



# Introducing Medical Assistance in Dying in Canada: Lessons on Pragmatic Ethics and the Implementation of a Morally Contested Practice

Andrea Frolic<sup>1,2</sup> · Allyson Oliphant<sup>1</sup>

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## Abstract

Medical Assistance in Dying (MAiD) in Canada has had a tumultuous social and legal history. In the 6 years since assisted dying was decriminalized by the Canadian Parliament in June 2016, the introduction of this practice into the Canadian health-care system has been fraught with ethical challenges, practical hurdles and grassroots innovation. In 2021, MAiD accounted for approximately 3.3% of all Canadian deaths annually, and more patients are seeking MAiD year over year as this option becomes more widely known. Unfortunately, some patients who want MAiD are unable to access it in a timely manner because of a lack of willing MAiD providers. This introduction describes statistics about the uptake of MAiD in Canada and the challenges presented by Canadians' rapid acceptance of this end of life care option. In this special edition of *HEC Forum* about the implementation of MAiD in Canada, authors depict a range of ethical challenges and strategies to address issues related to MAiD access and quality, organizational engagement, clinician recruitment and retention, and support for a morally diverse workforce. In each article, the authors reflect on the question: What are the practical ethics involved in introducing assisted dying into a new healthcare context, and how can ethicists and ethics resources collaborate with stakeholders to ensure the integration of ethical considerations as this practice continues to evolve?

**Keywords** Assisted dying · MAiD · Euthanasia · Canada · Sustainability · Access · Ethics · Ethics committees

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✉ Andrea Frolic  
iamfrolic@gmail.com

<sup>1</sup> Program for Ethics and Care Ecologies (PEaCE), McMaster University Medical Center, 1F9-1200 Main Street West, Hamilton, ON L8N 3Z5, Canada

<sup>2</sup> Department of Family Medicine, McMaster University, Ontario, Hamilton, Canada

## Introduction: Context and Criteria for Assisted Dying in Canada

The legal process to decriminalize euthanasia<sup>1</sup> in Canada unfolded over several decades. Two concurrent legal processes—a public consultation process focusing on end of life care in Quebec, and a legal case originating in British Columbia that wound up at the Supreme Court of Canada in 2015—ended with amendments to the Criminal Code by the Canadian Parliament that fashioned MAiD as a legally accessible option for eligible Canadians in June of 2016. The amendments to the Criminal Code provided the legal definitions, criteria and framework through which MAiD could be performed. This framework is described in Table 1.

In 2019 Jean Truchon and Nicole Gladieu, both of whom had “grievous and irremediable medical conditions” but did not have a natural death that was “reasonably foreseeable” successfully appealed to the Supreme Court of Quebec to have the reasonably foreseeable natural death (RFND) eligibility requirement struck down (Government of Canada 2021). The Government of Canada did not appeal this decision,

**Table 1** Eligibility for medical assistance in dying under Canadian Criminal Code amendments (2016)

- (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
- (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be **eligible—for health services funded by a government in Canada**;
  - (b) they are at least **18 years of age and capable of making decisions** with respect to their health;
  - (c) they have a **grievous and irremediable medical condition**;
  - (d) they have made a **voluntary request** for medical assistance in dying that, in particular, was not made as a result of external pressure; and
  - (e) they give **informed consent** to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care

### **Grievous and irremediable medical condition**

- (2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:
- (a) they have a **serious and incurable illness, disease or disability**;
  - (b) they are in an **advanced state of irreversible decline in capability**;
  - (c) that illness, disease or disability or that state of decline causes them **enduring physical or psychological suffering that is intolerable to them** and that cannot be relieved under conditions that they consider acceptable; and
  - (d) their **natural death has become reasonably foreseeable**, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.\*

\*This criterion was removed in the 2021 amendments to Canadian law governing MAiD

<sup>1</sup> Note on language: throughout this issue we use the terms *Medical Assistance in Dying (MAiD)* (the term used in the 2016 Canadian federal legislation that governs MAiD practice) interchangeably with *Physician Assisted Dying (PAD)* (the term used in the 2015 Supreme Court Decision *Carter v Canada* [2015] that decriminalized assisted dying) and *euthanasia*, the Dutch term for the practice. In all cases we are referring to *voluntary active euthanasia*, whereby a patient who meets legal eligibility criteria consents to the ending of his or her life through the direct actions of a physician or nurse practitioner, specifically, careful and deliberate injection of medications known to be fatal.

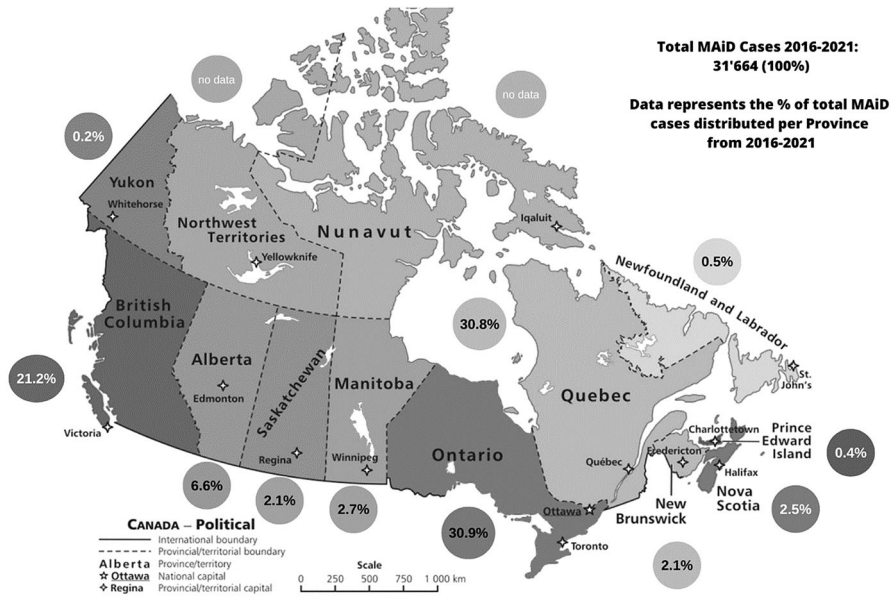
and amended the relevant sections of the Criminal Code after a period of public and parliamentary debate in (2020–2021). MAiD now operates on a two-track system. One track outlines simplified safeguards for those with a RFND, and the second track outlines a new set of safeguards for those who meet all other criteria, but who will not die a natural death in the foreseeable future (see legal summary through Government of Canada, 2021a, b). Recognizing that persons with a Mental Disorder as the Sole Underlying Medical Condition (MD-SUMC) motivating their request for MAiD will qualify through the second track, a 2-year stay was granted to explore the clinical and ethical complexities surrounding the provision of euthanasia to this population; MD-SUMC patients will gain access to MAiD in Canada in March 2023 (for a detailed legal analysis and history of MAiD in Canada, refer to the article titled “From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada” by Jocelyn Downie [2022]).

## Medical Assistance in Dying in Canada: The First 6 Years

Six years into the practice of MAiD in Canada, we can begin to see how this practice is taking shape across this vast and diverse country. The federal Criminal Code establishes the eligibility criteria that must be met and safeguards that must be upheld before MAiD is provided to a patient. However, it is the provinces and territories of Canada that are responsible for the delivery of health care services, including the implementation MAiD and enforcement of relevant regulations. Each jurisdiction has evolved a variety of approaches to organizing and delivering MAiD services based on their own geographies, population needs, political values and healthcare delivery systems. Some MAiD services are centrally coordinated through provincial systems to receive referrals, support patient access and streamline reporting processes, as in Alberta, Manitoba and Saskatchewan. Other provinces rely more on regional health authorities to coordinate services, as in the Maritime Provinces, British Columbia and Quebec. In the sparsely populated territories access is more informally organized. Ontario, which has the highest number of MAiD cases annually and is the focus of several articles in this issue, has a hybrid approach that combines some provincial coordination supports with local or regional MAiD services provided through hospitals or community-based providers.

The Government of Canada now collects data through a mandatory reporting regime that requires MAiD providers and assessors to report the outcomes of all patient requests for MAiD to the Federal Ministry of Health, including: how many patients receive MAiD; reasons why patients are found ineligible; how many MAiD patients receive palliative care; locations of MAiD deaths, and many other aspects of MAiD practice (see reporting guidance through Health Canada 2021). Based on the data collected, the Government of Canada releases annual public reports on MAiD practice. The most recent report includes data from 2016 to 2021 (Government of Canada 2022) (see Fig. 1).

In 2021, MAiD deaths comprised 3.3% of all Canadian deaths; 97.8% were patients with a reasonable foreseeable natural death (RFND) (Track 1) and 2.2% were non-RFND patients (Track 2) (Government of Canada 2022). There were significant



**Fig. 1** % of total MAiD cases 2016–2021 distributed per Province/Territory

provincial differences, from a low of 1.2% of deaths in Newfoundland and Labrador, to 2.7% of deaths in Ontario, to 4.7% of deaths in Quebec, to a high of 4.8% of deaths in British Columbia (Government of Canada 2022). The most common underlying conditions for persons seeking MAiD were cancer (65.6%), cardiovascular disease (18.7%), respiratory disease (12.4%) and neurological conditions (12.4%). Over 80% of all persons receiving MAiD had access to palliative care services, with 52.6% having received palliative care for over a month (Government of Canada 2022).

One unique feature of MAiD in Canada has been the involvement of hospitals in the provision of MAiD services, whereas in other jurisdictions assisted dying almost exclusively takes place in patient homes or residences with primary care providers. The practice as a whole is gradually shifting towards more community-based MAiD provision, a trend that may have been fuelled in part by the COVID-19 pandemic that kept many patients away from hospitals between 2019 and 2020. However, as the pandemic wanes, we are seeing a reversal of that trend. In 2020, 28% of MAiD took place in hospitals, and in 2021 it was 28.6%; whereas 48% of MAiD was provided in private residences in 2020 and 44.2% in 2021 (Government of Canada 2022).

## Missing MAiD Providers and a Looming Access Crisis

These data documenting the first 6 years of MAiD practice point to a significant shift in Canadian society and medical culture. In 2015 there were a handful of MAiD deaths, but by the end of 2021 a total of 31,664 Canadians had received MAiD, and

10,064 chose MAiD in 2021 alone (Government of Canada 2022). The rapid uptake of this end of life care option may be seen as a triumph of patient advocacy (championed by groups such as Dying with Dignity Canada: [www.dyingwithdignity.ca](http://www.dyingwithdignity.ca)), and clinical innovation as physicians, nurse practitioners, pharmacists, civil servants and healthcare administrators created new care pathways and practices through provincial or local communities of practice, and through the peer support and professional development efforts of the Canadian Association of MAiD Assessors and Providers (CAMAP), which was established in 2017 (CAMAP 2017).

However, the incredible “success” of the introduction of MAiD in Canada is also putting access at risk. It is not the law alone that facilitates access to MAiD—rather it is individual clinicians who create the option for MAiD by choosing to participate (Lowes 2016). MAiD is not a required part of any physician or nurse practitioner specialty, rather it is usually an “add on” to other clinical responsibilities. It is up to the discretion of individual clinicians to choose whether or not to step into this emotionally challenging, highly regulated, legally risky and morally/politically contentious practice (Oliphant & Frolic 2020). There is generalized concern across Canada that patient demand for MAiD is outstripping the supply of willing and available providers. In Nova Scotia the health authority stopped taking new referrals for MAiD for several weeks in the summer of 2021 because of a dramatic rise in demand and a lack of available clinicians (MacDonald 2021).

The looming crisis in MAiD access is illustrated clearly in the Ontario context: the province where the largest number of MAiD cases occur annually, and that includes the largest number of MAiD providers. The Chief Coroner’s Office of Ontario has been tracking the provision of MAiD, including the number of unique physicians and nurse practitioners providing MAiD, since 2017. As illustrated in Figure 2 of the Appendix, the number of patients receiving MAiD has expanded exponentially over the first 5 years, however, the number of unique MAiD providers engaged in the practice has not increased proportionally. In 2020 alone, despite the pandemic, the number of MAiD cases increased nearly 25% in Ontario, while the number of new MAiD providers increased only 9%. However, these data do not indicate a net increase in MAiD providers in Ontario because the Coroner only captures the number of new physicians and nurse practitioners who provide MAiD in a given month. They do not track the number of clinicians who leave the practice of MAiD for any reason; nor do they track clinicians who only provide MAiD once, or who only intend to provide MAiD for their own patients, but not for other patients outside their practice.

In 2017, the average number of Ontario MAiD cases per unique provider was just shy of 4 cases/year. As of June 2022, each MAiD provider in Ontario would have to complete approximately 16 cases per year in order to keep pace with the demand. If recruitment of new MAiD providers had kept pace with the 4 cases/year rate of 2017, and none of those providers had dropped out of the practice, Ontario would need over 500 additional MAiD providers over the course of the past 6 years to keep pace with demand. This reality reflects a trend towards a greater concentration of MAiD practice in a smaller number of MAiD providers over time.

The increased caseload for MAiD providers in Ontario is mirrored across Canada. The 2021 federal report shows a 32.4% increase in MAiD in 2021 over 2020,

but an increase in unique MAiD providers of only 17.2% over the same period. This represents an estimated 230 missing MAiD providers across the country in 2021 alone, if the rate of recruitment of new MAiD providers were to keep pace with the increase in MAiD cases overall in 2021. A total of 35.6% of MAiD providers only did one procedure in 2021, down from 40.2% of MAiD providers who did a single case in 2020. This means that across Canada the number of MAiD clinicians involved in multiple MAiD procedures annually continues to increase, with 16.5% of providers performing 10+ procedures annually (Government of Canada 2022). Most notably, oncologists, neurologists and cardiologists appear to be underrepresented as MAiD providers in Canada given that the main underlying conditions of patients who received MAiD in Canada in 2021 were cancer (65.6%), cardiac disease (18.7%), respiratory disease (12.4%) and, neurological conditions (12.4%). These medical specialties combined represent less than 2% of all MAiD providers, and thus are an untapped resource for future recruitment.

While having a greater concentration of MAiD cases being handled by a smaller number of providers may lead to sharper skills and deeper expertise, such specialization also makes the system supporting MAiD more fragile. In 2021, MAiD services across Ontario anecdotally reported challenges in providing timely access to MAiD, leading to new ethical dilemmas including triaging patients or transferring patients to distant centres for MAiD care (Jansen 2021). The difficulty in maintaining access to MAiD and keeping pace with rising numbers of requests is likely to be compounded by several factors in the coming years, including: widespread exhaustion and burnout amongst physicians and nurse practitioners secondary to the stresses of the COVID-19 pandemic, leading clinicians to drop out of MAiD practice; early adopters of MAiD moving on to other areas of practice or into retirement; increased legal risk and moral hazards related to the introduction of new populations who are legally eligible for MAiD; increased complexity of MAiD cases, which diminishes the number of cases a provider can manage; increased pressures in the health system post-pandemic which may translate into less engagement of clinicians in discretionary work that is not a core part of their practice, including MAiD.

## **Beyond the Norm(ative): Exploring the Practical Ethics of MAiD Implementation**

The ethics literature on the topic of euthanasia is vast; a recent search in peer reviewed journals uncovered 107,710 articles written in the past 10 years (2011–2021) referencing the key words ethics *and* euthanasia, assisted dying, assisted suicide or MAiD. The ethical literature tends to split along the lines of

normative or descriptive ethics. Normative ethics analyzes the rightness or wrongness of an action, and in the case of assisted dying, this has been explored thoroughly (Thomasma 1996; Schüklenk et al. 2011; Kelly et al. 2019). Since the passage of MAiD legislation in 2016 in Canada, a literature has emerged around who should or should not be MAiD providers, and under what personal and professional circumstances. This is of particular concern in specialties like psychiatry, hospice and palliative care, which historically had a significant number of conscientious objectors to euthanasia (Canadian Society for Palliative Care Physicians, 2018). Studies exploring the relationship between MAiD and palliative care often focus on how MAiD challenges the professional identity/vocation of palliative care; the moral role of clinicians supporting patients at end of life; or the quality of palliative care access and the capacity to reduce suffering through clinical interventions (Bélanger et al. 2018).

Alternatively, as a novel and morally-fraught clinical practice, there is an emerging descriptive ethics literature around MAiD in Canada. Descriptive ethics examines the values, morals and social factors that inform how people experience and engage with an ethically-charged practice like euthanasia—for example, the factors involved in clinician decisions to participate in or abstain from participation in a practice like MAiD (Bouthillier & Opatrny 2019). While the literature is often preoccupied with the ethics surrounding conscientious objection (McDougall et al. 2021; McGee 2020; Saad 2019), there is an emerging literature that describes the positive experiences of clinicians who choose to participate in MAiD and the factors that shape conscientious participation in MAiD as a practice that is felt to be morally and ethically aligned with the goals and values of medicine (Oliphant & Frolic 2020; Rutherford 2020). There is also an emerging literature describing the experiences of MAiD patients and families/loved ones who accompany their patients through the MAiD process, including the factors that influence the quality of that experience (Frolic et al. 2021).

As MAiD continues to evolve and be incorporative of a larger and more diverse patient population, there will be new ethical challenges that arise requiring ongoing engagement from the ethics community. Some examples of these ethical challenges are as follows:

- More complexity with respect to assessment criteria and practice for patients with MD-SUMC (Health Canada 2022) and for mature minors (Council of Canadian Academies 2018; Government of Canada 2022).
- The role of advanced directives for MAiD (Council of Canadian Academies 2019).



- How to “triage” patients or manage waitlists in a fair and equitable way when requests for MAiD from patients outstrip the capacity of MAiD providers to enable access in a timely manner.
- How to provide access to effective treatments for all forms of suffering that drive requests for MAiD (physical, social, psychological and existential), while honoring patient autonomy if they refuse treatment.
- How to balance the “rights” of patients to access MAiD and the “rights” of clinicians to honor their conscience and to maintain professional boundaries that support their own well-being.
- How to ensure informed choice, voluntariness, and patient autonomy are respected when contextual factors such as inadequate access to housing, mental health supports, and community resources are exacerbating suffering or impacting a patient’s quality of life.

This special issue of *HEC Forum* offers a unique contribution to the ethical literature on euthanasia by addressing the pragmatic ethical issues that have emerged around the implementation of MAiD in Canada over the first 6 years of practice. All of the authors have been engaged in MAiD practice and/or policy since it was decriminalized in 2016, and some describe their efforts to prepare the way for MAiD years before it became a legal option in Canada. The papers describe the unique ethical challenges involved in creating care pathways to support access to a novel and morally contested clinical practice. Additionally, the papers provide case examples of the roles that ethicists and ethics services have played in the implementation process in the two most populous provinces in Canada—Ontario and Quebec—which account for over 70% of all MAiD cases nationally from 2016 to 2021 (Government of Canada 2022).

The issue is organized into three sections:

*Section 1* The Emergence of MAiD in Canada and Quebec: the Social, Legal and Ethical Context.

*Section 2* The Pragmatic Ethics of MAiD Implementation: An Organizational Case Study in Four Parts.

*Section 3* Ethical Issues in MAiD Service Delivery: MAiD Care Coordination as an Emerging Professional Practice.

These articles address a range of questions regarding the pragmatic ethics of introducing MAiD to a health system, including:

- How have ethicists and ethics services participated in the introduction of MAiD in Canada over the first 6 years—both in the legal process that led to the current MAiD legislation (Downie 2022), and in addressing it as a novel organizational ethics challenge (Frolic & Miller, 2022; Bouthillier et al. 2022)?
- How have the views and concerns of stakeholders been identified and integrated into the development of MAiD services? What values ought to inform MAiD



service design to safeguard the moral well-being of a diverse workforce (Frolic et al., 2022b)?

- What are the ethical issues and values involved in the practical management and coordination of MAiD cases in Canada (Simpson-Tirone et al., 2022)?
- How can MAiD services be designed to overcome barriers to entry to practice and create sustainable access through recruitment and retention of MAiD providers and enabling infrastructure (Frolic et al. 2022a)?
- How can MAiD services evaluate their effectiveness in delivering on their commitment to provide values-based, high-quality and sustainable MAiD care (Frolic et al. 2022c)?
- What lessons may be learned from the introduction of MAiD in Canada that may apply to other emerging ethical issues or to other jurisdictions where MAiD is being implemented?

## Conclusion

MAiD in Canada is now 6 years old. The introduction of this highly controversial, complex and novel clinical practice has created new challenges for ethicists and ethics services—as well as new opportunities to evolve methods of organizational ethics engagement and service delivery to address the pragmatic ethical challenges that accompany MAiD practice. The meteoric rise in demand for MAiD in Canada means that healthcare organizations and governments must address these pragmatic ethical issues in order to recruit and retain sufficient numbers of MAiD providers to overcome barriers to entry to this practice, and facilitate appropriate access to this care option for future patients. In this special issue, the authors leave behind the debate about whether MAiD is right or wrong. Rather, they focus on the pragmatic ethics of how MAiD can be practiced in a principled and sustainable manner. They reflect on the implementation challenges ethicists and service providers had to navigate in the early days of MAiD, and how innovative professional practices and organizational ethics strategies evolved to promote transparency, integrity, quality and respect for moral diversity in the design and delivery of MAiD. We hope these papers encourage ethicists and ethics committees to reflect on how these lessons may apply to emerging ethical challenges in their own local contexts, including the introduction of euthanasia into new jurisdictions globally.

## Appendix

See Fig. 2.

### CUMULATIVE MAID CASES AND UNIQUE PROVIDERS IN ONTARIO

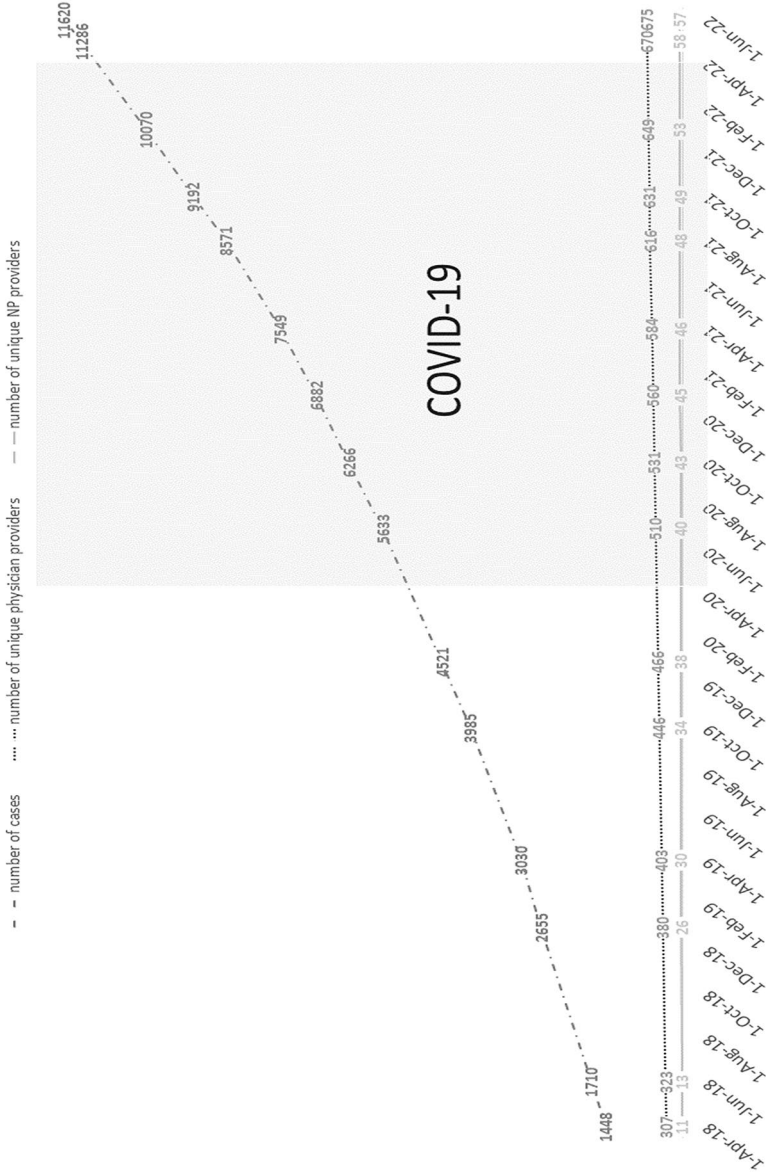


Fig. 2 Cumulative MAiD cases and unique providers in Ontario, 2018–2022 (Office of the Chief Coroner of Ontario, 2021–2022)

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**Data Availability** Data is publicly available through both the Office of the Chief Coroner of Ontario and the Canadian Federal Government.

## Declarations

**Conflict of interest** The authors have no conflicts of interest to declare.

**Ethical Approval** Ethics approval was not required for the construction of this manuscript, all data was publicly available.

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