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The realities of Medical Assistance in Dying in Canada

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Review Article

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Abstract

In 2015, the Canadian Supreme Court declared that an absolute Criminal Code prohibition on assisted suicide and euthanasia was unconstitutional. In response, the Canadian parliament enacted Bill C-14 in 2016 permitting assisted suicide and euthanasia for the end-of-life context, which it termed "Medical Assistance in Dying" (MAiD). In 2021, Bill C-7 expanded eligibility for MAiD to those with disabilities not approaching their natural death. By 2021, MAiD accounted for 3.3% of all deaths in Canada with some areas of Canada presently reporting MAiD death rates upward of 7%. In 2021, Canada had 10,064 deaths by MAiD, surpassing all jurisdictions for yearly reported assisted deaths.

Objectives. To examine the impact of the Canadian MAiD program and analyze its safeguards.

Methods. A working group of physicians from diverse practice backgrounds and a legal expert, several with bioethics expertise, reviewed Canadian MAiD data and case reports. Grey literature was also considered, including fact-checked and reliable Canadian mainstream newspapers and parliamentary committee hearings considering the expansion of MAiD.

Results. Several scientific studies and reviews, provincial and correctional system authorities have identified issues with MAiD practice. As well, there is a growing accumulation of narrative accounts detailing people getting MAiD due to suffering associated with a lack of access to medical, disability, and social support.

Significance of results. The Canadian MAiD regime is lacking the safeguards, data collection, and oversight necessary to protect Canadians against premature death. The authors have identified these policy gaps and used MAiD cases to illustrate these findings.

Introduction

In 2015, the Canadian Supreme Court, in *Carter v Canada*, declared that an absolute Criminal Code prohibition on assisted suicide and euthanasia was an unjustifiable interference with the constitutional right to life, liberty, and security of the person (Supreme Court of Canada 2015). In response, the Canadian parliament enacted Bill C-14 in 2016 (Parliament of Canada 2016). This legislation introduced an exemption permitting assisted suicide and euthanasia for capable, consenting adults with a serious disease, illness, or disability, with a "reasonably foreseeable natural death" (RFND) an irreversible decline of capability, and intolerable suffering (psychologically and/or physically). In Canada, both euthanasia and assisted suicide are collectively referred to as "Medical Assistance in Dying" (MAiD), but euthanasia, which is the administering of a lethal injection by a healthcare provider, accounts for almost every MAiD case to date (Government of Canada 2022).

In 2021, eligibility for the Canadian MAiD regime was further expanded through legislation, Bill C-7 (Parliament of Canada 2021). The legislation introduced a regime of 2 MAiD pathways. Several safeguards from the initial regime were removed from what was now called "Track 1," a pathway for which an applicant still has to have an RFND. Bill C-7 added "Track 2," a new pathway for those with a serious disease, illness, or disability and an irreversible decline of capabilities, but who are not approaching their natural death. This means de facto persons with disabilities. A delayed implementation clause for Track 2 ("sunset clause") stipulated that those with sole mental disorders would become eligible for MAiD in March 2023 (Gaind 2022a).

Bill C-7 was the government's response to a single lower court judgment in the province of Quebec (Truchon), which ruled that the RFND requirement was unconstitutional (Cours Supérieure Quebec 2019). Unusually, the federal government did not appeal the ruling despite having compelling reasons to do so (Lemmens and Jacobs 2019). Despite the fact that

the case did not deal with mental illness, and that the Supreme Court explicitly stated in the *Carter* case (Supreme Court of Canada 2015) that it was not ruling on MAiD for mental illness (Lemmens et al. 2023; Lemmens et al. 2019), the law nevertheless included mental illnesses as forthcoming qualifying diagnoses.

Since its legalization in 2016, the number of deaths by MAiD in Canada has risen dramatically each year. Within 3 years of its introduction, 2% of all deaths in Canada were by MAiD, and by 2021, MAiD had increased to 3.3% of all deaths in Canada (Government of Canada 2022). Some areas of Canada presently are reporting MAiD death rates upwards of 7% (Gentile and Boily 2023; Heath Canada testimony 2022). In 2021, Canada had 10,064 deaths by MAiD, surpassing all other countries for yearly reported assisted deaths (Buchholz 2022). It has been noted that California, which has roughly the same population, also legalized medically assisted death in 2016, but in comparison, only 486 people died using the California's assisted suicide program in 2021(Pullman 2023; Raikin 2022). Given the expanded Canadian legislation was just enacted in March 2021 and mental illness is planned to be a qualifying condition in the near future, MAiD death rates are expected to rise further.

Our working group published a 2-piece synopsis of MAiD in Canada, for which we refer you to the *World Medical Journal* (Coelho et al. 2022a; Gaind et al. 2022). Our present goal is to identify policy gaps in the Canadian MAiD regime as other jurisdictions are considering legalizing similar practices (Convention Citoyenne Cese sur la fin de vie 2023; Minnesota legislature 2023; Scottish Parliament 2022; White and Willmott 2022).

Methods

A working group comprising physicians from diverse practice backgrounds and a health law expert, several with bioethics expertise, conducted an in-depth review of Bill C-14 and Bill C-7 legislation. We reviewed official annual reports on MAiD in Canada. As well, we reviewed all parliamentary committee hearings considering the expansion of MAiD. This includes the Justice, Pre-Senate and Senate hearings on Bill C-7, as well as the Special Joint Committee on MAiD hearings and report. Grey literature was also considered, including fact-checked and reliable Canadian mainstream newspapers and published case reports. We identified policy gaps discussed below, using illustrative examples to highlight our findings.

Results

Inadequate data collection

Our official Health Canada Annual Reports on MAiD lack the stringent data collection parameters necessary to detect problems in the MAiD regime. The responsible federal government department, Health Canada, admitted during parliamentary committee testimony that these statistics largely reflect MAiD providers ticking boxes (Heath Canada testimony 2022). The data are acquired from the MAiD providers via self-reporting. There is no mechanism for objectively, prospectively, or retroactively identifying or uncovering any errors or abuses of the process. Providing assisted suicide and euthanasia outside the parameters of the law remains prohibited. MAiD providers filling out the forms know that any deviation of the key criteria may result in criminal prosecution, making self-declarations of error or deviation unlikely.

By way of example, the Health Canada Annual Report on MAiD states that patients dying by MAiD had high rates of access to palliative care. In contrast, an independent study demonstrated that palliative care access before MAiD provision was actually much lower than purported (Munro et al. 2020). An independent review article determined that monitoring of MAiD is grossly deficient (Kotalik 2020). Furthermore, cases of noncompliance with MAiD law and policy have been documented by different oversight bodies such as the Chief Coroner of Ontario (Government of Ontario 2022), the Commission on end-of-life care in Quebec (Commission sur les soins de fin de vie 2019), and the Correctional Investigator of Canada (Office of the Correctional Investigator 2020).

As well, narrative accounts are accumulating in the media about people applying and getting MAiD due to suffering associated with lack of access to medical, disability and social support, and often with intersecting components of disability and mental health issues (The Fifth Estate 2023; Zhu 2022). None of these cases or issues were identified by the Health Canada Annual Reports on MAiD.

Lack of oversight

Alan Nichols, who had a hearing and cognitive disability, had recurrent episodes of depression but lived independently. Following a police wellness check, he was involuntarily admitted under the Mental Health Act in British Columbia. Initially diagnosed as suicidal, he was soon after deemed capable of requesting MAiD. He received euthanasia 40 days after his admission, against the objections of his family, who was informed 4 days before the procedure. This occurred under the earlier legal framework where disability was not sufficient for eligibility and RFND was a necessary requirement. The local health authorities stated that the law allows "those who are on a trajectory toward death in a wide range of circumstances" to receive MAID and gave the family no specific diagnosis as basis for his qualification for MAiD (Lemmens 2021). When the family complained to the federal police (Royal Canadian Mounted Police [RCMP]), it suggested this was to be addressed by the professional regulatory authority, the Royal College of Physicians and Surgeons (RCPS). The RCPS indicated it would not conduct a disciplinary investigation unless the RCMP launched a criminal investigation. The RCMP then provided the family with Alan's MAiD application form which indicated he had identified "hearing loss" as the relevant medical diagnosis for his request. Despite contacting the medical and civil authorities, and writing over 40 letters, his family has not found any legal recourse (Nichols 2022).

Donna Duncan suffered a concussion, and it took over a year for her to receive the correct specialized care, during which time she continued to deteriorate. She received MAiD within days of her initial assessment. According to her daughters, she had no known terminal diagnosis. A police investigation into the circumstances surrounding her MAiD death did not proceed, after the hospital refused to cooperate. Records were not released as the hospital claimed the adult daughters were not acting in the "best interests" of the deceased (Anderssen 2023; Daflos 2022a; Duncan and Duncan 2022).

Rather than the government accepting responsibility for setting up procedures for investigation, the Justice Minister stated that oversight must be provided by family members complaining after the fact to initiate disciplinary actions or police investigations (The Fifth Estate 2023). Yet, the experiences of family members who have tried to pursue concerns suggest that cases cannot be transparently reviewed, and health authorities have invoked "best

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interest exceptions" to rebuff requests for access to medical records (Anderssen 2023).

Prioritizing access to MAiD over patient safety and needs

Sathya Dhara Kovac, 44, ended her life through the MAiD program. Kovac lived with a degenerative disease and her condition was worsening, but she wanted to live. However, she lacked the home care resources to do so. "Ultimately it was not a genetic disease that took me out, it was a system," Kovac wrote in an obituary to loved ones (Hoye 2022).

The Supreme Court's decision that spurred the partial legalization of MAiD did not create an explicit "right to die with dignity" and left it to the legislature to design a "strict regulatory regime" (Lemmens et al. 2023). Regardless, the decision is being interpreted by many as creating a positive right of access to MAiD, even when other forms of medical care are available and when psychosocial suffering can be ameliorated.

This view of MAiD as a right has arguably been formalized by the medical profession's regulatory college in Ontario which now requires physicians to provide an effective referral when a patient requests MAiD, even if the physician is a conscientious objector (College of Physicians and Surgeons of Ontario 2021). New Health Canada Model Practice Standards put forward that anyone who objects to providing MAiD, even if only in specific cases for specific circumstances (thus arguably even if that objection is based on an opinion that medical professional standards of care have not been met), is conscientiously objecting (Health Canada 2023), and thus would need to make an effective referral in provinces that require it.

At a recorded training session for MAiD assessors and providers, an attendee questioned this worrisome prioritization of access to MAiD when there are concerns about contextual vulnerability. The expert's response was clear that facilitation of the pathway to MAiD is paramount. The attendee asked, "Given the vulnerability of patients who are maybe requesting MAiD because of socioeconomic reasons … do you save yourself that moral and ethical distress by withdrawing?" The MAiD expert responded, "If withdrawing is about protecting your conscience, you have [an] absolute right to do so." But he added, "You'll then have to refer the person on to somebody else, who may hopefully fulfill the request in the end" (Raikin 2022).

The federal government's commitment to making MAiD universally available across the country, including by imposing funding obligations on provincial health authorities, is emphasized in the preamble of Bill C-14 (Parliament of Canada 2016). Meanwhile, Canada's funding for health-care and social support services remains below the Organization for Economic Cooperation and Development average (Whitelaw et al. 2022). Disability Inclusion Minister Carla Qualtrough seemed to acknowledge such concerns and admitted that "it is easier to access MAiD than to get a wheelchair in some parts of the country" (Qualtrough 2020). While most basic health-care services are publicly funded, there is no positive right to health care in Canada (Court of Appeal for British Columbia 2022; Government of Canada 2016; Henteleff et al. 2011; Supreme Court of Canada 2002). There are significant gaps in public funding for pharmaceuticals, mental health counseling, and dental care, for example, and there are long wait times for many publicly funded medical services and disability supports. Patients are therefore being guaranteed MAiD but not mental health care, palliative care, disability supports, and myriad other essential health services.

The Canadian parliamentary budget office estimated the potential cost savings of expanding MAiD as significant (Parliamentary Budget Officer 2021). The fact that providing state facilitated death is more cost-effective than providing supported health-care and community support to facilitate living well raises concerns about conflicting interests: any country facing financial pressures ought to be concerned about perverse cost-cutting incentives that are built into a health-care system.

Proactively offering MAiD to patients as though it is 1 of many standard treatment options

A military veteran and former Paralympian who has been trying to get a wheelchair ramp installed at her home for the past 5 years testified that she was offered MAiD by her caseworker, and it has been confirmed that at least 4 other veterans were also offered the option of MAID when trying to access resources and care (Yun 2022).

In New Zealand (Parliamentary Counsel Office, New Zealand 2019) and Victoria (Department of Health Victoria (Australia) 2019), medical personnel are prohibited from initiating discussions about assisted death. In Canada, the Canadian Association of MAiD Assessors and Providers (CAMAP) recommends that all those who "might qualify should be offered MAiD" as part of the informed consent process (Canadian Association of MAID Assessors and Providers 2020). No other country in the world has normalized assisted suicide or euthanasia in this way as a potential first line therapeutic option to address suffering. Offering MAiD to a patient who has not raised it could be interpreted as an indication that their suffering will likely become intolerable, and that MAiD is the recommended way out, impacting patient hope and resilience.

Further, Canada has a documented history of health-care providers' biases leading to negative perceptions of certain patients and subsequent negative health outcomes. For example, Indigenous people continue to face racism, even in seeking basic health care. A tragic story of health-care bias played out in the province of Quebec where Joyce Echaquan, a 37-year-old Atikamekw Nation mother of 7, died from apparent hospital negligence while being racially abused (Godin 2020). A British Columbia provincial report entitled, "In Plain Sight," notes that "84% of Indigenous peoples described personal experiences of racism and discrimination that discouraged them from seeking necessary care, and that reduced access to care, negatively affecting their health" (Government of British Columbia 2020).

The Disability Filibuster, a national disability grassroots initiative formed in opposition to Bill C7 and the expansion of MAiD, states in a recent letter regarding the safety of seeking medical services: "People spoke of being afraid to seek medical help because they were worried about their physician raising the possibility of MAiD. Some even went so far as to say they will be avoiding medical care" (Disability Filibuster 2022).

The problem of undefined terminology in the legislation

A man had a small stroke, affecting his balance and swallowing. The prognosis was that this man would be able to eat normally and regain most of his balance. The patient was depressed and isolated due to the COVID-19 outbreak on his ward. He declined all therapy and requested euthanasia. Neither of his MAiD assessors had expertise in stroke recovery. In this acute phase, while struggling with his mood and isolation, and with no therapy to gauge his final level of function, he received MAiD. He had no terminal diagnoses,

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but due to the fact that he was temporarily slightly undernourished, his MAiD assessors considered him Track 1 eligible (Coelho 2022a).

There is voluminous scientific research showing the right care for serious conditions can unquestionably lead to adjustment and recovery. For new serious illness or injury, suicidality is often present at the outset, but it does not persist over the long run (Nafilyan et al. 2023). In a recent Canadian study, which followed patients with spinal cord injuries, half of the participants reported suicidal ideation during the first 2 years of experiencing their injury. However, in retrospect, none of the participants thought that they would have been able to make an informed decision about MAiD in the early years after their injury, and none wanted MAiD after they had time to adjust to living in the community (Tchajkova et al. 2021).

The language in the Canadian MAiD legislation is imprecise and makes clear determinations and consistent implementation of clinical practice standards for MAiD difficult. Due to the imprecise term, "reasonably foreseeable natural death" (RFND), physicians' interpretations of eligibility have been challenged in the courts. In 1 such case, it was ruled that a patient's death does not have to be imminent, and their condition does not have to be terminal to meet the criteria for RFND (A.B. v. Canada (Attorney General) 2017; Germano 2017). Thus, for those whose deaths are considered to have a RFND (Track 1), some will have many years or even a decade of life left to live, and yet they can legally receive MAiD the same day they request it if 2 assessors agree (McMorrow et al. 2020).

Suffering is subjectively defined and can be rooted in psychosocial distress

Dying with Dignity, a Canadian lobby group for legalizing and expanding MAiD, continues to claim on its Myths and Facts page that "FACT: Suffering from a lack of social supports alone does not qualify a person for MAiD. No one can receive MAiD on the basis of inadequate housing, disability supports, or home care (Dying with Dignity Canada 2021)." However, increasing evidence, including the words of those who have themselves chosen MAiD, shows this claim to be misleading. Here is just 1 example of the many stories emerging:

A national CTV news story recounted how "Sophia" was unable to secure affordable housing compatible with her chemical sensitivities. She chose MAiD because she could not find a healthy and affordable place to live given her meager disability support income, and prior to her death by MAiD recorded a video where she stated "the government sees me as expendable trash" (Favaro 2022).

For those who are not dying (Track 2), Canada requires that the 2 MAiD assessors (medical doctor or nurse practitioner) conduct detailed assessments of patient eligibility. The timing to die by lethal injection is set at a minimum of 90 days after the first MAiD assessment is completed. To qualify for MAiD, a patient must be in a situation of irreversible decline of capability and experience intolerable psychological or physical suffering. These terms are not further defined by the legislation, and suffering is treated as purely subjective. If the patient says their suffering is intolerable, there is no requirement for further validation or requirement for clinicians to agree that there are no other options to address the suffering. A Canadian disability inclusion analysis report on the impact of the pandemic on disabled persons noted that persons with disabilities were encouraged to explore the option of MAiD for a lack of resources to live when they had not been contemplating this option. The report further highlights that a lack of social, economic, and health support increases the perception of intolerable suffering in persons with disabilities (Life Work Well Research Centre University of Guelph, DAWN Canada 2021).

No standard treatments must have been tried first or even be available

In Belgium and the Netherlands, 2 other jurisdictions that allow euthanasia outside the end-of-life context, before euthanasia can be provided the physicians must agree that there are no further medical or social support options that can relieve a patient's suffering. In Canada, patients are required to be advised of treatment options that may exist. For Track 2 cases, physicians have to verify that patients considered all other options, but it is left unclear what "considered" really means. There is no requirement that standard best-practice treatments have been appropriately attempted, or even that they are accessible (Lemmens et al. 2021). Tragically, some people are choosing to die while on wait lists for potentially effective treatment or because they are refused care.

A short film, titled "All is Beauty," along with its advertising trailers, was promoted by Simons (an upscale department store in Canada). In the series, a young woman is encircled by people on a beach, in a candle-lit forest, and in other settings that depict a romantic and lovely tableau of her final days before MAiD. "Even now, as I seek help to end my life, … there is still so much beauty," says Jennyfer Hatch. However, a national news agency has revealed that Jennyfer was the same woman who spoke up earlier (under a pseudonym) about her difficulties accessing treatment, prompting her to seek MAiD as a last-ditch effort for access to palliative care. Hatch died by MAiD in October 2022 at age 37. She was unsuccessful in her attempts to receive other care (Daflos 2022b).

Access to medical and social care in Canada is often not timely, which can compound patient suffering and desperation. For example, the average wait time to be treated by a psychiatrist can exceed by up to 5 times the 90-day waiting period to access a lethal injection (Moir and Barua 2021). This means that a person seeking death while awaiting treatment from a psychiatrist could die by MAiD long before they get access to appropriate treatment. The wait times for many other specialized health-care and social support services, including pain clinics, specialized long-term care homes, community-based housing, and disability benefits, also far exceed the 90-day assessment period (Lemmens and Krakowitz-Broker 2020). This highlights the need for comprehensive approaches to addressing suffering, rather than providing MAiD as the path of least resistance.

The issue of suicide contagion

After a national TV documentary showed a gentleman's euthanasia procedure in a positive light, a woman felt that MAiD was attractive and would be good for her. She is in her mid-life, has a recent spinal cord injury and hasn't had time to adjust, receive peer support or proper symptom control, nor reach maximal recovery, but she does now quality for Track 2 MAID within 90 days (Coelho 2022b).

We have long known that publicized suicides can lead to more people choosing suicide (Sinyor et al. 2018). Well-known is how suicide rates went up when Robin Williams completed suicide (Fink et al. 2018). This can also be seen in suicide clustering among Indigenous youth where 1 suicide can set off a series of suicides in a community (CBC news 2013). As well, literature has shown that increased exposure to lethal means increases rates of suicide (Miller and Hemenway 2008).

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There is a claim being made, in direct opposition to suicide prevention research, that access to euthanasia and assisted suicide is allowing for a humane option that will reduce suicide rates and violent means to end one's life. Canada's federal Justice Minister came under fire for advancing this argument. He stated, "remember that suicide generally is available to people. This is a group within the population who, for physical reasons and possibly mental reasons, can't make that choice themselves to do it themselves. And ultimately, this provides a more humane way for them to make a decision they otherwise could have made if they were able in some other way" (Raj 2022).

In reality, the evidence from reviews does not support the hypothesis that introducing MAiD reduces rates of (non-assisted) suicide (Doherty et al. 2022; Jones 2022). Further, data on suicide rates would not factor in people who may have been ambivalent and would never have attempted or completed suicide, but who chose to receive MAiD following social normalization of assisted suicide. In our view, the Justice Minister should be concerned about suicide contagion rather than normalizing what he acknowledges MAiD to be: "a species of suicide" (The Fifth Estate 2023).

Discussion

A human rights outcry

Three United Nations human rights experts (Quinn et al. 2021), over a 100 Canadian disability and social justice organizations (Vulnerable Persons Standard 2021), Indigenous advocacy groups (Levitz 2020), and hundreds of medical (Physicians Together with Vulnerable Canadians 2020) and legal experts have argued that Canada's euthanasia and assisted suicide laws put the lives of marginalized and vulnerable Canadians at risk (Kaiser et al. 2021).

Criticism is growing as an increasing number of media reports regarding worrisome MAiD stories are emerging in the Canadian press. Yet, those who support the expansion of MAiD tend to reject the claim that social service failures can create and sustain the predicaments that can make death an attractive choice.

Dr. Stephanie Green, President of CAMAP admits, "Our health system is woefully inadequate in serving our population with these resources." Even so, she adds, "I do not think we can hold these patients hostage" (Alberga 2022). She seemingly condones the use of MAiD despite the lack of political will to provide necessary psychosocial supports. Bioethicists supporting MAiD expansion have argued that limiting MAiD for reasons of psychosocial suffering "would translate into removing the agency of decisionally capable patients without offering them a way out of their predicament" and have remarkably claimed that providing MAiD in response to social suffering caused by "unjust social circumstances" is a form of "harm reduction" (Schuklenk 2022; Wiebe and Mullin 2023). This is particularly troubling considering that harm reduction strategies precisely aim at saving lives. In addition to distorting the concept of "harm reduction," from an equity and diversity point of view, the claim reflects a perspective based on privilege. This wrongly suggests MAiD is supporting the autonomy of marginalized people who are rather being driven to death by poverty and lack of care, despite knowing how to address poverty and improve care. Dr. Ellen Wiebe, a prolific MAiD provider (430 people as of May 2022) has said she will provide MAiD while people are on waitlists for medical treatment (Wiebe 2022). Although choices for MAiD in dire circumstances might be understandable, we put forward that they are to be considered the result of structural coercion, which undermines meaningful autonomy.

Health Canada is providing $3.3 million in funding to CAMAP to develop and implement a national, "accredited" MAiD curriculum. Video recordings of CAMAP experts teaching MAiD trainees appears to reveal the following: (1) doctor shopping for opinions that align with their own MAiD evaluation is acceptable; (2) poverty is a defensible rationale for MAiD, and (3) family anger is the biggest problem MAiD assessors face (Raikin 2022). CAMAP, which organized the session where these ideas are put forward, is officially funded to guide MAiD delivery in Canada.

Growing concern over expansion of MAiD to those with sole mental illness

The Canadian government legislated that MAiD would be provided to Canadians with sole mental disorders by March 2023 (Coelho et al. 2022b). In December 2022, under intense media scrutiny, coupled with rising criticism from psychiatrists, mental health advocates, and those with lived experience, the federal government announced that it would delay the March 2023 implementation (Major 2022) for 1 year (Zimonjic 2023) but would still go ahead with the expansion. This despite the fact that the world-renowned Centre for Addiction and Mental Health (2017), the Canadian Association for Suicide Prevention (2021), the Canadian Mental Health Association (2022), Ontario Association for Act and Fact (2018), and myriad other organizations stand in opposition (EAG 2022). A recent survey showed that the overwhelming majority of Ontario (the largest province in Canada) psychiatrists who responded said that they oppose MAiD solely on the grounds of mental illness (Gaind 2022b).

Evidence-based reviews, including the Expert Advisory Group in 2020 and a recent publication by Nicolini et al, conclude that predictions of irremediability for mental illnesses are at best, no better than chance (EAG 2020 ; Nicolini et al. 2022). The Council of Canadian Academies reported on MAiD for mental illness and highlighted the known risk of providing psychiatric MAiD to suicidal individuals who would otherwise recover with suicide prevention strategies (Council of Canadian Academies 2018). Yet these evidence-based cautions are dismissed by some MAiD expansionists at times with outright "alternate facts" (Gaind 2023).

Therefore, patients with mental illness, a population known for a high prevalence of psychosocial suffering, will be wrongly informed, during periods of despair and hopelessness, that their conditions are "irremediable" and will not improve, despite this being impossible to predict. In response to concerns that irremediability of any individual's mental illness could never be predicted (a legal requirement to provide MAiD for mental illness in Canada), Dr. Justine Dembo, a MAiD activist and psychiatrist who sat on the 2022 federal panel on MAiD for mental illness, suggested she would simply advise the patient of the uncertainty that they could recover so they could make their own "informed decision" to receive MAiD, despite the fact that legal reporting forms require indicating that the medical condition is irremediable (Hanomansing 2023).

On top of offering MAiD under false pretenses for mental illness, equally concerning is the fact that in the few European countries that provide euthanasia for mental illness, the majority of those requesting it are women and marginalized individuals disproportionately seeking relief from suffering, not from their mental illnesses per se, but because of marginalization, including unresolved social and economic suffering and loneliness, all of which are remediable problems (Kim et al. 2016; Verhofstadt et al. 2017).

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We know that lack of access to care for mental health needs is a major problem in Canada (Centre for Addiction and Mental Health 2022).

The facile notion, repeated often by Justice Minister Lametti, that "we must relieve suffering immediately," distracts from the root causes, and potential solutions, of that suffering.

What next?

Beyond the sustained push to facilitate access to MAiD, a Canadian parliamentary committee has recently, following a short process of expert hearings and review, made recommendations to expand MAiD for mature minors and allow advance directives (Special Joint Committee on Medical Assistance in Dying 2023). The Canadian government officially responded to these recommendations by declining to commit to further expansion at this time (Government of Canada 2023). However, the province of Quebec has already passed Bill 11 which among other changes, obliges all palliative care homes to provide MAiD and allows for MAiD by advance request for situations of dementia (National Assembly of Quebec 2023).

The cases we discussed here reveal a troubling normalization of MAiD as "standard treatment" for a broad range of suffering, including suffering caused or augmented by socioeconomic factors. Some commentators have lauded the Canadian system for endorsing that citizens opt for MAID to avoid being a burden on their families or society (Hanania 2023). In that context it is worrisome that 35.7 % of those who received MAiD in 2021 identified the perception of being a burden on family, friends, or caregivers, as a component of their intolerable suffering (Government of Canada 2022). Others have defended MAiD as a fully autonomous choice to avoid suffering in oppressed people who cannot access adequate socioeconomic resources (Wiebe and Mullin 2023). It reveals how we have moved further away from MAiD being the rare exception the Supreme Court originally appears to have envisioned. This is happening in a context of significant constraints on health-care and social support services, which puts pressure on individuals to consider MAiD as an accessible tool to relieve suffering. The rapid expansion of MAiD offers cost-savings for governments, creating arguably perverse incentives not to address the inadequacies of the health-care system which would protect against premature wrongful death.

Competing interests. None declared.

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