ISSN:2277-6907,
RNI NO.CHHHIN/2012/46660,
https://doi.org/10.56011/mind-mri-121-20233

Mind and Society
Vol. 12, No. 1, March 2023, 27-32

A Critical Review: Medical Assistance in Dying Policy in Canada

[1]**Breanna Webster** [2]**Rita Dhungel**

Medical Assistance in Dying (MAiD) has become more accessible in Canada for those with and without long-term chronic illnesses. The changes in legislation have brought significant concerns to Canadians and healthcare professionals. This paper critically examines current and past legislation from an anti-oppressive theoretical lens. Since the Canadian government has significantly changed the legislation, Bill C-7 was passed in 2016. This critical review paper begins with a discussion of a brief introduction followed by a theoretical framework for anti-oppressive practice. Eligibility and the access process for MAiD will be explored in this article. This paper concludes with the presentation of the implications for the social work profession and health care and provides some recommendations.

Keywords: medical assistance in dying, social work, AOP, Canada

Introduction/Context

This paper critically reviews the policies and implications of medical assistance in dying within Canada (MAiD). The purposes of this paper are to examine the assessment process of MAiD and discuss its applications and implications for the social work profession and the health care system. Alberta Health Services (2019) defined MAiD as "a healthcare option available to Albertans at the end of life. It allows a capable adult suffering from a grievous and irremediable medical condition to voluntarily request medicine that will bring about their death" (P. 1). While MAiD became legal in 2016, most Canadians did not necessarily agree with medical assistance in dying at the beginning of its applications. For example, Kim and Lemmens (2018) reported that in a public opinion poll of 1517 Canadians, only 22% supported legalizing assisted dying for psychological suffering" (2018, p. 4).

The 2021 federal report revealed a 32.4% increase in MAiD in 2021 over 2020 but only a 17.2% increase in unique MAiD providers 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 clearly speaks to the fact that the number of MAiD clinicians involved in multiple MAiD procedures annually continues to increase across Canada, with 16.5% of providers performing 10 or more procedures annually (Government of Canada, 2022).

Theoretical Framework

This paper is grounded in anti-opressive practice (AOP). Using an AOP theoretical framework allows those who are requesting, supporting, and administering MAiD to be treated with dignity, respect, and choice. We adopted AOP in this paper as defined by Lena Dominelli (1996):

> "A form of social work practice that addressed social divisions and structural inequalities in the work that is done with people, whether they be users ("clients") or workers. AOP aims to provide more appropriate and sensitive services by responding to people's needs regardless of their social status. AOP embodies a person-centered philosophy, an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives, a methodology focusing on both process and outcomes, and a way of structuring relationships between individuals that aims to empower users by reducing

---

[1] *Master Degree in Social Work, and is currently involved in her private practice in Canada.*

[2] *PhD Assistant Professor, School of Social Work and Human Services, the University of the Fraser Valley, Abbotsford, British Columbia, Canada*

the negative effects of social hierarchies on their interactions and the work they do together" (p. 170).

Professionals who use this framework are able to address and support vulnerable populations by addressing sexism, agism, racism, and the experiences of marginalized populations. Anti-oppressive practice does not discriminate based on cultural, religious, or political views. In order to appropriately integrate AOP into practice, the professional must have an understanding of historical and current views, legislation, and stigma that relate to the client (Gerassi & Nichols, 2021). While talking about MAID through AOP lenses, it is crucial to acknowledge that those who experience suicidal ideation are prone to injustice. Although scholars have addressed the oppression towards those who are suicidal, the oppression is yet to be labeled. Baril (2018)created the term "suicidism" in 2017 by borrowing terms such as ablism and sexism. Suicidism is "an oppressive system (arising from non-suicidal perspectives) functioning at the normative, discursive, medical, legal, social, political, economic, and epistemic levels in which suicidal people experience multiple forms of injustice and violence [...]" (Baril, 2018, p. 193). This definition allows those who experience oppression and stigma due to suicidality to feel heard and seen.

Using an anti-oppressive practice lens when working with those who request MAiD reduces oppression by allowing the person to make this decision without fear, lack of support, or exterior opinions. AOP allows the person to feel safe, independent, and empowered to make their own end-of-life decisions. MAiD performed around AOP will give the person the opportunity to end their life with dignity, confidence, and respect.

In order to appropriately use an AOP with MAID, healthcare providers must be aware of their personal and professional views, stigmas, and opinions. If "risk factors associated with demographics are not directly applied in a clinical setting, it results in stereotyping, assumptions, misdiagnosis, reduced access to healthcare, and poorer health outcomes" (Gilbert & Millyard, p.1). AOP allows providers to avoid further oppression by understanding how micro and macro structures contribute to oppression (Gilbert & Millyard, 2021).

Eligibility Criteria and the Assessment Process for MAiD

Medical Assistance in Dying (MAiD) became legal in Canada in June 2016 with Bill C (Health Canada, 2020). Canada introduced MAiD as an attempt to promote inclusive, less invasive end-of-life care. The goal of MAiD originally was to provide patients with the option to end their lives with dignity and choice (Vargo, 2022). Since medical assistance in dying became legal in Canada, many policies have been put in place to protect vulnerable populations. The legislation sets out eligibility criteria for those who wish to apply for MAID as well as safeguards physicians and nurse practitioners must follow (Health Canada, 2020). Since the initial legalization of MAiD, there have been significant changes to the original legislation. The most significant change to Bill C-7 was eligibility for those whose natural death was not in the foreseeable future, as long as they met all other criteria (Variath, Peter, Cranley, & Godkin, 2022). These changes were introduced in March 2021. The eligibility for MAiD now consists of:

- To be covered for health care services in your province, you must be over the age of 18.
- You must be over the age of 18 and competent to make your own decisions.
- have a grievous and irreversible medical condition.
- give informed consent to receive MAiD.
- Make a voluntary request for MAiD that is not the result of outside pressure or influence.

However, the Government of Canada (2022) highlighted that for patients to be eligible for a grievous and irremediable medical condition, they must meet the following criteria in the section on eligibility:

- have a serious illness, disease, or disability (excluding a mental illness until March 17, 2023).
- be in an advanced state of decline that cannot be reversed; and
- experience unbearable physical or mental suffering from your illness, disease, disability, or state of decline that cannot be relieved under conditions that you consider acceptable (Eligibility, Section 2,Paragraph 1).

Once one meets the criteria there is then a process with policies in place to request MAiD. For instance, Health Canada (2020) highlighted that "The legislation contains safeguards to make sure those who ask MAiD. The person needs to be able to "request the service of their own free will, are able to make health care decisions for themselves, are eligible (this means they meet all of the listed criteria) and can and do give informed consent, which includes being informed of all care options available to them to help relieve suffering" (Safeguards, section 3, para.1).

After submitting a written request, the person must undergo a medical examination to confirm that the illness cannot be treated or cured. Once the medical examination is completed, the person must wait 10 days. “You must wait a period of at least 10 clear days after signing your written request before the service can be provided so that you have time to consider your request. If you do decide to proceed after the 10 days, your practitioner can have confidence in your true desire to receive the service”. However, “an exception may be made to the 10-day reflection period if both your first and second medical or nurse practitioner agree that: your death is fast approaching OR you might soon lose your capacity to provide informed consent” (Health Canada, 2020, Obtaining Medical Assistance in Dying, section 3, paragraph 4).

According to the policies, once one submits a request to MAiD, the person has the option to retract his or her request at any time. For instance, Health Canada (2022) stated,

“You may choose to withdraw your request at any time in the process and in any manner. You are not obligated to proceed with medical assistance in dying even if you are found eligible for the service. Just before receiving medical assistance in dying, you will also be given a final opportunity to withdraw your request” (Obtaining Medical Assistance in Dying, section 3, para. 6).

This legislation will again be amended on March 17, 2023. Those who are diagnosed solely with a psychiatric condition will be eligible to apply for MAiD if they meet the criteria and have completed mental health treatment (Government of Canada, 2022**).** This has brought considerable concerns to Canadians across the country. CAMH (2017) claimed that “every day, vast numbers of Canadians find ways to live well with chronic and recurrent illnesses. For this reason, the Canadian Psychiatric Association argues that this interpretation of irremediable is too broad to use in the current context because it would allow those with very treatable illnesses to access MAiD” (P. 3).

The Canadian Psychiatric Association (2022) stated that one independent psychiatrist who specializes within the specific psychiatric illness should be one of the assessors and should complete a comprehensive clinical assessment to validate the diagnosis and ensure that gold standard treatment is provided for an appropriate amount of time based on standards of care. The assessment process should involve gathering the perspective of the multidisciplinary team about the patient’s illness and course of treatment. Others, such as registered nurses, social workers, and spiritual care practitioners, can assist and provide technical skills and support (Variath, Peter, Cranley, & Godkin, 2022).

If the criteria are met, there is a process with policies in place to request medical assistance in dying. Health Canada, 2022), for instance, highlighted that “the legislation contains safeguards to make sure those who ask for medical assistance in dying are protected.” The person needs to be able to “request the service of their own free will, are able to make health care decisions for themselves, are eligible (this means they meet all of the listed criteria), and can and do give informed consent, which includes being informed of all care options available to them to help relieve suffering” (Obtaining Medical Assistance in Dying, section 3, para. 4).

Implications for Health, Social Work Professions, and Families

In assessing the application process for MAiD, it is acknowledged that a significant amount of time and money will be spent on health care due to the two doctors notes, the physical examination, and the processes that are required. That could be a reason that Canada held out on legalizing it until 2016. This could also have to do with politics, as so many Canadians disagree with medical assistance in dying and the cost associated with it. As it relates to the social work profession, the Newfoundland and Labrador Association of Social Workers (2016) stated, “So what does this legislation mean in terms of social work practice? Social workers have always been involved in end-of-life care. Social workers work with individuals and families in acute care settings, palliative care settings, and long-term care settings to provide support around issues such as end-of-life care, grief and loss, and advance health care planning. As members of interdisciplinary teams and within their current scope of practice, social workers may be involved in the care of individuals who request and receive medical assistance in dying from MAiD” (P. 2).

The Newfoundland and Labrador Association of Social Workers (2016) further argued that “the principles outlined by the Canadian Association of Social Workers address the importance of a robust palliative care system and the need for strong safeguards to be put in place to ensure that people do not pursue medical assistance in dying due to the lack of palliative or end-of-life care options" (p. 3). This needs to be a decision made by the person who follows all policies outlined by the Canadian government, and not due to a lack of resources. When it comes to the implications or applications for social work practice for those who work with clients or patients requesting MAiD, practitioners have the support of the Canadian Association of Social Workers and their provincial body. For instance, the Nova Scotia Association of Social Workers (2021) provided an overview of a social worker's role at MAiD. Social workers may provide psychosocial and therapeutic support to those who request MAiD and their families. Social workers may provide information about MAiD to those who voluntarily request it. Social workers cannot suggest or advise a client about their decision to apply for or proceed with MAiD, nor can they provide or administer the substance that will cause death.

The Canadian Criminal Code (2021) stated in Article 5.1 that "for greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner, or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying". However, changes to legislation, eligibility, and safeguards have continued to challenge those working within the field. MAiD being part of the Canadian criminal code brings further concerns to healthcare providers. If the procedure is not carried out perfectly, there is the potential for considerable professional and legal consequences. (Simpson-Tirone, Jansen, & Swinton, 2022).

MAiD remains legally and ethically complex for professionals and Canadians. There is limited qualitative research that explores Canadian health professionals' perceptions of MAiD. Beuthin, Bruce, and Scaia (2018) reported that "healthcare professionals may struggle with balancing the commitment of treatment, care, and hope for recovery with the patient's right to make medical decisions" (P. 519). Dholakia, Bagheri, and Simpson (2022) also stated that evidence suggests many healthcare providers struggle with navigating personal and professional values around MAiD. Healthcare providers feel that MAiD does not align with their professional ethics of curing or controlling illness and assisting in the death process. It was noted that this has significant emotional and psychological effects on those professionals involved in the procedure. Healthcare professionals reported feeling emotions such as overwhelm, low mood, and anxiety.

According to Nuhn, Holmes, Kelly, Just, Shaw, and Wiebe (2018, the most considerable reasons for requesting MAiD were due to poor quality of life due to loss of independence, mobility, and the ability to communicate a sense of purpose through meaningful activity. Surprisingly, pain was significantly undermentioned as a cause of suffering. Many participants felt comfortable discussing their decision to pursue MAiD with family and friends. Many participants felt it was imperative to have the control to make the decision to end their life with autonomy. They felt they should be the ones to decide when their suffering and poor life quality should end (Nuhn, Holmes, Kelly, Just, Shaw & Wiebe, 2018).

Family members reported that the suffering of their loved ones caused them to reconsider their opinion on MAiD (Scott, 2020). Many family members discussed the terror their loved ones faced throughout the cognitive, physical, and emotional decline. Many family members acknowledged their appreciation for being able to support their family member in their decision to receive MAiD (Schutt, 2020). It was noted that family members can often feel ashamed about people knowing their loved one completed an MAiD. Some of the contributing factors to this could be privacy or religious and cultural beliefs. It may also stem from a fear of judgment or stigma. (Canadian Virtual Hospice, Module 26, Chapter 4, Paragraph 2)

Early in 2020, the federal government consulted a series of roundtables with stakeholders held online or through the mail to seek the views of Canadians regarding additional safeguards around MAiD. Over 300,000 Canadians participated in the roundtables, which resulted in the federal government introducing Bill 7-C to amend the Criminal Code. This recognized that the removal of death must be in the foreseeable future, as well as narrowing eligibility so that the person must suffer from a serious and incurable illness, disease, or disability. Canadians reported that they felt the process and criteria seemed relatively easy and uncontroversial (Downie, 2022). Notably, the most controversial element of this bill was the black-and-white definition created for a grievous and irremediable medical condition. Due to these changes, some individuals are no longer eligible under new federal legislation, causing constitutional law scholars to testify before the House and Senate committees reviewing the bill (Downie, 2022).

Recommendations and Critical Discussion

The Canadian Mental Health Association (2022) recommended that those requesting MAiD be connected with mental health resources such as mental health and disability support, housing and income support, and consultations with relevant professionals delivering these services. The Canadian Mental Health Association (2022) recommends a 90-day assessment period to identify the appropriate services the person requires. Due to the COVID-19 pandemic, healthcare and medical treatments have continued to be restricted across Canada. This has put significant strains on provincial, territorial, and federal healthcare systems and funding (Webster, 2022).

Although funding and mental health resources remain underfunded and scarce, The insufficient investment made now in mental health will contribute to significant costs and losses in the long term. This will fall heavily on the economy and government; policy makers can no longer neglect and underfund mental health as suggested by McGorry, Mei, Chanen, Hodges, Alarez, Jimenez, & Killackey, 2022. Offering further training for health care providers, such as education around decision makers, capacity, the assessment process, and how to support families during and after the procedure, is necessary, as suggested by Variath, Peter, Cranley, & Godkin (2002). To address the need for further MAiD practitioners who are committed and passionate about providing ethical and safe MAiD programming, it is critical (Dholakia, Bagheri, & Simpson, 2022). Providing professionals with emotional, social, and financial support that reflects their considerable investment in MAiD is critical, as suggested by Troton, Beuthin, Thompson, Bruce, Lemire-Elmore, and Daudt (2020).

In the case of MAiD, it could be said that Canada has some good policies to protect vulnerable people.Sadly, this only became legal in 2016. Without a doubt, if this prevents people from dying slowly and painfully, they have the right to do so.The policies protect those in vulnerable situations and allow them to be in control of their decisions. Using a social justice lens, those of us that get to go through our lives without manic episodes or hearing voices should support those who do and honor their right to end their life if that's what they see fit. We should support all people with psychiatric diagnoses because those of us without them do not understand their daily lives. It is disappointing that those who do not experience those symptoms get the opportunity to make decisions for people who do.

People with severe and chronic psychiatric diagnoses work closely with their interdisciplinary teams. It is important that each case be looked at independently and supported by the professionals who have seen these people at their worst. It is not up to us or the government to decide if their illness is deemed appropriate; it is up to them, the ones living with it each and every day.

Our professional values, beliefs, and assumptions at both personal and professional levels support the MAiD and claim everyone who is considered competent is entitled to make their own decisions regarding their health and life. Based on the Social Work Code of Ethics, as social workers, we believe that we need to support our clients to the best of our abilities and meet them where they are. If they do not want their loved ones to see them die a slow and painful death due to a chronic or incurable disease, then who are we to control their lives? However, the impact that MAiD would have on the families cannot be ignored. For example, Wagner and Maercker (2012) reported that "studies have shown a higher prevalence of post-traumatic stress disorder and depression among family members or friends witnessing medical assistance in dying" (p. 4). Therefore, mixed-methods research is critical to understanding the impact of MAiD on families with a focus on their mental health and psychological wellbeing and identifying some key supporting programs and services for the families. Anti-oppressive practice will continue to be critical to the experience and understanding of patients, families, and professionals who are involved in the MAiD process. Those who request MAiD will continue to experience oppression and stigma during end-of-life decisions. This is why it is imperative that providers and policymakers stay committed to dignity, choice, and inclusion.

References

Baril, A. (2020). Suicidism: A new theoretical framework to conceptualize suicide from an anti oppressive perspective. *Disability Studies Quarterly*, *40*(3).

Beuthin, R, Bruce, A, Scaia, M. Medical assistance in dying (MAiD): Canadian nurses' experiences. Nurs Forum. 2018; 53: 511– 520. https://doi.org/10.1111/nuf.12280

Code, C. (2022). Final Report of the Expert Panel on MAiD and Mental Illness.

CPA (Canadian Psychiatric Association). (2022). *Results of Member and Stakeholder Consultations on CPA Discussion paper - Medical Assistance in Dying (MAiD) for* Dholakia, S. Y., Bagheri, A., & Simpson,

A. (2022). Emotional impact on healthcare providers involved in medical assistance in dying (MAiD): a systematic review and qualitative meta-synthesis. BMJ open, 12(7), e 058523.

Downie, J. From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada. *HEC Forum* **34**, 321–354 (2022). https://doi.org/10.1007/s10730-022-09488-6

Fox, D. (2020). *Medical Assistance in Dying in Canada: Ethical, Policy, and Clinical Considerations* (Doctoral dissertation, University of Victoria).

Freeland, A., Godkin, D., Dembo, J., Chan, P., Knoops, F., Lachmann, M., & Charbonneau, M. (2022). Medical assistance in dying (MAiD) for persons whose sole underlying medical condition is a mental disorder: challenges and considerations. The Canadian Journal of Psychiatry, 67(1), 71-87.

Frolic, A., & Oliphant, A. (2022, December). Introducing medical assistance in dying in Canada:

\Lessons on pragmatic ethics and the implementation of a morally contested practice. In Hec Forum (Vol. 34, No. 4, pp. 307-319). Springer Netherlands

Health Canada. (2020, February 25). Government of Canada. Retrieved from https://www. canada. ca/ en/ health-canada/services/medical-assistance-dying.html

Persons whose Sole Underlying Medical Condition is a Mental Disorder: Challenges and Considerations. Ottawa (ON): CPA.

Gilbert, C., & Millyard, A. (2021). Putting Risk Factors in Context: an Anti-Oppression Approach. *CAND Journal*, *28*(1), 25-31.

Government of Canada. (2022). Third Annual Report on Medical Assistance in Dying. Government of Canada. Retrieved July 27, 2022, from https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html

Gerassi, L., & Nichols, A. (2021). Social Work Education that Addresses Trafficking for Sexual Exploitation: An intersectional, anti-oppressive practice framework. Anti-Trafficking Review, (17), 20–37. https://doi.org/10.14197/atr.201221172

Health Canada. (2020, February 25). Government of Canada. Retrieved from https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

Kidsgrief.ca. MyGrief. (2021). Retrieved from https://www.mygrief.ca/mod/lesson/view.php?id=893

Kim, S. Y. H., &Lemmens, T. (2016, October 4). Should assisted dying for psychiatric disorders be legalized in Canada? Retrieved from https://www.cmaj.ca/content/188/14/E337

McGorry, P. D., Mei, C., Chanen, A., Hodges, C., Alvarez Jimenez, M., &Killackey, E. (2022). Designing and scaling up integrated youth mental health care. World Psychiatry, 21(1), 61-76.

Medical Assistance in Dying: What Social Workers Need to Know. (2016, December 2). Retrieved from https://nlasw.ca/sites/default/files/inline-files/Medical Assistance in Dying (final).pdf

Nuhn, A., Holmes, S., Kelly, M., Just, A., Shaw, J., & Wiebe, E. (2018). Experiences and perspectives of people who pursued medical assistance in dying: Qualitative study in Vancouver, BC. *Canadian Family Physician*, *64*(9), e380-e386.

Schutt, K. C. (2020). Exploring how family members experience medical assistance in dying (MAiD). *Mémoire de maîtrisedirigé par Reimer-Kirkham Sheryl et Klaassen Derrick, Trinity Western University.*

Simpson-Tirone, M., Jansen, S., & Swinton, M. (2022, December). Medical Assistance in Dying (MAiD) care coordination: Navigating ethics and access in the emergence of a new health profession. In Hec Forum (Vol. 34, No. 4, pp. 457-481). Springer Netherlands.

Trouton, K., Beuthin, R., Thompson, M., Bruce, A., Lemire-Elmore, C., &Daudt, A. Z. H. (2020). Attitudes and expectations regarding bereavement support for patients, family members, and friends: findings from a survey of MAID providers. BC Med J, 62(1), 18-23.

Variath, C., Peter, E., Cranley, L., &Godkin, D. (2022). Health care providers' ethical perspectives on waiver of final consent for Medical Assistance in Dying (MAiD): a qualitative study. BMC Medical Ethics, 23(1), 1-14.

Vargo, A. (2022). Death with Dignity in Canada.

Wagner, B., Müller, J., &Maercker, A. (2012). Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide. European Psychiatry, 27(7), 542–546. doi: 10.1016/j.eurpsy.2010.12.003

Webster, P. (2022). Worries grow about medically assisted dying in Canada. The Lancet, 400(10355), 801-802.

Received:05.03.2023
Revision Received : 12.03.2023
Accepted : 30.03.2023

◆