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Medical Assistance in Dying: A Review of the Legislation

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The Canadian government has announced plans to review legislation governing Medical Assistance in Dying (MAID).[1] This article will provide an overview of the current legislation and Catholic Church teaching about MAID and will conclude with some of my thoughts about the issue.

THE LEGISLATION

The legislation allows the practice of two specific forms of medically assisted death.[2] One is euthanasia where, at the request of the patient and with the consent of the patient, a third party (either a physician or nurse practitioner) deliberately undertakes the intervention (e.g., administering a lethal injection) that will end the patient's life. The other is assisted suicide where, at the request of the patient and with the consent of the patient, a third party (either a physician or nurse practitioner) deliberately provides the means (a lethal dose of drugs, e.g.) that the patient will then use to end her life.

To be eligible for MAID, a patient must have a "grievous and irremediable medical condition" (241.2 (1) (c)) meaning that the "illness, disease or disability" is "serious and incurable" (241.2 (2) (a)) and causes "enduring physical or psychological suffering that is intolerable to them and ...cannot be relieved under conditions that they consider acceptable" (241.2 (2) (c)), the patient is "in an advanced state or irreversible decline in capability" (241.2 (2)(b)) and the patient's "natural death has become reasonably foreseen" (241.2 (2) (d)). As of this writing, all four of these criteria must be met in order for the patient to be considered to be suffering from a "grievous and irremediable medical condition" and so be eligible for MAID (241.2 (1) (a)).

As well, patients seeking MAID must be "at least 18 years of age and capable of making decisions with respect to their health" (241.2 (1) (b)). They must also be "eligible ... for health services funded by a government in Canada" (241.2 (1) (a)). To meet the requirements of informed consent, the request for MAID must be made by the patient, freely and without coercion (241.2 (1) (d)) and the patient must be given information about alternatives, including palliative care (241.2 (1) (e)).

In the case of MAID, the process of informed consent has two steps. There is the initial request that is made in writing (241.2 (3) (b) i). Then, after a waiting period of ten days (241.2 (3) (g)), consent must be sought again: "express consent" must be given again "immediately before ... the medical assistance in dying" (241.2 (3) (h)). The ten-day waiting period may be modified if the health care professionals believe that "the person's death, or loss of their capacity to

provide informed consent, is imminent...." (241.2 (3) (g)).

The legislation also addresses issues pertinent to health care professionals. For instance, in the case of MAID, pharmacists must be informed that the drugs they are preparing will be used for an assisted death (241.2 (8)). As well, "For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying" (241.2 (9)). There is no mention in the legislation about the necessity of making referrals.

ISSUES IN REVIEW

The main issues under review concern eligibility requirements. The Quebec courts became involved when persons suffering from chronic conditions, but whose deaths were not imminent, challenged the necessity of "natural death" being "reasonably foreseeable" in order to have access to MAID. A Quebec Supreme Court Justice ruled that this requirement was unconstitutional and in March 2020, the patient's death being "reasonably foreseeable" will no longer be a criterion for MAID in Quebec.[3] It remains to be seen what will happen federally.

In preparing for the summer 2020 review, the Canadian government has targeted three issues:[4]

1. Whether to make MAID available to persons who are younger than 18 but who nevertheless have the maturity make health care decisions. Should MAID be accessible to the so-called "mature minors" who are otherwise allowed to make decisions about their health care?

2. Whether to make MAID available to persons who may not be contending with physical conditions but who may instead be suffering grievously because of mental illness.

3. Whether patients can request MAID in advance. Initially, the issue centred on the scenario where patients would lose decision-making capacity between the time they made the request for MAID and the time it was to be administered, meaning they would be unable to give the required final consent. The use of "advance requests" has been proposed; however, it is unclear whether such requests would be limited to the specific situation, above, or would include requests to be made much earlier through advance directives such as living wills.[5]

CATHOLIC CHURCH TEACHING ON MAID

The Catholic Church is very clear about its stance on medically assisted death.[6] Because of its interest in the protection of all human life in all of its stages and conditions, because of a general prohibition against direct killing, because of its interest in the protection of the most vulnerable members of the community, because of the hope it places in human ingenuity and compassion to find ways of easing suffering—ways that do not include killing people—the Church prohibits all forms of medically assisted death.

While allowing withholding and withdrawing treatments in order to permit a dying process to proceed unimpeded, or when such treatment is deemed to be unduly burdensome or unable to achieve the outcome for which it was intended, the Catholic Church nevertheless prohibits the

direct killing of patients through euthanasia, assisted suicide and mercy killing.

SOME THOUGHTS

When I have taken interested groups through the legislation, very often the question is raised about the waiting period and why it would be waived in the case when death was imminent. What need would there be for MAID now that death was on its way? It didn't seem to make sense—and yet this clause sums up the heart of medical assistance in dying. Patients want to have a sense of control over what happens to them—and MAID (apparently) offers the ultimate sense of control: determining the time and manner of one's own death, and having assistance in it.

In this sense, MAID can be seen as an exercise in patient autonomy, that is, an exercise in the patient's right to self-determination. Since the late twentieth century, health care ethics and practice have been driven by this principle. However, as we move further into the twenty-first century and understand health in terms of communities as well as individuals, and recognise the role that social determinants such as poverty play in the wellbeing of communities and individuals, I believe that we must bring principles of social justice into the equation.

Many people are afraid that MAID will lead to an erosion of hospice palliative care. I don't share this fear. I think that governments will find themselves in the situation where they must fund palliative care in order to give MAID a sense of legitimacy. By standing alongside a robust system of palliative care, MAID will then be normalized as simply one of two very viable end-of-life options. My concern lies instead with the support for and care of persons suffering from chronic conditions, particularly persons in long-term care—and this is where issues of social justice come in.[7]

In long-term care institutions we have perhaps our most vulnerable patient populations supported by health care's most vulnerable care givers, the personal support workers (PSWs). It is a health care sector that is woefully underfunded—and it shows. Too often residents and visitors say that they would rather be dead than be in these facilities. But imagine what a long-term facility could be (or what life in the community could be like, given proper societal priority and funding)—where therapeutic relationships were able to develop between resident and carer, where the facilities were integrated into the community through gardens and activities and shared spaces, where the goal is to have residents—and carers—thrive as persons.

What happens to persons in long-term care facilities suffering from challenging and difficult illnesses and conditions but who nevertheless do not wish to have MAID? What are their chances of being able to live a life of dignity and meaning exactly as they are? Already long-term care is in critical condition. Is it possible that through further government funding decisions, life will be made close to unbearable for this marginalized patient population, so much so that MAID may seem suddenly desirable?

I think it is an amazing coincidence that, as cash-squeezed governments are facing a tidal wave of aging baby boomers, MAID has

become legalized. My guess is that, sometime after the summer 2020 review, the next round of public consultations will consider MAID and the question of substitute decision-making—of having others make decisions for persons unable to make or voice their own choices. My fear in all of this is that as we place our focus on people who wish to have assistance in dying, we will fail persons who wish to have assistance in living. ■

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[1] Department of Justice Canada, "Consultation on medical assistance in dying (MAID) eligibility and request process" https://www.justice.gc.ca/eng/cons/ad-am/index.html

[2] To view the current legislation, see: https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent . References to specific parts of the legislation will be noted in the text.

[3] . Department of Justice Canada, "Consultation on medical assistance in dying".

[4] Ibid. In preparation for the review, the government consulted with the Council of Canadian Academies which in turn prepared reports on the three issues. A summary of these reports can be found: The Council of Canadian Academies, *State of Knowledge on Medical Assistance in Dying for Mature Minors, Advance Requests, and Where a Mental Disorder is the Sole Underlying Medical Condition. Summary of Reports* https://cca-reports.ca/wp-content/uploads/2018/12/MAID-Summary-of-Reports.pdf

[5] Government of Canada, "Consultations on medical assistance in dying (MAID) eligibility criteria and request process" https://www.justice.gc.ca/eng/cons/ad-am/survey_maid_eng.pdf

[6] For Catholic Church teaching on assisted death, see: Sacred Congregation for the Doctrine of the Faith, "Declaration on Euthanasia" http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

John Paul II, *Evangelium Vitae* http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html (see sections 64-66).

[7] I wish to acknowledge that persons who require assistance with daily tasks of living because of chronic illnesses and conditions do not always live in residential care but live in the community where they face great challenges such as higher than normal rates of poverty and lack of assistive resources provided in a dignified manner. However, my own research to this point has been in the area of marginalization in long-term care facilities. See my: "Challenges in Ontario Health Care: A Personal Reflection." *Bioethics Matters* 17, no. 4 (2019): 1-4. http://www.ccbi-utoronto.ca/wp-content/uploads/2019/10/Bioethics-Matters_BCampion_Challenges-in-Ontario-Health-Care_Vol-17-4-Oct2019_Final.pdf "The Plight of ALC Patients: A Call to a 'Revolution of Tenderness'." *Bioethics Matters* 12, no.5 (2014): 1-4. http://www.ccbi-utoronto.ca/wp-content/uploads/2014/10/BioethicsMatters-Vol-12-5_Alternative-Level-of-Care-Patients_BCampion.pdf "Person-Centred Care and Persons with Alzheimer's Disease." *Bioethics Matters* 10, no. 5 (2012): 1-4. http://www.ccbi-utoronto.ca/wp-content/uploads/2019/11/BioethicsMattersVol10-5_Nov12-PersonCentredCare_AlzheimersDisease.pdf