

Editorial

Medical assistance in dying in Québec and Canada: legislative context and implementation issues

Asistencia médica para morir en Quebec y Canadá: contexto legislativo y problemas de implementación

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In June 2016, the Canadian parliament passed a law that modified the criminal code to legalize medical assistance in dying in both the form of voluntary active euthanasia (VAE), i.e. administration by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death, and physician-assisted suicide (PAS), i.e. provision by a medical 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.¹ This represented the culmination of a legislative process that took place in parallel to an end-of-life care legislation that came into force in December 2015 in the Province of Québec, which defined as medical care the administration by a physician of medications or substances to a terminally-ill patient, at the patient's request, in order to relieve their suffering by hastening death.² Canada being a confederation, the legal implications of regulating medical assistance in dying depend on the level of government concerned; of note, the Canadian criminal code is a federal competency, while laws regarding health care practices are under provincial jurisdiction. In this editorial, we review the legislative context that brought about the legalization of medical assistance in dying in Canada, and highlight some of the public health questions that remain surrounding the implementation of these legislations.

The legislations adopted in Canada and in Québec were developed through different processes. In Québec, a special public commission was instigated in 2010 with support across political parties. A lengthy process of public audiences and expert consultations yielded a report published in 2012 with a number of recommendations about end-of-life care, including the development of additional palliative care services, the recognition of advance directives as legally binding, and the inclusion of euthanasia as a medical option on the continuum of care at the end of life.³ Following advocacy on the part of palliative care associations, the provincial legislation that was finally adopted in 2014 defines palliative

care in accordance with the World Health Organization as care that neither hastens nor delays death,⁴ and considers free-standing palliative care residences exempt from offering VAE, while inpatient palliative care units must comply as part of the standard offer of services at public hospitals. At the federal level, the process originated from the judiciary branch rather than from political consultations. The federal legislation, which amended the Criminal Code of Canada, was enacted after the Supreme Court of Canada (*Carter v. Canada*) declared the following two provisions of the Canadian Criminal Code to be unconstitutional: prohibiting a person from consenting to have death inflicted on him or her and prohibiting a person from aiding another person to die by suicide.⁵ The federal legislation was enacted six months after the end of life care legislation that legalized VAE came into force in the Province of Québec.

Both legislations establish specific eligibility criteria for those who wish to prevail themselves of medical assistance in dying, as well as safeguards that must be complied with. At the federal level, the eligibility criteria are (a) the person must be eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada; (b) the person must be at least 18 years of age and capable of making decisions with respect to his or her health; (c) the person must have a grievous and irremediable medical condition, as defined by the law; (d) the person must have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and (e) the person must have given consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.¹ In Québec, the eligibility criteria are: (a) the person must be an insured person within the meaning of the Health Insurance Act; (b) must be of full age and capable of giving consent to care; (c) must be at the end of life; (d) must suffer from a serious and incurable illness; (e) must be in an advanced state of irreversible decline in capability; and (f) must experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.²

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Challenges to both the federal and provincial legislations have recently been brought before the courts. At issue with respect to the Québec legislation is the end of life criteria, while with respect to the Canadian legislation, it is the criteria of natural death being reasonably foreseeable. According to the court challenges, these two criteria are deemed too restrictive and contrary to the criteria set out in the Carter decision. In Québec and Canada, expert committees have also been recently created to study specific issues related to expanding access to medical assistance in dying to mature minors, those with advance medical directives, and those with mental illness as the sole medical condition.^{6,7}

Whereas there is no federal Commission to supervise the application of the provisions of the Criminal Code on medical assistance in dying, there exists such a Commission in Québec, as is the case in European countries that have legalized euthanasia. In other Canadian Provinces, coroners exercise supervision as part of their responsibility to investigate deaths that are not of natural causes. In these provinces, Ministries of Health keep statistics on the number of procedures carried out and provide some demographic and geographical data. In Québec, the End of Life Care Commission receives a declaration containing both quantitative and qualitative data from physicians having administered VAE. The Commission analyses the declarations to assess compliance with the law and produces annual reports. Although it is too early to establish a clear trend in the data, the number of cases of VAE appears to be growing over the first two years of implementation in Québec, with 167 cases during the first six months,⁸ and 625 declarations submitted between July 1, 2016 and June 30, 2017.⁹ In its most recent report, the Commission also concluded that 92% of cases were carried out in accordance with the law, with 3% of declarations being incomplete, and 5% not complying with at least one of the criteria, mostly the independence of the second physician.⁹ At the national level, the total number of medically assisted deaths was 803 between June 17 and December 31, 2016, and 1,179 between January 1, 2017 and June 30, 2017.^{10,11} This represents 0.9% of all deaths in Canada during the last six months of data reported.¹¹ As of the latest available reports, this brings the overall total under both the federal and provincial legislations to 2,149 deaths between December 2015 and June 20, 2017.¹¹

There remain important public health questions to be addressed regarding the implementation of medical assistance in dying in Québec and in Canada. Resistance to participating in the assessment of requests has been documented on the part of palliative care organisations.¹² The current federal and provincial legislations provide exemptions of conscience for health care professionals who can then refer requests to other colleagues who have been identified as willing to participate. An important research question concerns how palliative care services are managing requests and adapting to the practical implications of the new legislation.¹³ Requests for a hastened death are not uncommon in palliative care practice, and authors have argued that exploring the reasons for these requests can be contribute to alleviate distress.¹⁴ Beyond integration within existing end-of-life care services, similar to other countries that have legalized these practices¹⁵ there is also concern with differential access to both palliative care and medical assistance in dying across regions, which warrant more data and research. Countries that have adopted systematic and transparent assessments of end-of-life care practices should serve as an example; in The Netherlands, a nationwide survey is conducted for a stratified sample of decedents every five years.¹⁶ Anonymous surveys can contribute to document the occurrence of practices that are not sanctioned by current laws and that may not be otherwise reported as part of standard documentation practices. Finally, the impact of medical assistance in dying on health care providers and family members remains underexplored in most countries, including Canada.^{17,18}

Medical assistance in dying is now part of the Canadian legal and medical landscape. Preliminary data show that a growing number of Canadians are choosing it as an end-of-life care option. Recent court challenges and the study of specific issues related to eligibility by expert committees might eventually lead the way to even more Canadians being eligible. Continued attention should be paid to the ways these new legislations are being implemented in different regions of Québec and Canada, and how they are shaping end-of-life care practices. Medical assistance in dying should not come at the expense of those who are most vulnerable and the impact on the resources dedicated to palliative care should be assessed, especially given that these services were deemed insufficient to meet the demand by those developing the new legislations.³

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