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POLICY FRAMEWORK: PROPOSALS TO STRENGTHEN MAID SAFEGUARDS AND OVERSIGHT

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While the government of Canada has delayed the expansion of medical assistance in dying (MAiD) for mental illness as a sole underlying condition until March 2027, this postponement does not address existing problems with the MAiD system, both under Track 1 (reasonably foreseeable natural deaths) and Track 2 (not reasonably foreseeable natural deaths). This framework highlights key areas that require redress and proposes constructive policy options to better protect Canadians. These options will be explored in more detail in subsequent policy briefs. These proposals are necessary because:[1]

- MAiD is being chosen due to:
  - poverty or inadequate social supports;
  - people with disabilities facing discrimination; and
  - the inaccessibility of necessary medical treatments.[2]
- Deaths from MAiD have dramatically increased, year over year, and the total MAiD deaths in 2022 comprised 4.1% of total deaths.[3] This was significantly higher than Health Canada's projections, which had estimated Canada would reach 4% only in 2033.[4]
- Canada has outpaced other international jurisdictions in this rapid growth. In California, which introduced assisted death at the same time as Canada and has a comparable population, 3,344 Californians died by assisted death between 2016-2021, compared to 31,664 Canadians in the same period.[5]

1 Further concerns with MAiD can be found in Cardus's Submission to the Special Joint Committee on Medical Assistance in Dying, November 2023, as well as forthcoming reports on cardus.ca/research-library/health/.
2 Coelho, Ramona, John Maher, K. Sonu Gaind, and Trudo Lemmens. "The Realities of Medical Assistance in Dying in Canada." Palliative and Supportive Care 21, no. 5 (2023): 871–78; Maria Cheng, "'Put to death': Canada's too-permissive euthanasia laws a threat to the disabled, experts say," The Associated Press, August 11, 2022.
3 Health Canada, "Fourth Annual Report on Medical Assistance in Dying in Canada 2022."
4 Government of Canada, "Canada Gazette, Part 1, Volume 156, Number 21."
5 Daryl Pullman, "Slowing the Slide Down the Slippery Slope of Medical Assistance in Dying: Mutual Learnings for Canada and the US," The American Journal of Bioethics 23, no. 11 (2023): 64-72.

Given these issues, policy makers must ensure maximum safeguards and oversight so that MAiD is treated as an absolute last resort, and that vulnerable patients are protected to the greatest extent possible.

PROPOSALS FOR CONSIDERATION

What measures can be taken to strengthen safeguards for Track 1 and Track 2 MAiD requests? Options include:

- Requiring comprehensive documentation of a long history of treatments/services that are actually tried before someone can be found eligible for MAiD, in place of the current requirement that patients must merely be informed of, offered consultations, and have seriously considered the available options.
- Specifying the types of expert assessors that are required under Track 2 requests. Examples include requiring psychiatric expert assessment or socio-economic assessments depending on patients' conditions.
- Increasing the number of independent witnesses required when MAiD requests are made. Since 2021, the requirement was reduced from two independent witnesses to one independent witness.
- Reintroducing the 10-day waiting period from when a request is signed to when MAiD is provided under Track 1.
- Extending the 90-day waiting period between the first assessment and MAiD provision in Track 2 cases.
- Requiring express, final consent of patients in every case when MAID is administered. Removing the advanced waiver of final consent when patients' capacity to consent may be lost.
- Removing advanced consent for patients who self-administer a substance but do not die. Prohibiting practitioners from administering a second substance if the patient's incapacity follows failed-self-administration.
- Exploring the prohibition of practitioner-initiated discussions about MAiD.

How can oversight and accountability of the current MAID system be strengthened at the federal and provincial/territorial levels? Options include:

- Correcting the inherent weaknesses of self-reported data by MAID providers through an independent review mechanism.
- Improving existing federal data collection through detailed examination of the types of palliative care and disability supports received by MAiD applicants and recipients.

Improvements include the collection of data in discrete categories, which requires disaggregating the data around the suffering that yielded the MAID request. Presently, this data combines current physical symptoms with fear of future pain.

- Introducing mechanisms such as MAiD application review panels prior to a patient receiving MAiD to protect against coercion.
- Correcting jurisdictional confusion around compliance investigations. Creating an independent oversight body for post-mortem investigations allowing for full criminal investigations and the release of health records. Ensuring transparency by publicly reporting on the results of non-compliance investigations.

How can MAiD-free health care be protected for patients and practitioners? Options include:

- Exploring ways to ensure publicly funded, health care institutions are able to guarantee MAID-free care for patients. This applies to religious institutions and institutions that do not wish to provide MAiD for other reasons such as culturally-sensitive care or specialized disability care.
- Protecting the conscience rights of physicians by explicitly not requiring effective referrals and considering central care coordination services as an alternative.

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