely as aberrations rather than as egregious errors that should trigger reviews of MAiD processes in order to ensure that such errors do not occur again. Such an attitude is contrary to how evidence-based practice operates in healthcare. Adverse events are those instances in which an egregious error (that is, a patient injury or death arising from an error in established practice) causes a major overhaul of policy and practice. Ideally, this overhaul will result in newer, safer practices. When people are dying from euthanasia and assisted suicide for non-medical reasons of social suffering, this safeguarding is not happening.

## **Confusing an Understanding of Care**

Euthanasia and assisted suicide as MAiD have been justified as being part of healthcare by arguing that they offer a solution to suffering. “Suffering” is a broad and subjective term, however. No one can say what constitutes suffering except the person experiencing it. “Suffering” is also a term that people can immediately negatively relate to. Justifying euthanasia broadly and subjectively on this basis conflates an understanding of what care is with how suffering ought to be alleviated.

Care enhances well-being and supports living well, which includes alleviating suffering and providing comfort to the patient. Situations where patients are suffering to the point that they feel the need to request euthanasia or assisted suicide to end their life so as to end their suffering reveals a problem in the provision of care. In such instances, care should be improved, become more robust, and consist of relevant measures to ease or eradicate patient suffering without also ending their lives. Palliative care can achieve this goal in almost all cases. In instances when palliative care cannot alleviate suffering adequately, the scientific and healthcare communities should exercise great energy in conducting research that will fill this care gap.

Healthcare is fundamentally oriented to providing interventions and care to people that will restore health and well-being, and decrease or eliminate their suffering, for the purpose of life, not death. And while there are times when it is ethical to

23 C. Mulligan and M. Bond, “Ontario Man Applying for Medically-Assisted Death as Alternative to Being Homeless,” *CityNews*, October 13, 2022, <https://toronto.citynews.ca/2022/10/13/medical-assistance-death-maid-canada/>; L. Cecco, “Are Canadians Being Driven to Assisted Suicide by Poverty or Healthcare Crises?” *The Guardian*, May 11, 2022, <https://www.theguardian.com/world/2022/may/11/canada-cases-right-to-die-laws>.

end disproportionate, active treatment or withdraw life-support mechanisms, *care* itself should never cease in ethical healthcare. With MAiD, care does not need to occur; the act of euthanasia or assisted suicide ensures that the “care” always ends in causing death.

Addressing the root cause of suffering necessitates understanding who the person is in relation to their suffering circumstances (ethical healthcare), rather than defining a person by their suffering circumstances (as happens with euthanasia and assisted suicide). While this overarching ethical approach ought to guide all aspects of healthcare, it is the focused aim of palliative care, and particularly palliative care that is provided at the end of life. Yet, equitable access to palliative care is currently lacking in Canada, while MAiD has become a mandated and promoted part of the Canadian healthcare landscape.

## The Ethical Dangers of MAiD Expansion

As noted in the introduction, since MAiD was legislated into healthcare in 2016 the original requirements have undergone significant expansion. At the time of legislation, euthanasia and assisted suicide were restricted to Canadians over the age of eighteen who fulfilled other requirements. However, since its inception, proponents of MAiD were already considering expansion beyond the initial safeguards: for advance requests, for those who are mentally ill as a sole diagnosis, and for children deemed capable to consent (“mature minors”). These three expansions were all tabled for consideration three years out from decriminalization.<sup>24</sup> In this section, we provide an overview of how court decisions and new legislation have expanded the provision of MAiD, followed by a discussion of the three areas of proposed further expansion.

### Expansion Through the Courts and C-7

In 2019, plaintiffs in *Truchon c Procureur général du Canada* challenged the provision that restricted euthanasia and assisted suicide as MAiD to those with a reasonably foreseeable natural death, resulting in a Superior Court of Quebec decision that found this restriction unconstitutional.<sup>25</sup> Following this, the federal government introduced and subsequently passed Bill C-7, which received royal assent on March 17, 2021 and removed the foreseeable natural death provision for the eligibility of MAiD.<sup>26</sup>

While the rulings and amendments in *Carter*, *Truchon*, and Bill C-7 purported *not* to infringe upon the *Charter* right to life, liberty, and security of the person, the lack

24 Council of Canadian Academies, “Medical Assistance in Dying.”

25 *Truchon c Procureur général du Canada*, 2019 QCCS 3792.

26 Bill C-7, *An Act to Amend the Criminal Code (Medical Assistance in Dying)*.

of consideration for attending to the underlying needs of the people who request MAiD is, we argue, an infringement on their right to life, liberty, and security in view of MAiD expansion (if not its inception as well).

For instance, the 2021 guidelines changed the MAiD regulations drastically, allowing Canadians to now receive euthanasia and assisted suicide even if they do not have a fatal illness. Rather, MAiD can be requested based on Canadians' *perceived* suffering that "cannot be relieved under situations they find acceptable."<sup>27</sup> Essentially, if a patient determines that their life is not a benefit to them (whether or not their life will end because of their underlying medical condition), they can request to have it ended.

*Easing the regulations for MAiD by privileging the patient's decisions over their own health is not a credit to patient autonomy and a right to access care—it is tantamount to medical neglect, since it is a healthcare provider's responsibility to ascertain patient well-being and safety.*

As discussed earlier, in order for euthanasia to be legalized and integrated into healthcare contexts, healthcare providers are involved to offer a semblance of moral justification based on the primacy that the life of the patient is not perceived by the provider to benefit the patient. The Bill C-7 amendments radically shift this primacy into the hands of patients. In essence, as long as the patient now thinks their life is not worth living, they can have MAiD administered.

The provider, owing to the lack of the foreseeable death of the patient as a protective boundary, may operate on the basis that the patient does not deem their life to be beneficial, whether or not their life is objectively at risk. As such, the decision to end

a patient's life is not based on the healthcare professional's expertise but instead on the patient's ability to articulate that they are suffering in such a way that death is warranted. Given the increasing lack of safeguards, little is needed to substantiate such a claim.

Easing the regulations for MAiD by privileging the patient's decisions over their own health is not a credit to patient autonomy and a right to access care—it is tantamount to medical neglect, since it is a healthcare provider's responsibility to ascertain patient well-being and safety. It is also a failure of the courts and regulatory bodies to implement systems of change that will enable and empower Canadian citizens to live.<sup>28</sup>

27 Health Canada, "Third Annual Report," 12.

28 J.-S. Beaudry, "What's Missing from the Conversation About Assisted Death," *Policy Options*, October 16, 2019, <https://policyoptions.irpp.org/magazines/october-2019/whats-missing-from-the-conversation-about-assisted-death/>.

## Advance Requests

The original legislation for MAiD required patients to provide consent immediately before receiving euthanasia or the means for assisted suicide, but the 2021 legislative amendments allowed for limited advance requests under certain conditions.<sup>29</sup> An advance request is “a request for MAiD, created in advance of a loss of decision-making capacity, intended to be acted upon under circumstances outlined in the request after the person has lost decisional capacity.”<sup>30</sup>

Ongoing discussion to further allow for a liberal approach to advance requests has become more serious, setting the stage for further expansion. On the federal level, expansion of advance requests has been recommended by the parliamentary Special Joint Committee on Medical Assistance in Dying.<sup>31</sup> In Quebec, legislation was introduced in February 2023 to allow for advance requests for euthanasia.<sup>32</sup>

The practice of advance requests in Canadian healthcare has become an established process to manage how adults can make decisions about their health in the event that they lose the capacity to make those decisions in the future, due to unconsciousness or an advanced state of dementia, for example. As a 2018 report on advance requests for MAiD by the Canadian Council of Academies points out, Canada has an aging population, and thus “more people will experience capacity-limiting conditions, which will affect the demand and delivery of healthcare resources. [Advance requests] for MAiD, should they be allowed, would operate in this evolving context.”<sup>33</sup> One interpretation of this statement is that advance requests for MAiD might provide an economic solution to the burdens that the aging population will place on government-funded healthcare.

Considering the state of the current healthcare crisis in Canada, it is troubling that the potential implementation of advance requests for MAiD lies with the same level of government that disburses federal funds for Canada’s healthcare system. One might ask: how is the federal government going to reconcile the fiscal crises and Canada’s aging population against the backdrop of the current “evolving context”?

An advance request for MAiD is different than other kinds of advance requests, owing to the kind of action—namely death—that would be carried out. If a patient is permitted to make an advance request for MAiD, then if they lose the capacity to make health decisions in the future, they are automatically assenting to the possibility

29 Bill C-7, *An Act to Amend the Criminal Code (Medical Assistance in Dying)*.

30 Council of Canadian Academies, “The State of Knowledge on Advance Requests for Medical Assistance in Dying,” 2018, 34, <https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf>.

31 Special Joint Committee on Medical Assistance in Dying, “Medical Assistance in Dying in Canada: Choices for Canadians,” Parliament of Canada, February 2023, 73, <https://www.parl.ca/DocumentViewer/en/44-1/AMAD/report-2>.

32 M. Lapierre, “Quebec Tables Bill to Include Advanced Consent in Assisted Dying,” *CBC News*, February 16, 2023, <https://www.cbc.ca/news/canada/montreal/quebec-maid-advanced-consent-1.6750423>.

33 Council of Canadian Academies, “State of Knowledge on Advance Requests,” 34.

of having their life actively ended at the hands of the MAiD provider. The decision to carry out this act would be decided solely by the caregiver or substitute decision-maker(s), who would have to determine when the patient's life is no longer worth living. Unlike other decisions that a caregiver with power of attorney for healthcare must make on behalf of the patient, this is a decision to actively end life through the administration of lethal drugs. This is significantly different from the withdrawal of life support in a futile medical context, when the withdrawal of such supports allows the person to die naturally from the progression of their underlying condition.

Advance requests for MAiD, therefore, leave incapacitated patients open to the threat of death as opposed to receiving the treatment and care commensurate with and warranted by their potential and actual future healthcare situations.

## **Mental Illness as a Sole Diagnosis**

MAiD on the basis of mental illness was set to be legal as of March 17, 2023. Due to significant opposition, the government has delayed it until March 2024.<sup>34</sup>

Mental illness as a sole reason for requesting euthanasia or assisted suicide is troubling in light of the current regulations, which state that although Canadians who request MAiD must review and think about all the treatment options available to support them, they do not actually have to choose treatment over MAiD.<sup>35</sup> This is disturbing because mental-health illnesses are largely curable or at least manageable with treatment.

While the guidelines for requesting MAiD solely for mental health have not yet been released, unless the new guidelines are more restrictive than the current ones (which do not require the patient to receive treatment before receiving euthanasia or assisted suicide), it is possible that those with a mental illness may be able to request death on demand for this reason alone. In this case, healthcare in Canada is no longer a service to support the mentally ill but one solely operating on consumer demand.

## **Mature Minors**

Allowing children to receive euthanasia or assisted suicide is perhaps the most troubling proposed expansion. Currently, Canadians under the age of eighteen are

<sup>34</sup> Department of Justice, "Statement by Ministers Lametti, Duclos and Bennett on Medical Assistance in Dying in Canada," Government of Canada, December 15, 2022, <https://www.canada.ca/en/departement-justice/news/2022/12/statement-by-ministers-lametti-duclos-and-bennett-on-medical-assistance-in-dying-in-canada.html>; Department of Justice, "Eligibility for Medical Assistance in Dying for Persons Suffering Solely from Mental Illness Extended to March 17, 2024," Government of Canada, March 9, 2023, <https://www.canada.ca/en/departement-justice/news/2023/03/eligibility-for-medical-assistance-in-dying-for-persons-suffering-solely-from-mental-illness-extended-to-march-17-2024.html>.

<sup>35</sup> Government of Canada, "Medical Assistance in Dying"; Centre for Addiction and Mental Health, "Medical Assistance in Dying (MAiD) and Mental Illness—FAQs," February 2023, <https://www.camh.ca/en/camh-news-and-stories/maid-and-mental-illness-faqs>.

not able to request MAiD. As the Council of Canadian Academies report and the scholarly literature indicate, however, there is growing interest in this option.<sup>36</sup>

“Mature minor” is a term that refers to a person under the age of majority deemed capable of making a decision over their health, which includes understanding the substance, circumstances, and consequences of that decision. In Canada, the term typically denotes children under the age of eighteen, depending on the provincial or territorial legislation, who, if designated as a mature minor (and fulfilling all the necessary requirements in the jurisdiction in which they are designated as such) are able to make a medical decision.

There is legitimate interest in involving children in matters of health that concern them.<sup>37</sup> However, eliciting mature minors’ consent for euthanasia or assisted suicide as a “treatment” in tandem with existing and impending guidelines for MAiD is unethical.

It is not clear how euthanasia or assisted suicide could be conceived of as a need for mature minors, when, to date, there is not enough pediatric palliative or specialized pediatric palliative care to serve the children in Canada who would benefit from accessing it.<sup>38</sup> Rather, the scholarly literature in Canada reinforces the fact that there are children in pediatric intensive-care units who are not being transitioned into pediatric palliative care at the end of life, never mind other less critical but medically justifiable situations in which palliative care is warranted.<sup>39</sup> As such, Canada lacks the most basic infrastructure to support mature minors’ end-of-life care in the first place. This means that any health condition that could prompt a mature minor to request euthanasia or assisted suicide falls outside of current MAiD guidelines, given the fact that mature minors do not have access to all the treatment and care options that the guidelines stipulate would have to be considered before they could make a request.

In the shadow of increasing expansions to MAiD and guidelines to date, the question of mature minors raises the spectre of expanding euthanasia to other pediatric populations. As noted previously, some healthcare providers are calling for infanticide to become legal.

36 Council of Canadian Academies, “The State of Knowledge on Medical Assistance in Dying for Mature Minors,” 2018, <https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf>; H.K. Singh, M.E. Macdonald, and F.A. Carnevale, “Considering Medical Assistance in Dying for Minors: The Complexities of Children’s Voices,” *Journal of Medical Ethics* 46, no. 6 (2020): 399–404. <https://doi.org/10.1136/medethics-2019-105762>.

37 M. Montreuil and F.A. Carnevale, “A Concept Analysis of Children’s Agency Within the Health Literature,” *Journal of Child Health Care* 20, no. 4 (2016): 503–11, <https://doi.org/10.1177/1367493515620914>.

38 Widger et al., “Pediatric Palliative Care.”

39 M. Gagnon and D. Kunyk, “Beyond Technology, Drips, and Machines: Moral Distress in PICU Nurses Caring for End-of-life Patients,” *Nursing Inquiry* 29, no. 2 (2021): 1–11, <https://doi.org/10.1111/nin.12437>.



Arguments about “intolerable suffering” are occurring in a context of a national infrastructure bereft of adequate pediatric palliative care services.<sup>40</sup> Given the dearth of adequate palliative care to Canadian children’s pain and suffering, any move to expanding MAiD to include this group would be tantamount to the most extreme form of child abuse and neglect. Further, given the evidence of this care gap, it is deeply problematic that the government of Canada is advancing the MAiD regime while services such as palliative care, which could alleviate suffering prompting requests for MAiD, continue to show gaps and deficits in equitable access.

## Conclusion

Euthanasia and assisted suicide as MAiD have resulted in the erosion of the ethical principles of healthcare and the ethical provision of healthcare. It is being justified based on autonomy-absolutist perspectives, conflating conceptions of what constitutes suffering and what care should be provided to address it, and human-rights considerations based on access.

MAiD aggravates underlying issues within Canada’s existing healthcare system, namely, the lack of a national palliative care infrastructure robust enough to meet the problem of human suffering that MAiD is purporting to address. Our country currently lacks an adequate national palliative and specialized palliative care infrastructure across all care sectors.

While euthanasia was decriminalized and legislated into healthcare as a measure to rectify *Charter* right restrictions, to advance autonomy, and to reduce suffering, the reality of MAiD in Canada is instead one in which autonomy is being privileged absolutely and supports to help Canadians live well are not equitably accessible.

Given that MAiD offers death as the solution rather than addressing the challenges that suffering brings to those who are ill, Canada needs a radical pivot from autonomy-forward approaches to those that value dependency within healthcare access and delivery. At a time when Canadians are facing crises in healthcare, it is vital that we do not lose a sense of our humanity by qualifying those who are suffering as having a less-meaningful existence. Instead, we need to start providing life-giving alternatives to alleviating suffering, oriented to helping Canadians receive supports they need to live well and flourish.

*MAiD is the wholesale destruction of human lives, predicated on the notion that death is a solution to the difficulties inherent in living.*

40 J.-S. Beaudry, “Death as ‘Benefit’ in the Context of Non-voluntary Euthanasia,” *Theoretical Medicine and Bioethics* 43, no. 5–6 (2022): 329–54, <https://doi.org/10.1007/s11017-022-09597-w>.

MAiD is the wholesale destruction of human lives, predicated on the notion that death is a solution to the difficulties inherent in living. As the “Report of the *Lancet* Commission on the Value of Death” attests, the fact that death has become an over-medicalized event is ironically connected to the fact that dying and death receive little recognition as a meaningful life process in healthcare contexts.<sup>41</sup> Legislating death as a healthcare procedure, in the form of MAiD, is one such example of an over-medicalization of death in Canada.

The administration or provision of lethal drugs to patients should not be part of healthcare, and its introduction has dramatically eroded the ethical foundations of our very society. Instead, while dying and death are inevitable for everyone, it should be celebrated as a time when we, as a community of humane persons, did all we could to support living well through to life’s completion.

41 Sallnow et al., “Report of the *Lancet*.”

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