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Commentary

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More than we imagined? Unresolved tensions and the current state of physician-assisted suicide and euthanasia in Canada

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"It is as though the Canadian Constitution, through the Supreme Court, invented a magically effective medical product that is always at the ready."

– **Scott Kim**, Member, Council of Canadian Academies Expert Panel Working Group on MAID (Kim 2023)

Canadian legislators appear determined to make Canada a world leader on access to Medical Aid in Dying (MAiD), or as it is called in other countries: physician-assisted suicide, medically assisted death, or euthanasia. Before the Supreme Court's *Carter vs. Canada* case (2015), Canadians understood that MAiD meant a merciful end to interminable suffering for incurable disease. That understanding now appears quaint and outdated given current discussions about

MAiD for minors, infants, and patients suffering from mental health conditions. Whereas Canadians first understood MAiD as a rare and merciful end, when medicine had nothing left to offer, MAiD is now marketed as a treatment option to manage fear of eventual suffering, to eliminate the pain of loneliness and isolation, and even as a viable option when social needs cannot be met.

Last fall, Simons Canada, a fashion company, made international headlines with a video advertisement celebrating a romanticized depiction of MAiD (Harrington 2022). British media reported that the patient narrator, Jennyfer Hatch, had actually described to CTV, in June, how she felt like she was falling through the cracks (Pennock 2022). She did not have the social support she needed.

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Around the same time, the world watched and commented as several Canadian patients, driven by financial hardship, applied for MAiD. Stories surfaced about young adults being screened and approved for MAiD without informing parents or family (Subramanya 2022). In December, CTV News reported multiple veterans had been offered MAiD as treatment (Yun 2022). One veteran and former Paralympian had tried for five years to get a wheelchair ramp installed in her home; the case worker offered MAiD as a possible option instead.

Today, Canadian debate about MAiD sounds almost as banal as any other medical procedure. In December, Brassolotto, Manduca-Barone, and Zurbrigg (2022) reviewed Canadian news media in reference to MAiD and reported that, "Public discourse in Canada has largely shifted away from these philosophical debates (e.g., "should we permit assisted death?") and is now focused predominantly on policy development (e.g., "how do we provide assisted death?")." Canadians have shifted away from the "philosophical debates," because the Supreme Court of Canada settled them for us. *Carter v. Canada* (2015) told Canadians that ending a patient's life is lawful and warranted, in specific situations with proper safeguards. Given Court approval to end life, we can focus on implementation, which is precisely what we did.

Patient volumes and cost savings

Since Canada passed the law that legalized MAiD in 2016, 31,664 Canadians have gone through with MAiD. Just over 10,064 Canadians chose MAiD in 2021: 3.3 percent of all deaths, according to the federal government's annual report, an increase of 32.4 percent from 2020 (Health Canada 2022). Over 80 percent of requests for MAiD are approved. At this time, 17 percent of patients reported "isolation or loneliness" as one of the main motivations for death. Of note, Canada leads the world in organ donation from MAiD patients, with 6 percent of transplanted organs in 2021 harvested after MAiD (Favaro 2023).

Costs dominate almost every discussion about Canadian health care, and MAiD is no different. The federal government published an estimate in 2020 that indicated MAiD could save $149 million annually in health care costs. The Parliamentary Budget Officer (PBO) report, *Cost Estimate For Bill C-7 "Medical Assistance In Dying,"* outlined the potential cost savings expected with Bill C-7 and the expansion of MAiD to "patients whose death is not expected in the relative near term" (PBO 2020, 1). The report noted that current legislation, Bill C-14, without any changes, would offer a "net reduction in health care costs" of $86.9 million ($109.2 million in gross cost reduction minus $22.3 million cost to administer) in 2021. However, Bill C-7 promised an additional $62 million "net incremental reduction in health care costs" by expanding MAiD eligibility ($66.5 million gross savings minus $4.4 million cost to administer). Furthermore, Bill C-7 offered a larger relative financial impact at lower cost (greater efficiency), since patients initiate MAiD much sooner. Thus, with the adoption of Bill C-7, the "total net reduction in health care costs" would be $149 million (Bill C-14 baseline + Bill C-7 incremental savings).

The larger relative financial impact of Bill C-7 comes from the "disproportionately high" health care costs in the last year of life. In fact, the last year of life represents "between 10% and 20% of total health care costs despite these patients representing about 1% of the population. Nevertheless, this report should in no way be interpreted as suggesting that MAID [sic] be used to reduce health care costs" (PBO 2020, 3).

Bill C-7 received royal assent and became law in March 2021 (Department of Justice Canada 2021). Provisions for patients suffering from mental illness were included in the bill, with an exclusion delay until March 2023. Given

public sentiment (outcry) in late 2022 and early 2023, government extended the temporary exclusion, in February 2023, until March 2024 (Bill C-39) (Government of Canada 2023).

Given Canada's single-payer approach to health care, MAiD seems to present an unavoidable conflict of interest for government. MAiD also presents a financial conflict for physicians. MAiD requires less cognitive effort and presents less legal risk than other forms of clinical practice (no patient lawsuits post procedure). Although a small cohort of physicians has made MAiD a core element of their practice, only a tiny fraction of physicians gets involved. Of the 93,998 physicians in Canada, just 1577 provided MAiD in 2021 (CIHI Undated). Roughly one third of physicians who perform MAiD do it only once: 561 (35.6 percent). The number of physicians who only perform one procedure per year remains relatively constant: 538 in 2020, 488 in 2019. The number of doctors who offer two to nine and 10+ procedures has been growing from 655 in 2019 to 1015 in 2021.

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Physicians can offer patients two options for MAiD. A patient may choose a prescription for a combination of medications, which the patient takes on his or her own if able. Or a patient may choose a physician-administered (or nurse-administered) combination of intravenous medications. In both cases, medications include a potent mix of powerful sedatives and paralytic agents designed to cause a patient to lose consciousness and stop breathing. According to one review of 3557 patients, published in the *Canadian Medical Association Journal*, "The medications most often used were propofol (3504 cases [98.5%]), midazolam (3251 [91.4%]) and rocuronium (3228 [90.8%])" (Stukalin et al. 2022). Only seven patients chose the self-administered option in 2020. The physician/nurse-administered option offers the benefit of immediate backup in the (rare) event the first batch of medications fails to produce death, making the second approach much more popular with patients.

Hesitation around self-administered medications might explain the drastically different outcomes in California. In 2016, California also legalized MAiD with its *End of Life Option Act*, which allows patients to self-administer medications

intended to cause death. It does not allow physician-administered approaches (see definitions below). California shares a similarly-sized population as Canada and, in many ways, holds equally progressive views. However, only 486 people chose assisted death in 2021 – or 20 times fewer than Canada (Kay 2023).

New language for old ideas

Unlike other countries, Canada now avoids mention of "physician-assisted suicide," "medically assisted death," or "euthanasia." Canadian legislators invented new language: *medical assistance in dying,* now known as *medical aid in dying*.

Some might say they did not so much invent new language as repurpose it from palliative care. The palliative care community had spent decades normalizing death as part of life. MAiD legislation leverages positive connotations about palliative care, easing of the process of natural death, and applied those positive sentiments to a new process of hastening death. It is, if you will, equivocation by legislation.

Thus, MAiD signals death by clinical means, while avoiding details by intention. The need to avoid details using new language suggests, perhaps, public discomfort with the events themselves. Throughout history, other cultures have embraced death (including suicide, infanticide, capital punishment). Even in recent memory, Canadian advocacy groups worked to normalize the pursuit of a "good" death as simply part of pursing a good life. Now, Dying With Dignity Canada seeks to normalize MAiD and insists we avoid old words (Dobec 2022). MAiD has become the favoured term with American groups also. The Portland association, Compassion and Choice, argues that "suicide and euthanasia" are not compassionate terms (Compassion and Choices Undated).

Definitions

MAiD serves as an umbrella term under which regulatory changes can expand without drawing attention by a change in terminology. A range of different options exists within MAiD that are rarely defined in modern discourse. For example, MAiD presently includes physician-assisted suicide and voluntary active euthanasia. However, the latest debates have moved to consider non-voluntary active euthanasia; only involuntary active euthanasia remains completely outside public consideration in Canada. Although MAiD

advocates insist these terms are no longer relevant, they still refer to distinct clinical scenarios, which attract different levels of public support. These distinct elements require a brief review of definitions (Keown 2002, 9).

Physician-assisted suicide refers to a physician giving a patient the means (medications) to end his or her own life. In Canada, nurse practitioners have been given the ability to perform this act, so we call it "provider-assisted suicide."

Euthanasia – from the Greek word, *eu* ("well") and *thanatos* ("death") – refers to someone other than the patient ending the patient's life. Again, Canada allows nurse practitioners to offer this service to patients. Euthanasia can be active or passive, and it can be voluntary, nonvoluntary, or involuntary.

Active euthanasia refers to the active intervention of a physician or nurse to cause death, as described above. Passive euthanasia refers to the withdrawal of nutrition with the intent to cause death. This is not the same as stopping futile therapy. A clear line runs between stopping futile treatment, to let nature take its course, and taking action to intentionally cause death. Equivocation often serves to normalize intentionally causing death (euthanasia), when it should be clear and distinct from stopping futile care.

Euthanasia also differs on the level of consent. Currently, Canada allows voluntary-active euthanasia. This means a patient must be able to give full and informed consent prior to the procedure. Non-voluntary, active euthanasia refers to causing death for patients who are unable to consent (e.g., infants or adults with dementia) or for those who did not get the opportunity to provide consent. Finally, involuntary active euthanasia refers to causing death against a patient's wishes, which is uniformly denounced by all sides.

Incorporating MAiD into medicine

Long before the pandemic, Canadian hospitals had incorporated MAiD into established lists of medical treatments and therapies. Even before the MAiD legislation in 2016, most hospital medical advisory committees had struck subcommittees to update their current hospital rules and regulations to incorporate medically assisted death. Common medical policies include suggested dosing regimens (Stukalin et al. 2022).

Without any fanfare or excitement, the medical establishment incorporated MAiD like any other medical procedure. Hospitals now need only minor

tweaks to their eligibility criteria – small edits to procedural manuals – in order to implement ever-expanding MAiD criteria.

The Canadian Association of MAID Providers promotes the notion that all physicians have an obligation to mention MAiD as a viable treatment option (Kirkey 2022; CAMAP 2022). The broader medical establishment in Canada either remains silent or pushes to expand MAiD even further. Last fall, the Quebec College of Physicians (the provincial medical regulator and licensing authority) made the case before the parliamentary standing committee for the inclusion of euthanasia for infants born with conditions that make life impossible. Medical regulators across the country meet together regularly and discuss policy and regulatory changes. This does not mean all provinces agree with each other. However, it often happens that one provincial regulator will promote a policy approach, which the other colleges mimic if successful.

> *The medical establishment incorporated MAiD like any other medical procedure.*

Euthanizing infants may have been a push too far. Andrew Phillips, *Toronto Star* columnist, expressed shock (Phillips 2022). The *Star* usually amplifies the voice of Canadian progressivism, but not this time. Speaking to the Quebec College's argument, Phillips wrote, "Let's also be clear about this: authorizing doctors to actively euthanize infants – rather than allowing nature to take its course – does cross a line once thought inviolable." Government is "unable or unwilling to find a reason to draw a line anywhere."

The notion of a "line once thought inviolable" seems to run counter to messages promoted by MAiD advocacy groups. Dying with Dignity, the largest MAiD lobbyist group in Canada, promotes surveys that suggest 80 percent support for MAiD in Canada (Dying with Dignity Canada 2022). But the overwhelming support described by advocacy groups might not be as overwhelming as advertised. Ray Pennings and Angus Reid discussed the apparent Canadian "consensus" on support for MAiD and noted that both ends of the spectrum – for and against – have strong and committed opinions (Pennings 2020). The bulk of Canadians in the middle express "cautious support."

Unresolved tensions

For doctors and nurses, the issue becomes even more complex. While the wheels of medical bureaucracy appear to incorporate MAiD without pause or impediment, things look different in the clinic. The new legislation injects fundamental and unresolved ethical, ontological, and procedural tensions. Ethical tension arises from a reordering of goods. Ontological tension comes from redefining the nature of medicine. Procedural tension arises from a reordering of clinical examination, care, and referral. Let's look at each in turn.

Ethical tension

Medicine is not ethically neutral. It aims first towards the restoration or preservation of health. Barring that end, medicine aims towards the betterment of patients' lives by lessening unwanted symptoms and improving function wherever possible.

Before MAiD legislation, patient autonomy and respect for the patient's life, or life in general, could coexist in the clinic, due to an arbitrary limit to autonomy. Respect for patient autonomy, embodied primarily in informed consent, could exist as part of a larger, duty-based ethic (normative deontological ethic), which included a principled stance of non-maleficence. Prior to MAiD, non-maleficence included respect for human life, expressed in the Hippocratic Oath "do no harm" (*primum non nocere*). Although the Hippocratic Oath has been criticized for being anachronistic, imprecise, or simply useless in modern clinical care, the no-harm principle still resonates with most physicians and embodies popular notions about medical care. Pre-MAiD, clinicians could follow both autonomy and non-maleficence principles without ethical tension, given the arbitrary limits to each principle.

MAiD legislation upset this balance by redefining both principles. Patient autonomy now includes the ability to choose death, which requires a redefinition of non-maleficence. "Do no harm" no longer stands as an arbitrary moral absolute barring clinical participation in causing death, as long as a patient consents to it. "Preliminary evidence suggests that the shift away from the medicine's fundamental values of cure/control of disease to hastening death with the aim of alleviating intolerable suffering can have significant emotional effects on participating [health care providers]" (Dholakia, Bagheri, Simpson 2022, 2). Unfortunately, moral absolutes do not change or disappear simply because government changes legislation.

Ontological tension

Ontological tension arises from a redefinition of the nature of medicine itself. Those who support MAiD insist that it does nothing to change medicine. MAiD simply adds a treatment option that we had (arbitrarily) banned from consideration before *Carter v. Canada*. Clinical care has always aimed at ending suffering, and MAiD also aims to end suffering. Furthermore, the clinical equipment used for MAiD is also used in other clinical settings. Given the same goals and equipment, MAiD is simply medical treatment.

The argument rests on a confusion of relative and absolute ends. Medicine has aimed to end or alleviate suffering for several thousand years. However, medicine sought that end up to, but not including, the point at which attempts to end suffering cause death instead. Medicine's aim to end suffering was historically relative or qualified, not absolute. At the time of Hippocrates, people knew how to cause death and thereby end suffering. Indeed, the radical idea Hippocrates introduced was to qualify or limit the natural human desire to end suffering by excluding the option to end life. Alleviation of suffering could be pursued up to, but not including, the point of causing death. Hippocratic physicians took the radical stand of refusing to practise as though ending suffering was an absolute good. This forced these physicians to develop better ways to treat disease and ameliorate pain, given their arbitrary proscription against ending suffering by ending life.

MAiD legislation redefines the cessation of suffering as an absolute good. As a social change, this may be fine. But by embedding MAiD inside the medical profession, it arbitrarily redefines, not just medical ethics, but the nature of medicine itself.

No questions asked

In most clinical settings, MAiD does not surface as a major topic of discussion. When MAiD does make it into discussion about treatment plans, it tends to close debate on other treatment paths. It is as though the request for MAiD triggers a single, default treatment pathway. As mentioned above, the Canadian Association of MAiD Providers seeks to normalize the presentation of MAiD as a treatment option all physicians should (and must) consider.

This closure of discussion is substantively different than that experienced around abortion, pre-2016. For abortion, physicians could (for the most part) remain walled off from having to participate. Government developed robust direct

access for abortion, and physicians were never forced to refer. This allowed physicians to practise as though abortion did not exist, if they choose, in so far as their own clinical practice was concerned. Medical students could go through training without having to be involved, in any way, in a single termination of pregnancy.

Advocates have worked hard to avoid letting physicians practise as though MAiD/euthanasia does not exist. Given the peculiar needs of some (bedridden) patients who might request MAiD, the Superior Court of Ontario ruled that no physician has a Charter right to refuse to be involved with any patient who requests MAiD. A physician's right to freedom of religion, although recognized by the court under the Charter, was thought by the court to be justifiably limited or denied. The court upheld the College of Physicians and Surgeons of Ontario's new directive (2016) that all doctors must make an "effective referral" to another physician who would provide MAiD, for patients who request it, if a physician felt MAiD went against his/her religious beliefs. Even patients, who are otherwise coherent, ambulatory, fully independent, and who arrange, schedule, and attend a community clinic on their own must be given an "effective" referral for MAiD, if they request one. Expert witnesses suggested that physicians could retrain in pathology or dermatology to avoid ever having to see a request for MAiD.

Unfortunately, the court's ruling against freedom of religion also curtailed physicians' freedom of conscience. Professional judgment rests on freedom of conscience: the ability to act, or not act, in a professional capacity based on one's professional judgment. Even if a patient appears depressed and warrants treatment, the court has created (perhaps unintentionally) an environment in which physicians simply refer, if a patient requests MAiD. Experience, training, and professional opinion – not to mention years-long relationships with particular patients – warrant no consideration given a request for MAiD. The request, essentially, closes the usual clinical process (discussion, investigation, treatment, follow-up) and triggers a common referral pathway for MAiD. Why would a physician risk a complaint to the medical regulators for declining to refer for MAiD, even if a trial of antidepressants and counselling were clinically indicated? Better to leave that with the physicians involved in reviewing the referral and gaining consent for MAiD.

It remains to be seen what will happen to the moral, ontological, and procedural tensions. Can clinical care continue unchanged given the normalization of two fundamentally opposed objectives? Will the elevation of autonomy force

clinicians to re-evaluate their deeply held views about patients' lives and life in general? Will Canadians reassert the need to bolster and ringfence respect for life within clinical care? Does MAiD change those who provide the service? Can a clinician make assisted suicide and euthanasia a major part or sole focus of his/her practice and still be able to provide regular care? Will clinicians find a way to function as though, for the vast majority of care, MAiD does not exist?

Assumptions behind the arguments

Despite all the articles and arguments about MAiD, public debate seems to avoid the core assumptions at the centre of the issue. MAiD discussions rest on a particular vision of what it means to be human. MAiD makes most sense if we presuppose a specific anthropology and a constrained view of self-ownership. Humans are best understood as raw will: decision-making machines. Furthermore, humans own their own bodies and, as such, they each have full control over their property.

O. Carter Snead, Professor of Law at Notre Dame, wrote a recent book that reviews American law and court rulings on life and death issues called, *What It Means To Be Human: The case for the body in public bioethics* (Snead 2020). Snead looked at all the evidence and debate to see whether any consistent assumption about human anthropology emerged and shows that public debates assume "a vision that defines the human being fundamentally as an atomized and solitary *will*" (Snead 2020, 3). He notes that the modern understanding of personhood is not like the old, classical-liberal vision of individualism. Today, we see "human flourishing as the pursuit of projects of one's own invention and choosing – endeavours that express and define our true selves" (Snead 2020, 79). Our new vision reflects what Robert Bellah, sociologist, first called "expressive individualism." As Snead notes:

> Bellah identified 'expressive individualism' as a reaction to the more utilitarian version of individualism that placed a greater premium on the net social goods that emerge from the aggregated pursuit of self-interested individuals operating within a well-regulated system of laws. By contrast, expressive individualism 'holds that each person has a unique core of feeling and intuition that should unfold or be expressed if individuality is to be realized.' (Snead 2020, 79)

Snead argues that *expressive individualism* presents a limited view – it forgets about the body. "Because human beings live and negotiate the world *as bodies,* they are necessarily subject to vulnerability, dependence, and finitude" (Snead 2020, 88). An embodied anthropology seems to more accurately reflect and capture the full expanse of patient experiences in clinical care and end-of-life issues.

MAiD rhetoric also presupposes a peculiar sense of self-ownership. John Locke (1632-1704), father of liberalism, famously said that freedom rests on self-ownership: "every Man has a *Property* in his own *Person*. This no Body has any Right to but himself. The *Labour* of his Body, and the *Work* of his hands, we may say, are properly his" (SS 27, Second Treatise) (Locke 1948). Locke made it clear that each human is "Master of himself, and *Proprietor of his own Person.*" (SS 44, Second Treatise) (Locke 1948).

But self-ownership leaves out the other half of Locke's argument. John Locke did not leave self-ownership as a naked concept. He balanced the modern concept of self-ownership, of one's person, with the pre-modern concept of divine ownership of one's life, as "the workmanship of their own Maker, the Almighty" (SS 56, Second Treatise) (Locke 1948). Today, Locke's metaphysics is ruled out of order in public discourse, which leaves us with a lopsided view of Locke's original argument. Combined with the anthropology of expressive individualism described above, self-ownership seems to close debate on whether or not it makes sense that all individuals should be able to end their own lives, in any manner they see fit.

However, the resonant "truthiness" of self-ownership, at the same time, runs counter to equally resonant ideas about ownership in general. Most people agree that just because you own a priceless painting, ownership does not include the right to deface or destroy the piece of art. Most people would hope you would protect and preserve the Picasso in your possession. Furthermore, the worth of the priceless art includes more than just the value you or the market assigns to it. A great painting possesses intrinsic aesthetic value, in addition to its instrumental value as a source of pleasure or wealth for its owner. The same argument applies to historical sites and archeological finds. Most people expect the host country to protect the artifacts, even if the host does not share the same sense of value.

Of course, this leaves room for someone to argue that life has no intrinsic worth. Perhaps life only has worth as a consumable good – something to be used up by

the owner? "It's your life – do what you want with it." Each person must make the best of the life he has; we all have agency of some degree. But this does not mean we should conflate agency with value. Furthermore, the view that life is just a consumable good seems to impose an even larger burden of argument and proof on those who seek to popularize the notion. Indeed, the life-as-a-consumable-good approach seems to lead inevitably to the tragic, 20th century philosophies about lives not worth living.

Conclusion

Much has changed since the Supreme Court overturned the ban on assisted suicide in 2015. Discussions about MAiD have moved far beyond inevitable death in the near foreseeable future, irremediable suffering, terminal illness, or uncontrollable pain. Those debates raised images of truly grim clinical situations. All things being equal, death seemed a better option than a life of waiting for death with bed sores, oozing wounds, inability to swallow or speak, and unrelenting pain.

Today, poor people ask for euthanasia because they cannot access necessary services. Soldiers suffering from post-traumatic stress disorder are offered MAiD by their counsellors. Young people in their 20s can receive MAiD without consultation with family. Palliative care is (still) unavailable or hard to access, but access to assisted suicide and euthanasia remains strong.

Is this what Canadians want? Is this what Canadians imagined when we passed MAiD into law seven years ago?

Society exists on a set of arbitrary guardrails. Liberal democracy rests on laws, which in turn rest on assumptions and principles. What does it mean to be human? What social goods do we want to pursue? What does it mean to be a civilized country? The answers rest on assumptions and principles which are themselves unproveable. But they must be defended, or the basis for our laws becomes moot.

Liberal democracies function like flowing water. If a new channel opens, flow proceeds as though nothing happened. The machinery of institutions and state incorporate the new direction and continue to flow along as before. Only consensus and social fabric remain to shape the flow of ideas in a liberal democracy. Perhaps it is time to pause and find out if this is the direction Canadians expected MAiD to go. MLI

About the author

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Endnotes

1 Given the rationing of training spots and roadblocks against re-entering training after being in practice, the notion of physicians retraining in mid-career is a fiction (and the expert who suggested this knew better having spent years as Vice-Dean of undergraduate medical education at the University of Ottawa).

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