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Résumé de l'article

Pendant la majeure partie du débat sur l'assistance médicale à mourir qui a duré environ 40 ans au Canada, l'euthanasie et le suicide assisté ont été considérés comme des questions distinctes. Pourtant, en 2016, leurs différences éthiques, psychologiques et pratiques ont été ignorées lorsque les deux actes ont été regroupés dans la législation sous le terme générique d'« assistance médicale à mourir » (AMM). L'absence de distinction juridique entre les deux termes ignore d'importantes considérations éthiques du point de vue des praticiens de l'AMM. Bien que le principe du respect de l'autonomie doive rester au centre de l'évaluation de l'éligibilité à l'AMM, il ne peut être la seule considération. Ce texte examine les considérations et les principes éthiques qui sous-tendent les décisions d'octroi de l'AMM en analysant les progrès et les résultats du débat sur le suicide assisté et l'euthanasie, qui dure depuis 40 ans.

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Assisted Suicide and Euthanasia: Language Lost in MAiD

Rafal Gromadzki^{a,b}, Timothy Christie^{a,b,c}

Résumé

Pendant la majeure partie du débat sur l'assistance médicale à mourir qui a duré environ 40 ans au Canada, l'euthanasie et le suicide assisté ont été considérés comme des questions distinctes. Pourtant, en 2016, leurs différences éthiques, psychologiques et pratiques ont été ignorées lorsque les deux actes ont été regroupés dans la législation sous le terme générique d'« assistance médicale à mourir » (AMM). L'absence de distinction juridique entre les deux termes ignore d'importantes considérations éthiques du point de vue des praticiens de l'AMM. Bien que le principe du respect de l'autonomie doive rester au centre de l'évaluation de l'éligibilité à l'AMM, il ne peut être la seule considération. Ce texte examine les considérations et les principes éthiques qui sous-tendent les décisions d'octroi de l'AMM en analysant les progrès et les résultats du débat sur le suicide assisté et l'euthanasie, qui dure depuis 40 ans.

Mots-clés

AMM, assistance médicale à mourir, suicide, suicide assisté, euthanasie, Canada

Abstract

For most of Canada's approximately 40-year debate on medically assisted death, euthanasia and assisted suicide were considered distinct issues. Yet in 2016 their ethical, psychological, and practical differences were effectively disregarded when the two acts were grouped together in the legislation under the umbrella term "Medical Assistance in Dying" (MAiD). The lack of distinction under the law of the two terms ignores important ethical considerations from the MAiD practitioners' perspective. Although the principle of respect for autonomy must remain central to the assessments of MAiD eligibility, it cannot be the only consideration. This paper examines the ethical considerations and principles that underlie decisions to provide MAiD through an analysis of the progress, and results, of the 40-year debate on assisted suicide and euthanasia.

Keywords

MAiD, medical assistance in dying, suicide, assisted suicide, euthanasia, Canada

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INTRODUCTION

The evolution of Medical Assistance in Dying (MAiD) in Canada began more than five decades ago with the decriminalization of suicide in 1972. Subsequent milestones include the legalization of assisted suicide and voluntary euthanasia in 2016, and the establishment, in 2021, of two distinct tracks for MAiD: 'Track One' for patients with a reasonably foreseeable natural death (RFND) and 'Track Two' for those without a RFND. MAiD is now available for competent patients suffering from a grievous and irremediable medical condition, regardless of whether they are dying. Canada's assisted-dying regime is considered the most permissive in the world (1).

The connection between the decriminalization of suicide and the development of MAiD is significant. Until the Carter decision in 2016, Canadians grappled with a contradiction, namely, that it was legal for a person to commit suicide, but it was illegal for someone to help them perform this action. As a result, some Canadians had the option of ending their lives if they deemed their quality of life to be unacceptable; however, if they had a medical condition that prevented them from committing suicide without assistance, they were forced to live a quality of life that they found unacceptable. The 2016 Carter decision determined that this disparity violated the Canadian Charter of Rights and Freedoms.

The provisions of the Criminal Code of Canada that legislate MAiD do not distinguish between assisted suicide and voluntary euthanasia. If it is determined that a patient satisfies the legal eligibility criteria, then they can access either procedure. In fact, since legalization, over 99.9% of MAiD procedures have been voluntary euthanasia (2). Nevertheless, the ethical principles that underlie the two procedures are different. Historically, the rationale for assisted suicide was grounded in the principle of respect for patient autonomy. This principle asserts that individuals have the right to make decisions about their lives, including the choice to end their suffering through death. However, since voluntary euthanasia necessitates that the health care professional be the agent of death, principles beyond respect for patient autonomy become essential. The wish to relieve suffering, for instance, finds support through the principles of beneficence and non-maleficence.

In this paper, we critically appraise the elimination of the distinction between assisted suicide and voluntary euthanasia in Canada. Specifically, it will examine the historical development of MAiD, focusing on three distinct time periods: 1) the period before 2012 when both assisted suicide and voluntary euthanasia were illegal; 2) 2012-2019, the early stages of legalization; and 3) post-2019, the current era. After providing a historical background, we offer an analysis of the resulting changes and a consideration of the ethical implications of the current laws on Medical Assistance in Dying in Canada.

EVOLUTION OF ASSISTED SUICIDE IN CANADA

1972-2012: Prelude to Legalization

The history of assisted dying in Canada begins with suicide: the intentional act of causing one's own death. The very first Criminal Code of Canada in 1892 prohibited attempting suicide in section 238 and assisting suicide in section 237 (3). It was only in 1972 that Parliament passed Bill C-2 decriminalizing attempted suicide, recognizing that the criminal justice system was ill-suited to deal with what was a medical and social issue (4). However, the Criminal Code of Canada continued to prohibit individuals from consenting to death in s. 14: "No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given," and barred others from assisting those attempting suicide in s. 241(b): "Every one who aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years," (5). The prohibition of assistance in suicide was the catalyst for all parliamentary reports, legal challenges, and Criminal Code of Canada exemptions that led to the creation of the present-day MAiD regime.

The first official government reports to consider assisted suicide were concerned with the possibility of law reform and included additional considerations for euthanasia and the cessation of treatment. Issued in 1982 and 1983 these two reports form the foundation of the Canadian government's position on the topics and are referenced throughout subsequent reports (6), court cases (7-9) and commentaries (10).

The 1982 report by the Law Reform Commission, "Working Paper 28 Euthanasia, Aiding Suicide and Cessation of Treatment," (11) examined moral and legal problems that arose from medical advancements, the evolving role of patient autonomy in medical decision making, and the development of palliative care (11). The report focused on terminally ill patients within a medical context and defined the differences between euthanasia, assisted suicide, and cessation of treatment as components of end-of-life care. The second report, "Report 20 Euthanasia, Aiding Suicide and Cessation of Treatment," (12) published by the Law Reform Commission one year later in 1983 after lengthy public consultations, entered official recommendations on relevant legal reform.

The two Law Commission reports treated the possibility of the legal reform of assisted suicide as a separate matter from euthanasia. Assisted suicide for terminally ill individuals was posited as a natural next step following the decriminalization of suicide. The report stated that "assistance is not murder because there is no positive causal act. Moreover, the person involved is always free to change his mind," (11, p.52). However, the distinction between assisting suicide and murder was acknowledged as difficult to discern and maintain (11). If there is no motivation of compassion, the acts of aiding suicide and homicide are closely related. Although the legalization of assisted suicide was rationally defensible, the possibility of serious abuse led the Commission to recommend no changes to the law (11,12).

For the Commission's purposes of legal reform, euthanasia was defined as the voluntary positive action motivated by compassion of "the killing of the patient at the patient's explicit request, or when the consent to his killing could be implied from the circumstances of the case on grounds of benefit to the patient," (11, p.43-44). Although the Commission recognized the positive intention motivating the consideration of legal reform for euthanasia, they could not themselves recommend legalization of voluntary active euthanasia (11,12). They stated that not only does euthanasia preclude any possibility of patient recovery due to incorrect diagnosis or refinement of treatment, the possibility for abuse and misuse may be impossible to adequately mitigate. The commission stated that there is "a real danger that the procedure developed to allow the death of those who are a burden to themselves may be gradually diverted from its original purpose and eventually used as well to eliminate those who are a burden to others or to society. There is also the constant danger that the subject's consent to euthanasia may not really be a perfectly free and voluntary act," (11, p.46). The Commission's reports recommended that active voluntary euthanasia keep its legal definition as culpable homicide with no distinction in the criminal code based on motives (12).

While the Law Reform Commission did not lead to changes in Canada's Criminal Code, it articulated in concise, descriptive language, the concerns, causes, and fears that would continue to be part of the debate into the present. At the same time, as the Commission considered law reform, a major event in 1982 opened the door to new legal possibilities for enacting change in Canada: *The Constitution Act* and the *Charter of Rights and Freedoms* provided individual Canadians with a legal mechanism to challenge the country's laws. If a law was challenged in court and found to infringe on a constitutionally protected right, it could be struck down and declared of no force and effect.

The prohibition on assisted suicide would see its first constitutional challenge reach the Supreme Court of Canada in 1993, in the case of *Rodriguez v. British Columbia* (7). Sue Rodriguez was suffering from amyotrophic lateral sclerosis (ALS), a neurodegenerative disease that would inevitably result in the total loss of her motor function. She was concerned that once her body reached an advanced state of decline where she would no longer find her quality of life tolerable, she would not be able to commit legal, unassisted suicide because of her disability. Ms. Rodriguez explicitly challenged the Criminal Code of Canada prohibition of assisted suicide arguing that s. 241(b) of the Criminal Code violated her Charter rights: the law specifically infringed on her right to seek assistance in dying at a time of her own choosing (s.7 liberty and security of the person), was cruel and unusual punishment (s.12), and discriminated against the disabled (s.15).

In a split 5-4 decision, the nine-member Supreme Court upheld the constitutionality of the absolute prohibition on assisted suicide (7). Whereas the majority decision stated that there was no s.7 or s.12 violation, the equality rights under s.15 of Ms. Rodriguez were assumed to be infringed. However, the Supreme Court found the infringement justified, as only a blanket prohibition on assisted suicide could protect the vulnerable from being induced to commit suicide in a time of weakness – the stated goal of s.241(b). The court expressed the concern that an exemption for some groups would start down the slippery slope from assisting in suicide towards acceptable euthanasia, opening the door to the possibility of abuse. Although the majority decision was upheld, three dissenting opinions were also presented by four Supreme Court judges (7).

Following Rodriguez, the Government of Canada undertook a new survey of the legal, social, and ethical landscape and formed the Special Senate Committee on Euthanasia and Assisted Suicide. Their June 1995 report, “Of Life and Death,” represented fourteen months of hearing witness testimonials and receiving letters and briefs on end-of-life care from interested parties (6). The Committee was unanimous in providing recommendations for expanded access to palliative care and the need for improved clarity of the law on withdrawing and withholding life-sustaining treatment. However, no consensus was reached on assisted suicide and euthanasia (chap.7). They acknowledged that there is considerable disagreement about whether euthanasia and assisted suicide are ethically distinct from decisions to forgo life-sustaining treatments or other end-of-life care (Introduction), whether assisted suicide is fundamentally distinct from euthanasia (chap.8), and what course of action should be recommended (chap.7,8).

The Committee defined assisted suicide as “the act of intentionally killing oneself with the assistance of another who provides the knowledge, means, or both”, and euthanasia as “a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person’s suffering where that act is the cause of death,” (chap.2). The majority of the Committee maintained a fundamental distinction between assisting suicide and euthanasia. The reasoning being that in assisted suicide, the principal agent of death was the dying person whereas in euthanasia the principal agent of death was another person (chap.8). Also, the person committing suicide has the option to change their mind until the very end in a way that might not be possible when another person is the principal agent of death. The majority rejected both assisted suicide and euthanasia, as they acknowledged that allowing assisted suicide but not euthanasia would lead to an infringement of the s.15 Charter right of equality (chap.7,8). The members of the Committee in the minority who proposed changes to the Criminal Code to allow for assisted suicide also agreed that not including euthanasia would lead to s.15 challenges. However, even those who recommended legalization did so only within the framework of a dying person requesting euthanasia, and that euthanasia should only be permitted for competent individuals who are not physically capable of committing assisted suicide (chap.8).

2012 – 2019: Early Stages of Legalization

Over the decade that followed the Special Senate Committee report, several bills were proposed in parliament to enact changes to the criminal code prohibition of assisted suicide (13-18), but none passed at the federal level. Provincially, however, legislative change was achieved in Quebec in 2014 with the passing of Bill 52 (19). Quebec, acting on recommendations from the 2012 provincial report, “Dying with Dignity,” (20) permitted terminally ill patients to seek an end-of-life option not available in the rest of Canada. Bill 52 put Canada’s first official assisted-dying regime into practice.

According to the “Dying with Dignity” report, the Quebec National Assembly’s Select Committee needed to answer the question of how to respond to requests for help to die. The Committee proposed a new option in the “continuum of end-of-life care” and enumerated the criteria and safeguards that should be implemented with this option. The option proposed was called, “Medical Aid in Dying,” (20, p.76). According to the Committee, adults in Quebec in the terminal stages of a serious, incurable disease should be able to seek “Medical Aid in Dying” (20, p.81) – not euthanasia, not assisted suicide. A new, neutral term was decided upon as the word “euthanasia” was considered too emotionally charged (20 p.76) and according to the report, “assisted suicide certainly cannot be considered a form of care,” (20, p.79). Medical Aid in Dying was the exclusive wording found in Bill 52, “An Act Respecting End-Of-Life Care,” (19) which enacted the criteria and safeguards proposed in the report with few changes.

At the federal level, the prohibition of assisted suicide would again be challenged as an infringement of Charter rights in 2015 in the case of *Carter v. Canada* (8). Once more, at the core of the case was a person with ALS: Gloria Taylor. Mrs. Taylor argued that the law forced her to make the ‘cruel choice’ of committing legal suicide while she was still physically able but wanting to live or wait until her quality of life was no longer acceptable and not be allowed to die because no assistance would be legally available. This time the Supreme Court was not divided and unanimously upheld the ruling of the trial judge, Justice Lynn Smith, striking down sections 14 and 241(b) of the Criminal Code of Canada as unconstitutional and of no force and effect (8, par.147). The decision did not distinguish between euthanasia and assisted suicide, and instead for the first time grouped them together: “For purposes of this claim, ‘physician-assisted suicide’ and ‘consensual physician-assisted death’ will be collectively defined as ‘physician-assisted dying’,” (21, par.23). The landmark decision of the Supreme Court of Canada in *Carter v. Canada* ended the long-held absolute prohibition of assisted suicide, ushering assisted dying into law.

Following the *Carter* decision three committees – formed to determine the process of federal legalization – released reports in quick succession. First the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying released their report in November of 2015 (22), where “physician-assisted dying” was the only subject under consideration with no mention of euthanasia or assisted suicide, and no distinction between the two noted. The second report was that of the Federal External

Panel on Options for a Legislative Response to Carter in December of the same year (23), followed by the Special Joint Committee on Physician-Assisted Dying's "Patient Centered Approach" released in February of 2016 (24).

The External Panel on Options for a Legislative Response to Carter v. Canada undertook another survey of professional and public opinions as well as the laws and experiences in other jurisdictions and considered the role of the language used around assisted death (23). To retain consistency with the Supreme Court of Canada, the External Panel used "physician-assisted death" throughout the report. However, they acknowledge that they were collecting data on two distinct types of assisted dying: voluntary euthanasia and assisted suicide (23). They defined each of the terms and recognized that the difference between the two is in the role of the physician. "In voluntary euthanasia, the physician takes the final act that will end the individual's life... In assisted suicide, an individual performs the final act to end their life... In both types of physician-assisted dying, the act is voluntary and requested by the individual; the only distinction is the actual role the physician plays," (23, p.44).

The External Panel report pointed out concerns that were raised over the obfuscating effects of not using well-defined words with established meanings (23). Arguments were raised over the importance of precise language to enable clear thinking and avoid confusion. Beyond clarity, the idea that the terms "assisted suicide" and "euthanasia" were different "psychologically and ethically," and should therefore be considered separately were also put forward (p.45). However, these views were tempered by a recurring notion that words like euthanasia and suicide were emotionally charged and even carried stigma in various communities. The External Panel noted that they operated with the "understanding that both methods of physician-assisted death are contemplated by the Supreme Court in Carter, and therefore that both may be among the options available to Canadians suffering from grievous and irremediable medical conditions that cause them enduring suffering" (p.51). The Panel's own conclusion was that there is often a need to distinguish between the two terms and it would do so throughout the report whenever that need arose.

The third report released before legislation was passed was the Special Joint Committee of the Senate and the House of Commons on Physician-Assisted Dying's "Patient Centered Approach" (24). The report defined two distinct acts in the terminology section: "euthanasia" was defined as the intentional act of ending the life of another person to relieve their suffering and "assisted suicide" as ending one's own life with the assistance of another person. The report reiterated the idea that the terms are too "loaded and stigmatizing," (p.10). Rather than further debating the issue explored in the External Panel report, the Special Joint Committee recommended that the neutral term "Medical Assistance in Dying" (MAiD) be used in any future legislation on this topic. This new term coined by the Committee was preferred to "physician-assisted dying," as it "reflects the reality that health care teams, consisting of nurses, pharmacists, and other health care professionals, are also involved in the process of assisted dying" (p.10).

In June of 2016, following the Supreme Court of Canada decision, the Government of Canada amended the Criminal Code of Canada and passed Bill C-14: the Medical Assistance in Dying Act (25). Bill C-14 continued moving the language away from the use of "assisted suicide" and "euthanasia." The term proposed in the "Patient Centred Approach," "Medical Assistance in Dying," was the recurring and consistent verbiage used throughout the bill. Instead of distinguishing between assisted suicide and euthanasia, C-14 grouped the two actions into a single exemption calling it Medical Assistance in Dying (MAiD). Bill C-14 defined Medical Assistance in Dying as: "(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death," (25, Definitions 241.1).

To qualify for MAiD under Bill C-14 individuals must be eligible for government-funded health services, make a voluntary request for assistance in dying, be at least 18 years old, be capable of making health decisions, give consent after being informed of available options, and have a grievous and irremediable medical condition. This "grievous and irremediable medical condition" requires a serious and incurable illness, disease, or disability; an advanced decline in capability; enduring physical or psychological suffering; and a reasonably foreseeable natural death. Medical practitioners must further ensure that requests are submitted in writing, signed by two independent witnesses, the person can withdraw at any time, another practitioner confirms eligibility, ten clear days are observed between request signing and the procedure, the patient was provided an opportunity to withdraw their consent immediately before the procedure, and that necessary measures were taken to allow communication of decisions.

2019 – Present: Recent Developments

Bill C-14 would prove to be just another step in the evolution of the assisted-dying debate as the inclusion of the reasonably foreseeable natural death criterion soon became the subject of another constitutional challenge. In 2019, Quebec's Superior Court would hear the case of Jean Truchon and Nicole Gladu (9). Unlike the previous challenges of Ms. Rodriguez and Mrs. Taylor, where death was reasonably foreseeable, Mr. Truchon and Ms. Gladu had lived with chronic conditions and had no prognosis of a reasonably foreseeable natural death. They claimed that the criteria that required death to be reasonably foreseeable in Bills 52 and C-14 infringed their right to life, liberty, and security of the person, as well as their right to equality and was counter to the decision of the Supreme Court of Canada in Carter v. Canada. Ultimately, Justice Baudouin struck down the C-14 requirement of a reasonably foreseeable natural death as an infringement of Mr. Truchon's and Ms. Gladu's rights. Although Justice Baudouin accepted the importance of the objective of protecting vulnerable people, she held that physicians were able to detect problems with capacity, coercion, abuse, social, economic, and other vulnerabilities in MAiD requests.

The federal government chose not to appeal the decision to the Supreme Court of Canada. Instead, they drafted a replacement bill – Bill C-7 (26) – which received Royal Assent on March 17, 2021. The bill removed the requirement for final consent, removed the ten-day wait period between request and procedure, reduced the number of required witnesses to one, and added a second set of safeguards for those seeking MAiD when the patient's natural death is not reasonably foreseeable. When a MAiD request is made without a reasonably foreseeable death, all previous criteria apply with the additional clauses of providing written opinions from an expert on the condition, allowing 90 days or whatever time period a medical practitioner deems appropriate within the circumstances to elapse between initial assessment and procedure, and ensuring the person seeking MAiD has been informed of available means to relieve their suffering and that they have given this serious consideration.

Bill C-7 excluded mental illness from the definition of illness, disease, or disability under the MAiD criteria. However, the exclusion was not intended to be permanent but was to facilitate further study of the complex issue (26). Three reports were released in 2022 and 2023 which looked not at whether MAiD *should* be extended to individuals where a mental disorder is the sole underlying medical condition, but rather *how* it will be done. Two reports were released by the Special Joint Committee on Medical Assistance in Dying titled, "Medical Assistance in Dying and Mental Disorders as the Sole Underlying Condition: An Interim Report," (27) and "Medical Assistance in Dying in Canada: Choices for Canadians," (28). These reports and their recommendations considered relevant testimony and were based in the findings of "The Final Report of the Expert Panel on MAiD and Mental Illness," (29) which opens with the acknowledgment that the Panel's role was "not to debate whether or not persons with a mental illness as their sole underlying medical condition should be eligible for MAiD" (29, p.8).

WHY THE DISTINCTION BETWEEN EUTHANASIA AND ASSISTED SUICIDE MATTERS

The current MAiD regime in Canada is the result of patients arguing that a legal prohibition on assisted suicide violates their rights under the Canadian Charter of Rights and Freedoms. Central to the argument is the concept of a "cruel choice." As noted earlier, this cruel choice is as follows: there are some individuals who know that the natural history of their disease will result in their death, but they also know that their quality of life might become intolerable before they die. By the point that their quality of life is unacceptable to them, they likely will be physically unable to commit suicide on their own. Since the law prevents anyone from assisting them, they have a cruel choice to make. They can either end their lives while they are still physically able to do so, hence missing out on a quality of life that they find acceptable, or they can continue to enjoy their life knowing that once they reach the point where their quality of life is no longer acceptable, the law will prevent them from receiving assistance to end their lives, and they will have to continue living a quality of life that they find abhorrent.

The 2016 Carter decision determined that this "cruel choice" violated the Canadian Charter of Rights and Freedoms and hence these patients had a right to physician-assisted death. Likewise, the Carter decision considered assisted suicide and voluntary euthanasia together, which most likely stems from a discussion held by the Special Senate Committee on Euthanasia and Assisted Suicide in 1995, where they noted that allowing assisted suicide but prohibiting voluntary euthanasia would not survive a Charter challenge. The argument would be that some people are unable to end their lives, even with assistance, and hence they will need someone else to actively end their lives, not just assist them.

As a result, there are three distinct patient populations, which the legislation does not properly distinguish: 1) those who qualify for MAiD and are physically able to commit suicide, 2) those that qualify for MAiD but require assistance to commit suicide, and 3) those that qualify for MAiD and are physically unable to commit suicide even with assistance. The Canadian legislation provides the same exemption, regardless of the patient's physical ability. In other words, if a patient is eligible for assisted suicide, they are also eligible for voluntary euthanasia. This lack of distinction ignores important ethical considerations from the MAiD practitioners' perspective.

The role of the MAiD practitioner differs between assisted suicide and voluntary euthanasia, and the ethical probity of each procedure will differ depending on the type of patient. For instance, contrast a patient facing a cruel choice with a patient experiencing intolerable suffering because of living in unjust social conditions (defined as a lack of access to necessary services like supportive housing and proper pain management). Notable cases include "Sophia," who received MAiD due to her inability to find accommodation suitable for her multiple chemical sensitivities disorder, and "Mr. Farsoud," who qualified for MAiD due to the distress caused by the fear of homelessness after a rent increase (30,31). While some commentators argue that the media sensationalize such cases, they illustrate instances of MAiD eligibility where the patients are not confronted with the cruel choice scenario. In these cases, it is appropriate to ask whether it is ethical for the MAiD practitioner to be the agent of death.

Assisted suicide is most appropriate for the first two groups of patients, those who can end their lives on their own and those who require assistance to end their lives. For patients who are physically able to end their lives on their own, they will still need a MAiD practitioner to provide them with the means and knowledge to do this safely and without violence or trauma. This was a major consideration in the Truchon decision. Voluntary euthanasia, however, is most appropriate for the third group, those who cannot end their lives even with assistance. The main ethical consideration is not whether the patient is legally eligible for MAiD but whether it is ethical for the practitioner to be the agent of death.

The principle of respect for autonomy can justify the practitioners' role in assisted suicide for the first two groups. However, it is more difficult to justify the practitioner being the agent of death in these situations. The ethical principles that justify the MAiD practitioner acting as the agent of death are autonomy, beneficence, and nonmaleficence. In other words, there must be additional considerations for voluntary euthanasia that do not necessarily apply for assisted suicide. For example, a MAiD practitioner can have a duty – that is be morally obligated – to respect a patient's autonomy, however, they can never have a duty to kill or euthanize their patient. Although a practitioner can never have a duty to perform voluntary euthanasia, it can be morally good if it is done for the right patient, at the right time, for the right reasons. These reasons will require further consideration than just legal eligibility and respecting patient autonomy. The practitioner must also be satisfied that it will help the patient and will do no harm, which are not considerations for assisted suicide.

CONCLUSION

In conclusion, this paper critically examined the historical development of MAiD in Canada, with a particular focus on the merging of assisted suicide and voluntary euthanasia. The legalization of attempted suicide and suicide by Bill C-2 in 1972 highlighted a stark disparity: while individuals with the physical capability to end their lives faced no legal repercussions, those physically unable were barred from receiving assistance, leading to the widely acknowledged “cruel choice” dilemma. Despite the differences between assisted suicide and voluntary euthanasia, where healthcare professionals play a more direct role as the agent of death, Canadian legislation fails to delineate between the two procedures. Our argument in this paper underscores that while assisted suicide may find ethical justification in the principle of respecting patient autonomy, voluntary euthanasia necessitates additional ethical considerations such as beneficence and nonmaleficence. This crucial distinction, essential for ethical practice, remains unaddressed in current law.

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