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When Death Becomes Therapy: Canada's Troubling Normalization of Health Care Provider Ending of Life

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Undeniably, a strikingly higher number of people die with direct health care provider involvement in Canada's euthanasia regime, euphemistically termed "Medical Assistance in Dying" [MAiD], than under a California-style assisted suicide system. Daryl Pullman (2023) rightly identifies several key reasons: the fact that in about all cases it involves a lethal injection by health care providers, rather than assisted-suicide with self-administration of medication; the law's vague and broadly interpreted access criteria; "acquiescence and […] indifference of federal and provincial authorities, the courts, and medical associations"; and, briefly mentioned, the failure to treat ending of life as a last resort (Pullman 2023). Particularly the last points are worth exploring further since they are likely among the key reasons why Canada's regime results in substantially higher percentages of euthanasia deaths even when compared to the few other liberal euthanasia regimes, and with an accumulation of reports of arguably troubling practices. These points are also connected to the law's origin in constitutional litigation, which has had a remarkable impact on the Canadian debate and policy.

THE RHETORIC OF a CONSTITUTIONAL RIGHT TO MAID

Pullman sketches well the legal saga of how Canada first partially legalized MAiD, and then expanded it within 5 years outside the end-of-life context (Pullman 2023). Indeed, the Supreme Court's *Carter* decision did *not* create an unrestricted constitutional right to physician-ending-of-life but only invited parliament to legalize some form of "physician assisted dying" (Grant 2023; Lemmens, Kim, and Kurz 2019). It issued broad parameters for law reform, tied its reasons to the "circumstances of the case" (a case of a patient approaching her death) and confirmed the role of the criminal law in protecting life. Yet despite the case's limitations, advocates for broad legalization, advisory committees in which the latter often received influential positions, health professional organizations, and media commentators, quickly embraced a rhetoric of a "constitutional right to MAiD," focusing largely on access and expansion (Gaind et al. 2022). How broad the law needed to be to respect the *Carter* decision remains a matter of interpretation. The Quebec *Truchon* judgment mentioned by Pullman, which declared the safeguard of the restriction to end-of-life unconstitutional, was a trial court decision that was not binding on higher courts and outside Quebec (Lemmens and Jacobs 2019; Grant 2023). Yet, the federal government invoked the decision, disingenuously claiming its hands were tied, to push for expansion of MAiD, including for mental illness (Lemmens 2023a).

The decision not to appeal the *Truchon* decision, which was publicly announced in the midst of a federal election in Quebec, a province in which the expansion of MAiD appeared very popular, seems an example of instrumental political use of a judicial process. How the government subsequently failed to consult with disabled persons, Indigenous communities, and others particularly affected (the former in fact explicitly treated as intended "beneficiaries" of an

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expanded MAiD law), by invoking court-imposed urgency; and then pushed through a new law, in the midst of the pandemic, and against the explicit objection of nearly all disability advocacy organizations, various Indigenous organizations, and international human rights rapporteurs and experts; and how, contrary to its initial endorsement of evidence-informed prudence, it ended up including MAiD for sole reasons of mental illness (Gaind et al. 2022), will remain a stain on Canada's human rights record. Commentators have rightly argued that the expanded MAiD law is discriminatory, since it deprives disabled persons who are not approaching their natural death from the same protection against premature death that others continue to receive (Grant 2023; Lemmens and Jacobs 2019). Indeed, facilitating the death of others, even when they consent, remains criminally prohibited, and others continue to be protected by suicide prevention policies. But even merely procedurally, it is hard to think of a more explicit ignoring of "nothing about us without us," a participatory principle reflected in the United Nations Convention on the Rights of Persons with Disabilities.

Invoking a seemingly unrestricted constitutional right to MAiD, or perhaps intimidated by the perception of its existence, not only many politicians and MAiD advocates, but also health care providers and health profession organizations largely stopped engaging meaningfully with evidence-informed clinical, ethical, and policy arguments about potential benefits and harms of expanding MAiD. The parroting of rights rhetoric, with frequent references to "discrimination," distorted the Canadian debate. Proportionality review embedded in constitutional or human rights-analysis must be informed by evidence-informed clinical, policy and ethical arguments. Yet, in Canada, rights rhetoric largely replaced evidence-informed debate.

INSTITUTIONAL AND PROFESSIONAL PROMOTION OF MAID AS THERAPY

This emphasis on the right to access, and the under-appreciation of the right to and need for protection, is reflected in several aspects of Canada's MAiD regime. It is embedded, indeed, as Pullman (2023) emphasizes, in the broad interpretation of key access criteria. But there is more. What Pullman frames as "acquiescence and […] indifference of federal and provincial authorities, the courts, and medical associations" (Pullman 2023) can be characterized as a prioritization of access to MAiD as a quasi- inherent beneficial practice. Canada's law, and policies by federal and provincial authorities and professional bodies predominantly focused on facilitating access to death. Insufficient attention was paid to what the Supreme Court reaffirmed as a key purpose of a regulatory regime that remains constructed, after all, around an exemption to a still existing criminal law-based prohibition aimed at preventing death and protecting life.

Pullman discusses aptly how the doctor-patient dynamic, particularly in the challenging context that surrounds end-of-life choices, characterized by ambiguity and vulnerability, is likely a key factor of the higher uptake in euthanasia regimes. He rightly questions how the "choice" argument ignores contextual pressures, the complexity of the doctor- patient relation, how resilience can either be fostered or, on the contrary, undermined in the health care encounter, and the level of control over death medical professionals obtained (Pullman 2023). But direct physician-involvement does not explain how Canadian MAiD practice went beyond the until recently most liberal euthanasia regimes in the world, and this even prior to including MAiD for mental illness. In 7 years, two Canadian provinces, Quebec and British Columbia, have bypassed the percentage of euthanasia-deaths in Belgium and the Netherlands, which legalized euthanasia in 2002. In Quebec, 7% of all deaths are now the result of a health care provider's lethal injection (Serebin 2023).

A key factor is that Canadian physicians appear compelled to offer MAiD when patients ask for it, sometimes for even only indirectly disease- or disability-related suffering (e.g. lack of adapted housing or appropriate support [Coelho et al. 2023]), and when effective medical treatment options remain (Li 2023). This is enabled by the design of the criminal law exemption, promoted by practice guidelines and professional regulations, and confirmed as unproblematic by statements or actions (or lack thereof) of professional regulators and institutional players in charge of implementing policy and enforcing compliance.

Canada's law indeed uniquely fails to require that health care providers agree that there are no other options to relieve patient suffering (Kim 2023). They must ensure that patients are informed of all options, and, for patients not approaching their natural death, that they "carefully considered" these options. For patients not approaching their death, a 90-day assessment period aims in part at exploring options. But there is no duty to ensure that options are made available, and refusing treatment or support options does not prevent patients' from getting MAiD (Lemmens, Shariff, and Herx 2021). Furthermore, the 90-day assessment period can be shortened, while many wait times for health care or disability support exceed by far the 90-day period (Coelho et al. 2023).

Belgium and Dutch law, in contrast, explicitly require that physicians must agree that there are no other medical options left (Kim 2023; Lemmens 2018). In practice, some Belgian and Dutch physicians have arguably become also too comfortable providing euthanasia when patients refuse treatment (Chabot 2017; Lemmens 2018); and persistent treatment refusal can at one point turn euthanasia into the last perceived option. But it reflects a strong attitudinal difference, affirms the role of health care providers in promoting resilience, confirms the normal functioning of the medical standard of care (Lemmens, Shariff, and Herx 2021), and facilitates professional disciplinary inquiry when physicians are in principle legally obligated to refuse MAiD if other options remain. Canada's MAiD law explicitly emphasizes the right to obtain MAiD when patients themselves consider standard treatments to be intolerable. A mere declaration in patients' files that they refused all other treatments basically shields physicians of liability.

Interestingly, the law still requires a "grievous and irremediable medical condition" as a pre-condition for MAiD. This could be understood as if patients only become eligible when no medical interventions remain, regardless of treatment refusal. But the requirement of irremediability appears largely ignored or at least not interpreted that way. For example: guidelines developed by the Canadian Association of MAiD Assessors and Providers [CAMAP], an organization funded by the federal government to educate physicians about MAiD, a federal report on MAiD for mental illness, and a recent Health Canada model practice standard, all reflect an emphasis on ensuring access to MAiD, largely on demand.

CAMAP emphasizes patient choice and recommends, for example, that health care providers introduce the option of MAiD for any person who might qualify (Canadian Association of MAID Assessors and Providers 2020). Considering the well-documented undervaluing by many health care providers of disabled persons' quality of life (Janz 2023), there is reason to be concerned that MAiD is put on the table, even when patients do not ask for it. Controversy already erupted when a case worker suggested to military veterans looking for health and disability support that there was always the option of MAiD. CAMAP members also appear to support providing MAiD when patients face long wait times for treatment, or when lack of social support and poverty are determinant factors for MAiD requests. (Raikin 2022; Coelho et al. 2023).

The concept of irremediability has also been a key source of disagreement in the debate over MAiD for reasons of mental illness. While many experts explicitly oppose MAiD when mental illness is the sole underlying condition, in part based on the argument that irremediability cannot be predicted in individual cases in mental illness (Gaind et al. 2022), its inclusion in the expansion of the law (albeit with a suspension until March 2024), as well as a recent federal expert panel report, clearly reflect that this is not treated as an impediment to providing MAiD. The federal expert advisory panel, set up by the federal government to provide guidance toward the future implementation of MAiD for mental illness recognizes that predictions of irremediability are clinically problematic, but still suggests that MAiD should be made available to respect patients' rights (Health Canada 2022).

A "model practice standard," recently published by Health Canada to promote inter-provincial alignment of MAiD practices, reaffirms the same (Health Canada 2023). In addition to recommending that MAiD should be introduced to those who might qualify, its approach to "conscientious objection" showcases the focus on ensuring access. The standard suggests that health care providers who object to providing MAiD in specific cases become conscientious objectors; and this even when they otherwise practice MAiD. Several Canadian provinces already impose on conscientious objectors an "effective referral" obligation, which entails a duty to ensure that patients are referred to professionals willing to provide MAiD. Physicians who, knowing that other medical options will likely help the patient, feel duty bound by their professional standard of care to refuse MAiD and to insist on trying other options first, would risk professional discipline for failing to refer their patient to a physician willing to end their life. Come March 2024, imagine a psychiatrist faced with a severely depressed patient insisting to get MAiD, who is confident that one of the many treatment options will likely turn the patient around.

INSTITUTIONAL RELUCTANCE TO INVESTIGATE

Institutional failure or refusal to further investigate questionable MAiD practices, sometimes even accompanied by preventing family members' access to medical files with reference to the deceased's confidentiality or "best interest" have already been documented (Coelho et al. 2023; Anderssen 2023). But even when some official agencies express concern, others go out of their way to reassure the public that there are no problematic practices and to encourage physicians to ensure access. Recently, Quebec's College of Physicians and Surgeons, the province's professional regulator, publicly repudiated Quebec's End of Life Care Commission, the only independent provincial monitoring agency in Canada set up to review all MAiD cases in a province. The Commission's president had felt the need to remind physicians of some crucial legal requirements, including: a serious and incurable disease, with old age not being a sufficient basis for MAiD; capacity to consent; relentless, intolerable and irremediable suffering; and of the unacceptability of doctor-shopping for second approvals (Commission sur les soins de fin de vie 2023). In 2022, the Commission forwarded 15 cases to the College for disciplinary inquiry. Yet, the president of the College publicly trivialized the Commission's "sortie," siding with a spokesperson of advocacy organization Dying with Dignity, which accused the Commission of physician-intimidation (Serebin 2023), and declaring that none of the cases deserved professional discipline, let alone criminal prosecution.

He also confidently stated that Quebec's record number of MAiD deaths was unproblematic. Faced with a rapid increase of a novel medical intervention, particularly one initially introduced as only exceptionally required, a professional regulator surely would want to ask: do so many more Quebecers than others experience intolerable suffering—still a precondition for access—when faced with illness or disability? Is a lack of access to quality care and support making more conditions irremediable in Quebec? Are some physicians over-practicing MAiD, after all a billed practice? Or have perceptions of suffering and dying so fundamentally shifted in the province? If so, why?

Official reports provide further reasons for concern, for example when they identify the following components of "unbearable suffering" among those who died by MAiD in 2021: perceived burden on family, friends or caregivers (35.7%); inadequate pain control (or concern) (56.6%); loss of control over bodily functions (a challenge many disabled persons experience) (33.8%); and isolation or loneliness (17.3%) (Government of Canada 2022). A significant minority further had no access to palliative care or disability supports. Moreover, accumulating fact checked media reports reveal that patients are receiving MAiD for reasons that raise serious social justice concerns (Coelho et al. 2023; Janz 2023).

WHAT LESSONS TO BE LEARNED?

Pullman rightly concludes that the US and other jurisdictions should learn lessons from Canada's MAiD regime. But having witnesses closely how it has unfolded particularly in Canada, I increasingly doubt we can confidently recommend other countries to go down the California path. First, there is a global push for legalizing medical system organized ending of life, in whatever form it takes. Advocates coordinate efforts, share experiences, write joined publications, and adjust tactics depending on local sensitivities. Shared tactics include trivializing problematic case reports as "anecdotes," overly confidently accepting official data—disregarding the limits of self-reported data—, and emphasizing the absence of criminal prosecutions against practitioners, while ignoring the inherent legal hurdles people face when trying to obtain accountability from the medical establishment for family members who are no longer there to testify (Lemmens 2023b).

Canada's regime has been shaped by its origin in constitutional litigation. The rhetoric of a "constitutional right to MAiD," skillfully promoted by advocates and uncritically accepted by others, facilitated further expansion. What the Canadian history also suggests is that the dynamic of normalization of direct health care provider involvement in facilitating death as part of medical practice is hard to counter. Particularly when the medical apparatus has fully embraced it as part of medical practice, professional and political forces have an interest in justifying how it unfolds, and in trivializing concerns. The radical nature of the procedure may contribute to that: it becomes hard to admit for anyone involved that a well-intended practice that ended the life of so many may have resulted in many tragic mistakes. Once the practice is introduced, a push for expansion appears to follow. Assisted suicide today may open the door to open-ended euthanasia tomorrow.

Second, notwithstanding fundamental differences, euthanasia and assisted suicide regimes in Canada, the US, and other countries, share an underlying presumption that several disability advocates and scholars characterize as fundamentally ableist: that it is valuable to facilitate the death of people who are disabled, while their suffering, including in the end-of-life context, could be addressed by accommodation, targeted interventions, and quality support; and that suicide prevention is no longer as important for disabled persons, whether they are at the end-of-life or not (Braswell and Garland-Thomsan 2023). They also both promote the choice to die in a context where poverty, and failures in health care and social support often undermine meaningful autonomy and create structural coercion (Dignity Denied 2023).

Canada's developments show how health professionals and institutions can quickly normalize and self-justify practices even when they appear to run astray of the most basic professional standards of care; and how providing death on demand can be turned into a medical therapy even for only remotely disease-related suffering. Any jurisdiction contemplating some form of legalization of this practice should think about what it means for medicine and society at large to move in that direction.

DISCLOSURE STATEMENT

The author has been a paid expert witness for the federal Attorney General in the *Truchon v Canada (AG)* and *Lamb v. Canada (AG)* cases, a pro-bono expert for a human rights organization in a South African assisted suicide case and a pro-bono witness for the plaintiffs in a Canadian case related to access to palliative care. He has been an advisory board member of the Vulnerable Person Standard, a disability advocacy organization set up to provide guidance on Canada's MAiD policy. He is currently co-authoring as paid expert a report on ethical aspects of different options for legalizing assisted dying for the Jersey government.

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Of Slopes and Ropes: Learning from the Diversity of European Regulations of Assisted Dying

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In his target article, Daryl Pullman explores and explains the divergent developments of the frequency of medical assistance in dying (MAID) in Canada and California in the US (Pullman 2023). One of his principal points is that it may be explained by the different modes of MAID (euthanasia in Canada, assisted suicide in California) and the more or less liberal application of legal regulations. In fact, this can be corroborated from European experiences.

European data clearly show that euthanasia (medical termination of life on request) leads to different numbers of MAID than assistance in suicide, where the patient has to swallow or self-inject the lethal substance. The two European countries with the longest practice of forms of assisted dying are the Netherlands and Switzerland. In the Netherlands euthanasia has been practiced since the late 1970s, with a law regulating it in 2002 (Onwuteaka-Philipsen et al. 2012), as opposed to Switzerland, where it is assistance in suicide that has been openly practiced by right-to-die organizations since the 1980s, based on a liberal criminal law (Hurst and Mauron 2017). While in the Netherlands 5.1% of all deaths occur by assisted dying according to the most recent official report concerning the year 2022 (Regional Euthanasia Review Committees 2023), the published numbers of the major Swiss right-to-die societies for Swiss residents amount to 2.19% of all deaths in 2022 in total (EXIT 2023; EXIT Association pour le Droit de Mourir dans la Dignité 2023). In both countries, this percentage

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