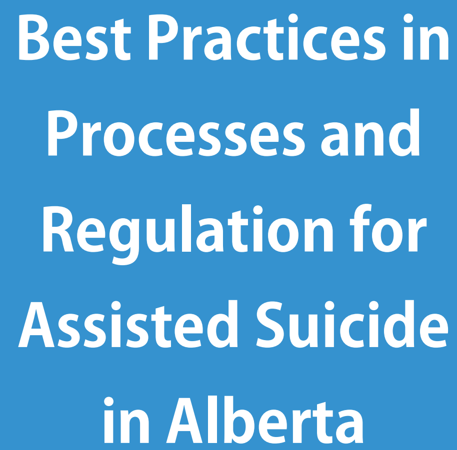

Best Practices in Processes and Regulation for Assisted Suicide in Alberta

Legislative Brief Submitted to the Alberta Government

December 17, 2024

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Defending Faith, Family, and Freedom

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Executive Summary

This executive summary outlines the critical recommendations regarding proposed policies and regulations for assisted suicide legislation in Alberta. As societal attitudes toward end-of-life choices evolve, it is imperative that legislative frameworks are established to ensure that assisted suicide practices are conducted safely and ethically, while simultaneously safeguarding vulnerable populations.

The brief highlights the necessity of comprehensive regulations aimed at creating a structured process for individuals considering assisted suicide. Proposed measures include rigorous eligibility criteria, mandatory psychological evaluations, standardized training of euthanasia providers, and the establishment of waiting periods to facilitate informed decision-making. These steps are designed to prevent coercion and ensure that individuals are making autonomous choices free from external pressures.

Moreover, this brief emphasizes the importance of training and certification for healthcare providers involved in assisted suicide procedures. Such measures will enhance the protection of patients through the promotion of best practices and adherence to ethical standards. Additionally, ongoing monitoring and evaluation of assisted suicide cases will be instituted to assess compliance with established protocols and identify areas for improvement.

To further safeguard vulnerable populations, the brief proposes the creation of an oversight committee tasked with reviewing cases of assisted suicide. This committee would consist of multidisciplinary experts, including ethicists, medical professionals, and representatives from advocacy groups for the elderly and disabled. Their role would be to ensure that the rights and welfare of at-risk individuals are prioritized and that any potential abuses are promptly addressed.

In conclusion, the proposed assisted suicide policies and regulations aim to strike a balance between the autonomy of individuals seeking relief from suffering and the imperative to protect vulnerable members of society. By implementing these recommendations, the government seeks to foster a compassionate response to end-of-life decisions that respects individual choices while safeguarding the integrity of the healthcare system and public trust.

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Introduction: Rapid Advancement in Assisted Suicide Laws

Assisted suicide is a matter of life and death. In just eight years, Canada has gone from assisted suicide being illegal, to a country with some of the most permissive and liberal assisted suicide laws in the world. Not only has this dramatically increased the number of Canadians obtaining euthanasia since, it has prompted a critical examination by citizens, governments, and courts about the prevailing practices and regulatory frameworks governing this complex issue. Assisted suicide raises complex and sensitive issues and, in this report, we provide some suggestions for bests practices and processes for regulating the matter in Alberta.

In the Canadian context, the term "Medical Assistance in Dying" (MAiD) refers to the law that permits eligible individuals to receive assistance in ending their lives. This law encompasses two primary modalities: physician-assisted suicide and euthanasia. Physician-assisted suicide involves a physician prescribing medication that the patient self-administers to terminate their life. This is rare in Canada.

Euthanasia, on the other hand, describes a scenario where a healthcare professional directly administers the lethal substance that leads to the death of the person seeking it. This type represents the majority of assisted suicides in Canada. A distinct form, sometimes known as passive euthanasia, occurs when artificial life support is withheld or discontinued, resulting in the patient's expiration (e.g., removal of feeding tubes, withholding of oxygen, or discontinuation of ventilators), which is outside the scope of this brief.

In 2015, the Supreme Court of Canada case of *Carter v. Canada (Attorney General),*[1] followed by the enactment of Bill C-14 in 2016, marked pivotal moments in Canadian history. Bill C-14 resulted in an exemption to the *Criminal Code* of Canada provisions relating to culpable homicide, the administration of a noxious substance, and aiding suicide, which legalized MAiD for capable, consenting adults who presented as enduring intolerable suffering due to grievous and irremediable medical conditions who faced a “reasonably foreseeable natural death” (RFND) and were otherwise eligible.[2]

The scenario of an individual suffering with intolerable pain and facing certain death is what most Canadians think of when the conversation turns to assisted suicide. However, the introduction by the federal government of Bill C-7 in 2021 greatly expanded eligibility for assisted suicide to people who may no be facing death but have a chronic health condition or disability

Once “Track 1” was expanded, certain safeguards were removed and a new “Track 2” was introduced for those with serious disease, illness or disability, even if the individual was not approaching a natural or foreseeable death and therefore didn’t meet the RFND criteria used for Track 1 MAiD. As well, the plan of the present Canadian government, now delayed, intends to make MAiD available to those solely suffering from a mental illness.[3]

On February 15, 2023, a report, “Medical Assistance in Dying in Canada: Choices for Canadians,” was tabled in the legislature. Of 23 recommendations made in the report, one suggested that euthanasia should be offered to “mature minors” if they are deemed to be facing RFND.[4] The report recommended that the government

[1] *Carter v. Canada (Attorney General)*, 2015 SCC 5 (CanLII), [2015] 1 SCR 331, https://canlii.ca/t/gg5z4
[2] Ss. 241 – 241.4, *Criminal Code*, RSC 1985, c C-46, https://canlii.ca/t/56crs
[3] https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/realities-of-medical-assistance-in-dying-in-canada/3105E6A45E04DFA8602D54DF91A2F568#ref33
[4] https://www.parl.ca/Content/Committee/441/AMAD/Reports/RP12234766/amadrp02/amadrp02-e.pdf

require that parents or guardians of such a minor child be "consulted" during the assessment process for assisted suicide.

The report also suggested the government should, within five years of the date of the report, "undertake consultations" with minors on the topic of assisted suicide, and conduct "research into the views and experiences of minors with respect to MAiD," including "minors with terminal illnesses, minors with disabilities, minors in the child welfare system and Indigenous minors."

This legislative progression not only reflects a shift towards a more permissive approach to end-of-life care and a de-emphasis on easing suffering to allow a natural death, but also raises essential questions about ethical, practical, and legal considerations that must be navigated to ensure both patient autonomy and safety.

As Alberta specifically moves forward with its consultation process regarding assisted suicide, it would do well to explore and ultimately legislate best practices that not only uphold the inherent value of human life of those seeking assistance but also promote stringent regulatory standards to mitigate potential abuses and protect vulnerable populations such as youth, the elderly, the disabled, those living in poverty and/or homelessness, people suffering with both diagnosed and undiagnosed mental illness, and patients with chronic illness. These individuals are at greater risk of feeling pressured to choose death over life due to societal or familial expectations.

Critics of the expansion of MAiD also raise other concerns. The focus on providing lethal options may divert resources away from enhancing pain management, palliative care advancements and supportive care initiatives that could improve quality of life for patients nearing death. The government's focus on providing death may impact the societal and financial supports that should be in place for those who are struggling with poor health, disability, old age, and mental illness.

Understanding the Context

Assisted suicide is a complex and sensitive issue that often arises in the context of terminal illness, chronic pain, or severe poverty, housing, financial, and/or mental health challenges. Many individuals who consider assisted suicide may be experiencing profound feelings of hopelessness, isolation, or despair, and especially depression. It is crucial to recognize that these feelings in an individual can sometimes stem from a lack of adequate societal support rather than an intrinsic desire to end their lives.

Assisted suicide raises profound ethical questions about the value placed on human life and the societal implications of normalizing such practices against life. It creates a dichotomy between those citizens whose suicides which society takes steps to actively prevent and those people society assists in ending their lives, potentially fostering discrimination against certain groups based on their health or disability status or perceived quality of life.

Under the current federal law, two physicians or nurse practitioners are required to agree that an individual can be euthanized. There is no legislation indicating which health care professionals that patients can visit or how many they can visit until they find one that will sign off on the desired euthanasia.

Alberta Review of Regulatory Process with Assisted Suicide

The Alberta Government announced on November 18, 2024, its intention to review assisted suicide policies in the province, including seeking public input on allowing Canadian citizens deemed eligible to have assistance from a medical doctor in ending their life.[5]

There is no legislation in Alberta that deals directly with MAiD. Rather, Alberta Health Services (AHS) has put in place policies to manage MAiD in this province with a view to compliance with the *Criminal Code* exemptions.

Among other things, AHS receives the initial requests for MAiD then sets up MAiD assessments by physicians or nurse practitioners. AHS receives approvals or denials from the health professionals and devises and implements tie-breaking procedures if the unanimous consent of two physicians is not obtained. AHS ultimately arranges for the death to occur at the location specified by the individual seeking MAiD. In some cases, some of those medical professionals involved with and conducting MAiD are employees of AHS and some are not.

At present, there is no specific legislative mandate for the MAiD work conducted by AHS.

Freedoms Advocate is in a distinctive position to provide insights and analysis. We are currently involved in a number of assisted suicide cases that pose critical inquiries regarding human rights around life, including the application and interpretation of the criteria for MAiD**.** These cases involve a constitutional challenge to the Track 2 MAiD process, which examines the validity and enforcement of current regulations permitting assisted suicide for patients who do not have RFND (a foreseeable death), and concerns about the possibility of undiagnosed psychological issues and whether MAiD is being made available to a person who suffers solely from mental illness. One case relates to pressure imposed on a hospital patient by health authorities encouraging MAiD.

These kinds of issues have been before the courts previously. In a notable case from Alberta, a 27-year-old woman residing with her parents sought MAiD, prompting her father to express concerns about her overall health and the possibility of undiagnosed psychological issues.[6]

In that case, no documentation was submitted to the Court by the daughter to clarify how the woman met the qualifications for assisted suicide. Evidence presented in court indicated that she consulted two physicians, with only one agreeing to her eligibility for assisted suicide. The law stipulates that two doctors must concur on an individual's decision to end their life, yet there would appear to be no express prohibition against a patient seeking multiple opinions until they find two physicians who consents to euthanasia. The woman subsequently consulted a third doctor, who granted her approval for assisted suicide.

Evolution of Assisted Suicide Law in Canada

In 2015, the Supreme Court of Canada, in the case of *Carter v. Canada*, ruled that a complete prohibition on assisted suicide and euthanasia as outlined in the *Criminal Code* constituted an unjustifiable infringement on the constitutional rights to life, liberty, and personal security.[7] Subsequently, in 2016, the Canadian Parliament

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[5] https://www.alberta.ca/release.cfm?xID=91369864D2C5B-B19B-A8C2-050F1A7F46D8D27B
[6] https://ici.radio-canada.ca/rci/en/news/2060081/calgary-judge-rules-27-year-old-can-go-ahead-with-MAiD-death-despite-fathers-concerns#:~:text=A%20Calgary%20judge%20has%20issued,parties%20and%20the%20medical%20professionals
[7] https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/14637/index.do

passed Bill C-14.[8] This legislation established an exemption that allows assisted suicide and euthanasia for competent, consenting adults suffering from a serious illness, disease, or disability, provided they are facing a RFND and an irreversible decline in capability, and intolerable suffering, whether psychological or physical.

Year	Legal Status	Details
2016	Legal	Implementation of Bill C-14 allowing medical assistance in dying for eligible individuals.
2019	Legal	Expansion of eligibility criteria to include those suffering solely from mental illnesses postponed for further review. Introduction of Track 2 for individuals not facing RFND.
2021	Legal	Revisions to assisted dying laws, with a focus on providing clear guidelines for healthcare providers.
2022	Legal	Ongoing discussions on expanding eligibility for those with mental health conditions and mature minors.
2023	Legal	Regulatory review of current practices and recommendations for improving accessibility and processes.

In Canada, the terms euthanasia and assisted suicide are collectively known as "Medical Assistance in Dying" (MAiD). Assisted suicide involves a physician providing drugs directly to the patient to self-administer to end their life. Euthanasia, which involves a healthcare provider administering a lethal injection, represents almost every assisted suicide case in Canada.[9]

In 2019, the Superior Court of Québec's *Truchon c. Procureur général du Canada* [10] decision, a single lower court judgement, ruled that RFND was unconstitutional.[11] The government did not appeal the decision. While that case did not deal with mental illness, and the 2015 Supreme Court of Canada *Carter* case explicitly stated it was not ruling on mental illness qualifying for assisted suicide, the federal government subsequently included mental illness as a qualifying diagnosis for euthanasia.[12]

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[8] https://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/p2.html
[9] https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/realities-of-medical-assistance-in-dying-in-canada/3105E6A45E04DFA8602D54DF91A2F568#ref42
[10] *Truchon c. Procureur général du Canada*, 2019 QCCS 3792 (CanLII), https://canlii.ca/t/j4f8t
[11] https://vlex.com/vid/truchon-v-procureur-general-819818681#:~:text=Truchon%20v.-,Procureur%20G%C3%A9n%C3%A9ral%20Du%20Canada%3A%20Superior%20Court%20Of%20Quebec%20Finds%20Limiting,To%20End%20Of%20Life%20Unconstitutional
[12] https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-Where-a-Mental-Disorder-is-the-Sole-Underlying-Medical-Condition.pdf

Thus, the present federal government has eliminated the stipulation that a person's natural death must be reasonably foreseeable and has established a dual-track system for assisted suicide. The new legislation has temporarily excluded individuals who are experiencing only mental health issues, only to allow for a period of consultation and review in response to public outcry.[13] [14]

Bill C-14 was initially intended to allow eligible adults facing RFND and suffering from grievous and irremediable medical conditions to seek assistance in dying, contingent upon a rigorous evaluation process intended to ensure informed consent and mental capacity.

The legal framework mandates a two-physician assessment and a waiting period to safeguard against impulsive decisions, reflecting what may have been an effort at the time to balance individual autonomy with ethical considerations.[15]

Recent discussions around expanding access, such as including individuals with mental health conditions, highlight the evolving nature of this legal framework. As the conversation continues, there remains a critical need for best practices in regulation and oversight to protect vulnerable populations and continue to place a high value on all human life, regardless of illness, disability, mental condition, or living conditions.

In January 2021, three independent international human rights experts expressed concerns to the United Nations regarding the expansion of laws allowing assisted death for individuals with chronic conditions. They warned that this change could lead to a “two-tiered system” in which people with disabilities might feel pressured towards suicide.[16]

The Complication of Altruistic Organ Donation After Euthanasia (ODE)

According to the first international review of assisted suicide in Canada, Canadian patients who opt for euthanasia provide more transplant organs than any other country globally that allows physicians to administer euthanasia.[17]

As of May 2022, eight countries in the world allowed death by “intravenous practitioner-administration of lethal substances,” the type of MAiD compatible with subsequent organ donation. Patients in Canada who decided to end their lives via euthanasia contributed to almost half of the world’s documented organ transplants occurring after euthanasia.[18]

The international review also noted that altruism could become a motivating factor in ending one’s life. There is “risk that knowing how many people their organs could help, will prevent the MAiD patient from feeling absolute freedom to change their mind, right up until the last time they are asked whether they wish to proceed, just before substance administration,” stated the report.

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[13] https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s2
[14] https://www.theglobeandmail.com/canada/article-maid-report-parliamentary-committee/
[15] https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf
[16] https://www.alliancevita.org/en/2021/01/euthanasia-for-the-disabled-un-experts-warn-of-undue-pressure/
[17] https://onlinelibrary.wiley.com/doi/epdf/10.1111/ajt.17198
[18] https://onlinelibrary.wiley.com/doi/epdf/10.1111/ajt.17198

Assisted suicide patients from Canada contributed to almost half of the world's documented organ transplants occurring after euthanasia.

Organ donation after euthanasia "raises some important ethical concerns involving patient autonomy, the link between the request for MAID and the request to donate organs and the increased burden placed on seriously ill MAID patients," added the report.

In Canada in 2021, the most commonly cited situation of "intolerable physical or psychological suffering" reported by patients who wanted assisted suicide was "the loss of ability to engage in meaningful activities (86.3 percent), followed closely by the loss of ability to perform activities of daily living (83.4 percent)," according to a Health Canada report.[19]

In 2016, there were just over 1,000 deaths by euthanasia. That number skyrocketed to 31,644 in total by the end of 2021. In 2021 alone, Canada had 10,064 assisted suicide deaths, surpassing all jurisdictions for yearly reported assisted deaths.[20]

The number of people obtaining assisted suicide was up 32.4 percent in 2021 from 2020, according to Health Canada. Just under half of people chose to have their deaths at home in 2021, roughly 44 percent. There were 12,286 written requests for assisted suicide in 2021, up 27.7 percent from 2020. Of those, 81 percent were provided euthanasia.

The Newest Data on Euthanasia Deaths in Canada

The fifth annual report from Health Canada, published December 11, 2024, summarizes the scope of assisted suicide requests and assessments across the country in 2023. According to the report, over 15,000 individuals received MAiD, representing a 15% increase from the previous year. The data was gathered from physicians, nurse practitioners, pharmacists, MAiD assessors, and pharmacy technicians.[21]

The report provides further details on MAiD applicants, including demographic information and the types of medical conditions prompting requests. It also examines the availability and use of alternative support services or health interventions offered to individuals seeking MAiD.

In 2023, a total of 15,343 people received MAiD out of 19,660 applications made to Health Canada. However, 2,906 applicants died before MAiD could be administered, 496 withdrew their requests, and 915 were deemed ineligible.

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[19] https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2021.html

[20] https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/realities-of-medical-assistance-in-dying-in-canada/3105E6A45E04DFA8602D54DF91A2F568#ref33

[21] https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#:~:text=This%20report%20details%2019%2C660%20reports,496%20individuals%20withdrew%20their%20request)

The report breaks down MAiD recipients by age, gender, medical condition, and socioeconomic status. It also provides provincial-level data, showing that Quebec, Ontario, and British Columbia accounted for the majority of MAiD applications in 2023. Additionally, the report notes a steady increase in the number of medical professionals performing MAiD, with over 2,200 practitioners identified in 2023, up from 1,271 in 2019.

One Vancouver doctor, also running an abortion clinic in that city, told a special parliamentary committee on assisted suicide that she had provided euthanasia for some 430 patients as of May 2022.[22]

60,301 people have died as a result of assisted suicide in Canada since 2016

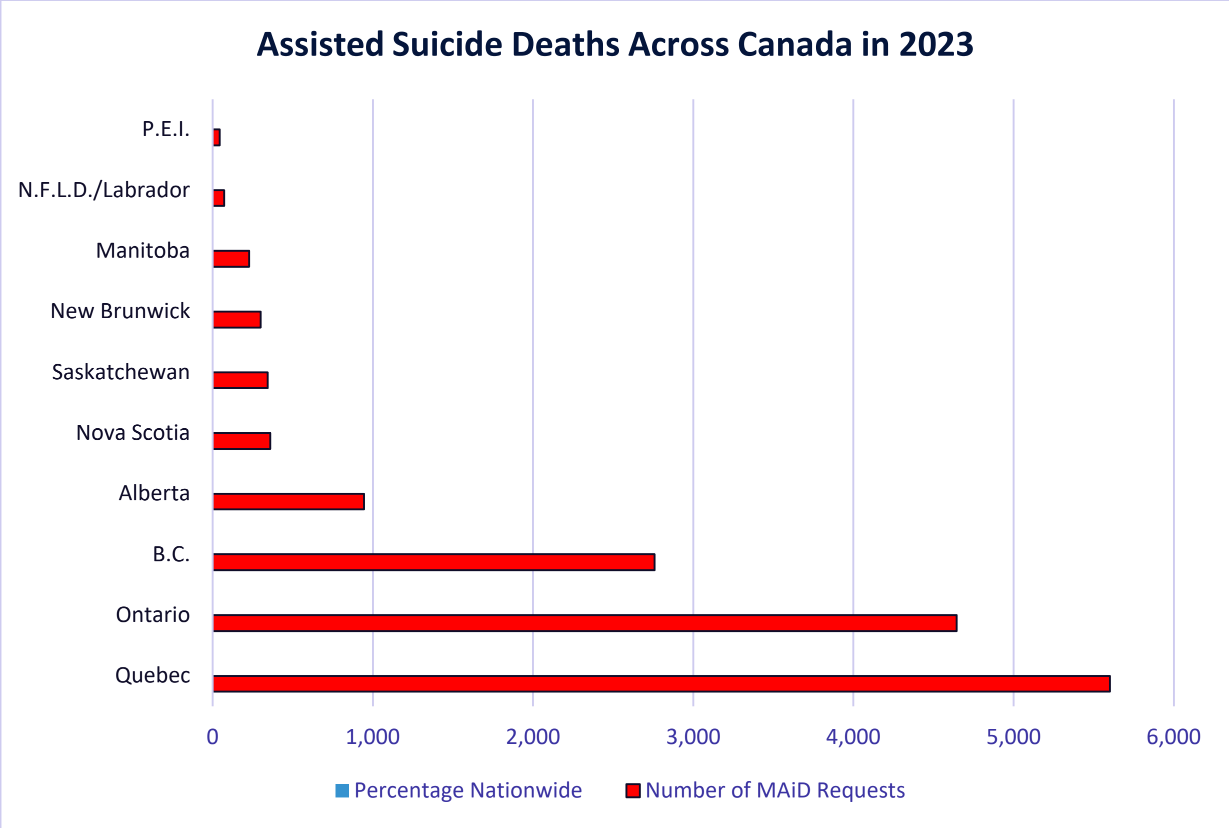
According to Health Canada, applicants for Track 1 had a median age of 77 and were nearly evenly split between men and women, with 52% male and 48% female. A significant majority (64%) of requests in this track came from cancer patients.

The median age for Track 2 applicants was 75, with women accounting for 58.5% and men 41.5%. The most commonly cited underlying medical conditions in this group were neurological conditions and "other" conditions such as diabetes, frailty, autoimmune conditions, and chronic pain. Individuals in Track 2 were also more likely to have a disability compared to those in Track 1, at 58.3% and 33.5% respectively.

The largest age groups represented in Track 2 were 75-84 (29.4%), 65-74 (26.4%), and 85 and older (20.7%). Applicants aged 55-64 made up 12.2% and those 45-54 were 7.2%. This means that 4.1% of Track 2 MAiD recipients (or 629 individuals) were under 45 years of age. No more granular information about the ages of those 629 individuals was provided.

Health Canada's analysis also found that Track 2 applicants were more likely to be from lower income households and "unstable" neighborhoods with higher numbers of renters, apartment buildings, single individuals, and recent movers. Those in lower income areas were more likely to access MAiD, with 24% of Track 1 applicants and 28.3% of Track 2 applicants coming from the lowest income level, compared to 17.8% and 15.8% respectively from the highest income level.

[22] https://nationalpost.com/feature/canada-MAiD-assisted-suicide-doctor



The data on MAiD applications across Canada in 2023 reveals several notable trends. Quebec, with a population in 2023 of about 8.9 million people,[23] had the highest number of MAiD recipients, with 5,601 applicants accounting for 36.5% of all MAiD requests nationwide. Ontario, with a population of about 15.8 million[24] ranked second, with 4,644 people applying for MAiD, representing 30.3% of the total.

British Columbia, with a population of about 5.52 million people[25] came in third, with 2,759 MAiD applications making up 18% of the national total. Alberta, population about 4.7 million,[26] had the fourth highest number, with 944 individuals (6.4%) applying for MAiD.

Nova Scotia, population just over 1 million[27] and Saskatchewan, at 1.22 million roughly,[28] each accounted for a smaller but still significant share, with 359 (2.3%) and 344 (2.2%) applicants respectively. New Brunswick,

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[23] https://www.statista.com/statistics/569873/population-estimates-quebec-canada/#:~:text=This%20statistic%20shows%20the%20estimated,people%20were%20living%20in%20Quebec.
[24] https://www.ontario.ca/page/ontario-population-projections#:~:text=Highlights.%20Highlights%20of%20the%20new%202023%E2%80%932051%20projections,over%2022.1%20million%20by%20July%201%2C%202051
[25] https://www.statista.com/statistics/569885/population-estimates-british-columbia-canada/
[26] https://www.statista.com/statistics/569880/population-estimates-alberta-canada/#:~:text=This%20statistic%20shows%20the%20estimated,was%20about%204.7%20million%20people.
[27] https://novascotia.ca/finance/statistics/archive_news.asp?id=19662&dg=&df=&dto=0&dti=3
[28] https://www.saskatchewan.ca/government/news-and-media/2024/march/27/strong-population-growth-continues

population just over 834,000[29] had 299 MAiD applications, representing 1.9% of the national total, while Manitoba, population roughly 1.23 million,[30] followed with 227 applications (1.5%).

At the lower end, Newfoundland and Labrador, population just over 538,600[31] had 72 MAiD applications (0.5%), and Prince Edward Island, population just over 173,000[32] had the fewest with 44 cases (0.3%). Data from the Yukon and Northwest Territories was not included in the report.

Overall, a total of 60,301 people were provided with death as a result of assisted suicide in Canada since 2016, according to Health Canada.

Small Number of Health Care Providers Dominate MAiD Volumes

The newest data also revealed that a small group of 89 practitioners was responsible for a disproportionately high volume of MAiD cases, accounting for 35.1% of Track 1 applications and 28.6% of Track 2 cases in Canada. Additionally, 73.2% of Track 2 cases were approved by just two practitioners without seeking input from a third assessor. This data suggests a trend of MAiD services being concentrated among a relatively small number of medical professionals, which may raise questions about equitable access and oversight of this sensitive and ethically complex procedure.

In 2022, there were 1,837 doctors and nurse practitioners participating in assisted suicide deaths.[33]

The report found that the number of medical professionals authorized to perform MAiD had nearly tripled between 2019 and 2023. According to Health Canada, there were 2,200 MAiD practitioners in 2023, with 94.5% being physicians and 5.5% being nurse practitioners. This represented a significant increase from just four years earlier, when there were 1,271 MAiD practitioners.

Under the *Criminal Code*, a medical professional engaging with MAiD must be "independent" which is defined as: (a) not being a mentor to the other practitioner who is involved on the particular MAiD case, and not responsible for supervising their work; (b) not knowing or believing that they are a beneficiary under the will of the person making the MAiD request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; and (c) not knowing or believing that they are connected to the other practitioner or to the person making the request for MAiD in any other way that would affect their objectivity.[34]

There remains a question as to whether a medical practitioner who is associated with an organization which supports MAiD and its expansion would meet the *Criminal Code* independence requirements.

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[29] https://www.statista.com/statistics/569871/population-estimates-new-brunswick-canada/#:~:text=This%20statistic%20shows%20the%20estimated,people%20living%20in%20New%20Brunswick.
[30] https://www.gov.mb.ca/mbs/publications/mbs501_pop_2023_a01.pdf
[31] http://www.citypopulation.de/en/canada/cities/newfoundland/#:~:text=*%20538%2C605%20Population%20[2023]%20%E2%80%93%20official%20estimate.,0.28%%20Annual%20Population%20Change%20[2017%20%E2%86%92%202023]
[32] https://www.princeedwardisland.ca/en/information/finance/pei-population-report-quarterly
[33] https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html
[34] s. 241.2 (6) *Criminal Code*, RSC 1985, c C-46, https://canlii.ca/t/56crs

Further, a medical professional who evaluates a patient for assisted suicide is often the same professional who carries out the actual MAiD death procedure. Depending upon how the compensation for services is structured, this dual role can raise concerns about impartiality and the potential for conflicts of interest, as the same physician who assesses a patient's eligibility for assisted suicide (and is compensated for it) may also have a direct hand in the process of administering it (and being compensated again for that).

In recent months, it has become apparent that certain vulnerable populations are disproportionately offered MAiD, emphasizing the necessity for continuous evaluation and adaptation of the regulatory framework to enhance both its efficacy and ethical integrity.[35] [36] [37] [38]

Additional Ethical and Regulatory Considerations in Assisted Suicide

The expansion of assisted suicide legislation in Canada presents significant ethical and regulatory implications, particularly as it now encompasses not only terminal illnesses but also non-terminal conditions causing intolerable suffering, and proposes to add those suffering from mental illness in the near future.

As stipulated in Bill C-7, the eligibility criteria have shifted, allowing individuals whose natural death is not reasonably foreseeable to seek euthanasia, thereby raising profound ethical questions about suffering and autonomy.[39]

Critics argue that this liberalization risks a slippery slope, potentially undermining the inherent dignity of life and pressuring vulnerable individuals to pursue assisted death as a solution to their suffering.[40]

However, those in favour of euthanasia assert that individuals should have the right to make informed choices regarding their own suffering and end their life if they wish.

Ultimately, the effectiveness of any regulations hinge on robust safeguards that ensure informed consent and prevent coercion as well as serve to uphold and implement the law.

The ethical considerations surrounding assisted suicide in Canada necessitate a careful examination of who is being offered assisted suicide and if they disproportionately represent those at a socio-economic and health disadvantage.

Ontario has implemented an oversight system for MAiD through the Office of the Chief Coroner (OCC) that provides some useful data for that province.[41]

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[35] https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/14637/index.do
[36] https://www.theepochtimes.com/world/sask-senior-says-MAiD-presented-as-option-when-considering-cost-of-palliative-care-5771483
[37] https://www.theepochtimes.com/world/man-with-post-vaccine-syndrome-granted-euthanasia-ontario-MAiD-report-5747370
[38] https://www.theepochtimes.com/world/MAiD-recipients-often-reside-in-poorer-neighbourhoods-ontario-reports-5746527
[39] Anna Vargo. "Death with Dignity in Canada". Voices in Bioethics, 2022, https://www.semanticscholar.org/paper/3da630c7d2dd2f0e776818b824febd75b7f40e37
[40] Catherine Frazee, H. Chochinov. "The Annals of Medical Assistance in Dying". Annals of Internal Medicine, 2016, https://www.semanticscholar.org/paper/aae555b9eb5394a851e17b6b47546be85503f626
[41] https://arpacanada.ca/ontario-MAiD-death-review-committee-reports-2024/

A recently released report released by OCC indicates lower income Canadians with housing issues are more likely to obtain assisted suicide. In some cases, social conditions such as isolation, or living in areas with high levels of marginalization, were factors in individuals opting to end their life.

In one case highlighted by the committee preparing the reports, a man in his 40s was approved for assisted suicide with a diagnoses of inflammatory bowel disease. The man reported alcohol and opioid use but was not offered addiction treatment. Another woman in her 50s who could not find housing to accommodate a medical condition of severe chemical sensitivities reported suffering from social isolation and decided to end her life.

The report indicated that more 400 euthanasia cases were carried out despite individuals not meeting the necessary criteria. Additionally, a position paper from the BC Palliative Care Association contends that advancements in pain management have rendered euthanasia unnecessary, instead offering effective and compassionate end-of-life care.[42]

Central to this debate is the principle of respect for patient autonomy, with proponents asserting that individuals should have the right to make informed decisions about their own end-of-life care. However, by 2026, Canada may allow those who suffer only a mental illness, and no physical health conditions, to access assisted suicide. The proposed legislation has been postponed twice following significant opposition from disability advocates.[43] The next step could be for the government to consider expand the practice of assisted suicide to children or at least mature minors. This has happened in other countries as part of the progression of euthanasia permissiveness.

In September of 2024, several disability rights organizations filed a legal Charter challenge to MAiD accusing the government of abandoning those with disabilities and failing to provide adequate social supports.[44]

The group informally known as the “coalition” includes Inclusion Canada, DAWN-RAFH Canada DisAbled Women’s Network Canada/Réseau d’action des femmes, Indigenous Disability Canada, and Council of Canadians with Disabilities (CCD), as well as two individual plaintiffs, say Track 2 assisted suicide is discriminatory.

“Under Track 2 MAiD, people with disabilities are the sole group offered assisted suicide when their death is not reasonably foreseeable. Allowing assisted dying based solely on disability sends a harmful message that the lives of people with disabilities are less valuable, undermining our ongoing efforts toward inclusion and respect,” said the coalition on Oct. 2, 2024.[45]

The lawsuit asks the court to strike down Track 2 MAiD, arguing that the law has a direct negative impact on those with disabilities or who seek assisted suicide due to social deprivation, poverty, and lack of essential social supports.

Assisted suicide also raises ethical considerations, when the intention behind assisted suicide, ending a patient’s life, intersects with the medical imperative to “do no harm.”

[42] https://bc-cpc.ca/wp-content/uploads/2019/10/Grey-BCPC-Clinical-Best-Practices-2-Pain.pdf
[43] https://www.theglobeandmail.com/canada/article-maid-report-parliamentary-committee/
[44] https://inclusionalberta.org/connections/coalition-launches-charter-challenge-of-track-2-MAiD/#:~:text=The%20coalition%20is%20urging%20the,%E2%80%9CPeople%20are%20dying
[45] https://inclusionalberta.org/connections/coalition-launches-charter-challenge-of-track-2-MAiD/#:~:text=The%20coalition%20is%20urging%20the,%E2%80%9CPeople%20are%20dying

Yuna Lee, a prominent figure in discussions surrounding end-of-life care, has articulated her views on the distinctions between assisted suicide and palliative care. Her insights are particularly relevant in the context of ongoing debates about patient autonomy, ethical considerations in healthcare, and the role of medical professionals in end-of-life decisions.[46]

Emphasizing intent, as seen in discussions surrounding palliative sedation, highlights that while both euthanasia and palliative care practices aim to alleviate suffering and provide comfort and quality of life without hastening death, the primary objective of assisted suicide is to voluntarily end life as a response to suffering, differing significantly from the ethical justifications of palliative care interventions, according to the bioethicist.[47]

The ethical dilemmas surrounding assisted suicide in Canada also invoke profound considerations for both healthcare providers and patients. There is tension between the medical Hippocratic Oaths directives to do no harm and the growing societal push for patient autonomy, which mandates respecting individuals' rights to make decisions about their own suffering, even if that means choosing death at the hand of medical professionals.

Moreover, the increasing integration of artificial intelligence in healthcare poses additional ethical challenges, such as ensuring algorithmic fairness and protecting patient privacy.[48] One significant effect of AI integration in assisted suicide is its ability to enhance decision-making processes. AI systems can analyze vast amounts of data quickly, providing insights that may assist physicians in evaluating requests for euthanasia or physician-assisted suicide. For instance, AI can help identify patterns in patient histories or assess compliance with legal criteria established under laws, however there are moral implications of allowing machines to participate in such deeply human decisions. Reliance on AI might dehumanize the process or lead to decisions driven by algorithms rather than compassionate care.[49]

As patients navigate the emotional complexities of terminal illness, they confront societal stigma and personal moral beliefs, which can influence their preferences for assisted dying.[50]

The interplay of these ethical dimensions underscores the crucial need for best practices in the regulation of assisted suicide to foster a compassionate and responsible healthcare environment.

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[46] https://philpapers.org/rec/LEECCU
[47] Consciously Choosing Unconsciousness". Voices in Bioethics, 2024, https://www.semanticscholar.org/paper/b549afbb3983ab2a3151e51ce7ae296948448179
[48] https://journal.iistr.org/index.php/JPHS/article/download/215/148
[49] https://pubmed.ncbi.nlm.nih.gov/10979056/
[50] https://pubmed.ncbi.nlm.nih.gov/10979056/

Proposed Suggestions for Oversight and Regulatory Framework

Proposed Suggestions for Oversight and Regulatory Framework

A Systematic Approach to Safeguards

The discourse surrounding assisted suicide in Canada necessitates a careful balance between ethical considerations and regulatory frameworks to ensure the safety of vulnerable populations. There is insufficient data collection in many cases without mechanisms to monitor and evaluate assisted suicide practices.

Many Canadian jurisdictions have no review process for MAiD until after a patient has been euthanized, if at all. Even if family members, concerned with the provision of assisted suicide to their loved one, file a formal complaint, it may be handled through a provincial or territory regulatory college for physicians or nurses, and there may be no legal or criminal penalties even if polices were not followed properly.

Quebec established a Commission on End-of-Life Care that oversees MAiD in 2014, after the passing of *Bill 52, An Act respecting end-of-life care*. It referred some 38 cases from 2021 to 2023 to the province's regulatory college for physicians.[51] In 16 of the assisted suicide cases flagged, the End-of-Life Care commission suggested the patient did not have a serious and incurable illness. However, critics have suggested that the findings of the commission have not led to a measurable impact on decisions to approve a patient for MAiD, indicating a disconnect between clinical assessments and the practical application of MAiD crtieria in healthcare settings.

The president of the Quebec physician regulatory college responded to critics by saying that more than 99 percent of MAiD deaths were administered according to regulations and that the college would not allow anything to discourage physicians from administering MAiD.[52]

Safeguards in Other Jurisdictions with Assisted Suicide Laws

Spain implemented law, as of March 25, 2021, that implements several robust safeguards to protect vulnerable citizens who might seek out assisted suicide. Patients must be fully aware and conscious when making their request, and must suffer from a serious or incurable disease or a serious chronic condition that leads to intolerable suffering.[53]

The patient must submit a clear written request indicating they want to end their life. There is a mandatory 15-day waiting period before the patient can submit a second request. Once the second request is submitted, it is forwarded to a regional commission composed of at least seven members, including medical, legal, and nursing experts. This commission reviews the application to ensure all criteria are met and assesses whether the patient's suffering meets the legal standards for assisted dying.[54]

The regional commission appoints two professionals who have no prior connection to the case to evaluate the application independently. Their role is to provide an unbiased assessment of whether the patient's situation aligns with the eligibility criteria.

If the patient is considered not eligible, the file is sent to a commission for review by a different physician and a lawyer. If those two individuals do not agree, the request for euthanasia goes to an evaluation committee.[55]

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[51] https://policyoptions.irpp.org/magazines/december-2024/assisted-dying-oversight/
[52] https://www.cmq.org/en/news/mise-au-point-le-college-repond-a-la-commission-sur-les-soins-de-fin-de-vie
[53] https://www.boe.es/eli/es/lo/2021/03/24/3
[54] https://www.boe.es/eli/es/lo/2021/03/24/3
[55] https://www.boe.es/eli/es/lo/2021/03/24/3

Interestingly, Spain has also taken steps to protect conscience rights of medical providers, stating that any physician can withdraw on grounds of "conscience" from taking part in assisted suicide.

Those who do assist with euthanasia are legally required to carry out a "deliberative process" on diagnosis, "therapeutic possibilities and expected results, as well as possible palliative care." Patients are required to receive comprehensive information about their medical condition and available alternatives before proceeding with their requests for assisted dying.

Both Belgium and Netherlands euthanasia law emphasizes that physicians should discuss all possible treatment options with the patient.[56] Cases are reviewed by independent review commissions to ensure the deaths comply with legal protocols and ethical standards, however the reviews take place after the fact.[57]

Belgium is one of the most permissive countries in the world when it comes to euthanasia. That country allows foreigners to travel there to obtain assisted suicide creating in effect an assisted suicide tourism sector.[58]

Austria has allowed assisted suicide since 2021 for adults without mental health conditions who have a diagnosis and are mentally competent.[59]

The country of Columbia has allowed euthanasia for terminally ill patients since 2014 and in 2016, approved children over six for assisted suicide. Children over the age of 14 do not require parental consent. By 2022, Columbia allowed patients with severe health conditions that "patients consider a threat to their dignity," to receive euthanasia, even if the condition was not terminal.[60]

As of December 2023, no known jurisdiction or country in the world has implemented a formalized dispute mechanism specifically designed for families or other parties contesting MAiD decisions made by eligible patients. The prevailing legal frameworks up until now have heavily emphasize patient autonomy and informed consent over familial objections and other ethical considerations.

If Alberta were to implement a formalized dispute mechanism concerning MAiD decisions, it would indeed be pioneering in this regard. Such an initiative could involve creating guidelines that allow family members to formally express their concerns, while ensuring that these processes do not infringe upon the rights of terminally ill individuals experiencing profound unbearable suffering to seek out options for a comfortable death.

This proposed mechanism could take various forms:

Mediation Services: Establishing mediation services where families can discuss their concerns with healthcare providers and ethicists before any final decision is made.

Review Panels: Creating independent review panels composed of medical professionals and ethicists who could assess contested cases. A review panel or ombudsperson could be a critical participant in providing an avenue for families to seek clarification or appeal decisions they believe may not align with the individual's true wishes.

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[56] https://www.ejustice.just.fgov.be/cgi_loi/loi.pl?cn=20020128&la=fr
[57] https://www.government.nl/topics/euthanasia
[58] https://theweek.com/health/assisted-dying-euthanasia-world
[59] https://www.bbc.com/news/world-europe-59847371
[60] https://colombiareports.com/colombia-legalizes-assisted-suicide-in-historic-ruling/

Legislative Frameworks: Developing legislative frameworks that outline clear procedures for addressing disputes while maintaining respect for patient autonomy.

Despite the international gap in specific mechanisms for family dispute resolution regarding a patient's decision to obtain assisted suicide, it is clear from the Ontario reports that assisted suicide best practices must be implemented through rigorous evaluation of both existing legislation and emerging clinical practices in palliative care. This should reflect the cooperative efforts seen in other health fields, particularly those demonstrated by interagency strategies in military suicide prevention.[61]

As the landscape of assisted suicide continues to evolve, informed policy development—driven by scientific insight, solid data, and stakeholder engagement—will be imperative.

The Role of Pain, Fear, and Isolation in Assisted Suicide Requests

Many patients contemplating assisted suicide may be living with issues such as:

- Chronic Pain Management: Inadequate pain control can lead to feelings of hopelessness.
- Mental Health Concerns: Depression or anxiety may exacerbate suicidal thoughts.
- Social Isolation: Lack of social connections can intensify feelings of loneliness.

One of the most significant factors influencing patients' decisions to seek euthanasia is the experience of intolerable pain. Research indicates that pain is not merely a physical sensation but encompasses emotional and psychological dimensions that contribute to a patient's overall perception of suffering.

Pain as a Major Factor in Euthanasia Requests

According to a nationwide survey conducted in Belgium following the legalization of euthanasia, approximately 44 percent of euthanasia requests were associated with the presence of pain.[62] This statistic highlights the critical role that pain plays in end-of-life decision-making. Patients facing terminal illnesses often report that uncontrolled or severe pain significantly diminishes their quality of life, leading them to consider euthanasia as an option for relief.
Pain can manifest in various forms, including acute pain from disease progression or chronic pain due to treatment side effects. The complexity of managing such pain often leaves patients feeling helpless and desperate for solutions. Consequently, when traditional palliative care measures fail to provide adequate relief, some patients may view euthanasia as a viable alternative.

Fear of Future Suffering

In addition to current physical symptoms, fear plays a crucial role in the decision-making process regarding euthanasia. A study focusing on terminal cancer patients revealed that concerns about future suffering were among the most significant issues faced by these individuals. Patients expressed fears not only about potential physical pain but also about losing control over their lives and experiencing a decline in dignity.[63]

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[61] https://academic.oup.com/milmed/article/189/Supplement_3/357/7735879
[62] https://pubmed.ncbi.nlm.nih.gov/21570807/
[63] https://pmc.ncbi.nlm.nih.gov/articles/PMC4292985/

This fear is compounded by the uncertainty surrounding disease progression and the potential for unbearable symptoms as death approaches. The anticipation of suffering can lead patients to seek control over their circumstances through euthanasia, viewing it as a means to avoid an uncertain and potentially painful future.

Loss of Control Over One's Life

Another critical aspect highlighted in the cancer euthanasia study was the loss of control experienced by terminally ill patients. Many individuals facing serious illnesses feel that they are no longer able to dictate their own lives or make choices regarding their care. This perceived loss can lead to feelings of despair and hopelessness, prompting some patients to consider euthanasia as a way to reclaim agency over their situation.[64]

The interplay between fear, pain, and loss of control creates a complex emotional landscape for patients at the end of life. It underscores the importance for healthcare providers to address not only physical symptoms but also psychological and existential concerns when discussing end-of-life options with patients.

Waiting Periods

One critical aspect of the euthanasia process is the implementation of waiting periods. These waiting periods serve multiple purposes that are crucial for ensuring that the decision is made thoughtfully and responsibly including:

Reflection and Deliberation: Waiting periods provide patients with the necessary time to reflect on their decision. This is especially important given the circumstances often surrounding euthanasia requests, such as terminal illness or severe pain. A period of reflection can help ensure that the decision is not made impulsively but rather is the result of careful consideration.

Assessing Mental Competence: The decision to opt for euthanasia must come from a place of informed consent. Waiting periods help healthcare providers assess the patient's mental competence over time. Conditions like depression or temporary psychosocial distress can influence a person's desire to choose euthanasia, and a waiting period allows for further evaluation of mental health.

Exploring Alternatives: During a mandatory waiting period, patients may have the opportunity to explore other palliative care options that could alleviate their suffering. This exploration can include consultations with medical professionals specializing in pain management or mental health. It ensures that patients are fully aware of all available options before making a definitive choice.

Family Considerations: Euthanasia decisions can affect not just the individual but also their family and loved ones. Waiting periods allow families to engage in discussions, express their feelings, and potentially reach a consensus on the best course of action. Family involvement can provide emotional support to the patient as they navigate this difficult decision.

Legal and Ethical Oversight: Implementing waiting periods allows for adequate legal and ethical oversight within the euthanasia process. It is ideal with a framework that includes a review board. It ensures adherence to established protocols and safeguards against hasty decisions that could lead to unintended consequences. This scrutiny can encourage adherence to the principles of autonomy, beneficence, and non-maleficence.

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[64] https://pubmed.ncbi.nlm.nih.gov/10979056/

Multi-Disciplinary Assessments

In examining the best practices and future legislative and regulatory recommendations for assisted suicide in Alberta, it is essential that future law mandate standardized protocols. A comprehensive assessment process should be established to evaluate an individual's mental and emotional health before they can access assisted dying services.

Regulation could mandate that healthcare providers conduct thorough assessments involving family members and significant others where appropriate or at least require the matter to be addressed with the patient in order to identify these underlying issues. This might require a team approach with mental health professionals, pain specialists, or social workers who can provide additional insights into the patient's situation. The stipulation that the physician providing the approval for euthanasia must not be the same practitioner performing assisted suicide could be an additional layer of safeguard and protection.

Any assessment should favour a multidisciplinary approach, including physicians, psychologists, pastors, and social workers, to encompass the individuals social, religious, physical, and emotional needs, ensuring that underlying issues such as isolation, poverty, homelessness, depression, anxiety, or other psychological conditions do not unduly influence a person's decision to die.

Once underlying issues are identified, to the greatest extent possible having regard to available resources, it is crucial to offer comprehensive support tailored to the patient's needs. This could include:

Pain Management Programs: Implementing effective pain management strategies can significantly improve quality of life for those suffering from chronic conditions.

Mental Health Services: Access to counseling or psychiatric care can help address mental health concerns that contribute to suicidal ideation.

Social Support Networks: Encouraging participation in community groups or support networks can alleviate feelings of isolation. Connecting patients with peer support groups or community resources fosters a sense of belonging.

Educating Patients About Alternatives: Patients considering assisted suicide may not be fully aware of the alternatives available to them. Education plays a vital role in this process.

Discussing Palliative Care Options: Informing patients about palliative care services that focus on comfort rather than curative treatment can shift their perspective on living with illness.

Exploring Life-Affirming Choices: Highlighting activities that promote well-being—such as hobbies, volunteer work, or family engagement—can encourage patients to find meaning in life despite their challenges.

Involving Family and Community: Encouraging the involvement of family members and friends in discussions about care options can enhance support for the patient.

Family Counseling Sessions: Encouraging these sessions can help families understand the patient's struggles while also educating them on how best to provide emotional support.

Community Resources: Connecting families where they are involved with local resources (e.g., respite care services) allows them to share caregiving responsibilities and reduce caregiver burnout.

Continuous Follow-Up: Routine follow-up appointments are vital for closely monitoring the patient's condition, evaluating the effectiveness of their care plan, and making necessary adjustments over time. This continuous provider-patient relationship helps foster a sense of support and stability for the patient throughout their treatment journey.

Mental Health Status Checks: Regular assessments by mental health professionals can help track changes in mood or outlook.

Adjustments in Care Plans: As circumstances change (e.g., progression of illness), care plans should be revisited and modified accordingly.

By implementing these steps systematically, healthcare providers can create an environment where patients feel supported and valued, potentially reducing the inclination toward patients choosing assisted suicide for social and mental issues rather than unbearable physical suffering.

Preventing "Doctor Shopping"

The known practice of "doctor shopping" where patients go through three, four, five or more doctors until they find someone to sign the approval for euthanasia is also an area to address through law and policy. When assisted suicide was first legalized in Canada, the public was assured that stringent guidelines and protocols would be implemented to ensure that patients met specific criteria before receiving assistance in ending their lives, such as two independent doctors signing their approval. However, in practice, when a patient is denied assisted suicide, there exists a risk that they may seek out other healthcare providers who might be more amenable to fulfilling their requests—a phenomenon commonly referred to as "doctor shopping."

This actually occurred in a recent case. A patient suffering with a mental illness was denied MAiD in Alberta but then travelled to British Columbia and secured the approval of two different doctor. The legal documents state that when her MAiD application was turned down by a medical team in Alberta, she contacted B.C. Dr. Ellen Wiebe, a well-known assisted dying advocate and euthanasia provider.[65]

Preventing this behavior requires a multifaceted approach involving legal, ethical, and medical considerations and robust regulations for health care providers. This might include mandatory reporting of euthanasia requests. Healthcare providers could be required to report instances of patients seeking assisted suicide. This could involve creating a centralized database where all requests for assisted suicide are logged. If a patient approaches multiple doctors within a certain timeframe, this information can trigger an alert for further investigation. If certain physicians consistently approve every assisted suicide request and these ultimately trigger disputes, that may also call for further investigation.

Regulations could stipulate that patients seeking death can only approach two physicians who must reach a unanimous consensus. Should one doctor not concur, the case may be referred to a broader committee for review, or the patient could put forward a new application based on a change of circumstances.

Effective communication among healthcare providers is also crucial in preventing doctor shopping. Legal measures could include the establishment of legal penalties for physicians who knowingly assist patients in circumventing existing laws regarding assisted suicide can deter unethical practices. Creating informed consent laws and ensuring those are strictly followed helps protect both patients and physicians by ensuring that all parties understand the implications of requesting or providing assistance in dying.

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[65] https://globalnews.ca/news/10838852/bc-judge-halts-alberta-womans-maid/

Standardized Assessment Protocols

Implementing standardized assessment protocols is a critical component in the process of evaluating patients who are considering assisted suicide. These protocols would be designed to ensure that every patient undergoes a consistent and comprehensive evaluation, which is essential for making informed decisions regarding their end-of-life options.

The assessment process could include several key components:

Comprehensive Medical Evaluation: Patients must undergo a thorough medical examination to assess their physical health status and any underlying medical conditions that may affect their decision-making capacity or prognosis.

Psychological Evaluations: A crucial aspect of the assessment involves psychological evaluations conducted by qualified mental health professionals. Mental health assessments often include structured interviews, standardized questionnaires, and clinical observations. These evaluations aim to identify any mental health conditions, such as depression, anxiety, or other psychiatric disorders, that could impair the patient's ability to make rational and autonomous decisions about assisted suicide. Current approaches to medical capacity set a very low bar which may not be appropriate in assisted suicide applications specifically involving mental illness.

Informed Consent Process: Patients must be provided with detailed and comprehensive information about the procedure, potential outcomes, and alternatives to assisted suicide. This ensures that they can make an informed choice free from coercion or undue influence. Policies should consider ensuring that this information is supplied by physicians other than those who are involved in the MAiD approval process.

Evaluation of Decision-Making Capacity: Assessors must evaluate whether the patient possesses the cognitive ability to understand the nature and consequences of their decision regarding assisted suicide. This includes assessing their ability to appreciate their situation, reason about treatment options, and communicate a choice consistently over time. Regulations could consider whether the standard for assessing capacity in the context of MAiD should be more stringent and whether current assessors have adequate training and experience, specifically mental health experience, and potentially implement a consistent, standardized training program for assessors.

Documentation and Follow-Up: All findings from these assessments should be meticulously documented in the patient's medical records. Follow-up appointments may also be scheduled to reassess the patient's condition and decision-making capacity if there are concerns about changes in mental health status.

Review Boards

To further safeguard against potential abuses in the assisted suicide process, independent review boards play a vital role as impartial arbitrators before granting approval for such procedures. These boards typically consist of a diverse group of professionals which could include independent physicians who do not participate in performing assisted suicides, legal experts familiar with healthcare law and ethics, and community members representing public interests. This diversity helps ensure that multiple perspectives are considered during deliberations.

The primary function of these review boards would be to assess and evaluate each case thoroughly before any assisted suicide can be authorized. The board would evaluate whether all necessary assessments have been completed according to established protocols and whether the patient meets all legal requirements for eligibility.

Review boards would also consider ethical implications surrounding each case, ensuring that patients' rights are respected while balancing societal values regarding life and death decisions.

The board would have the ability to engage in discussions based on evidence presented during assessments, including medical reports and psychological evaluations. They could also interview patients or family members if deemed appropriate or necessary for clarity on specific issues related to consent or understanding.

After careful consideration, review boards could provide recommendations regarding whether or not to proceed with assisted suicide requests based on established criteria and ethical guidelines.

By implementing standardized assessment protocols alongside independent review boards, healthcare systems can create a more robust framework for evaluating requests for assisted suicide while prioritizing patient safety and ethical integrity.

Communication and Education for Patients

Other considerations include establishing secure communication channels between healthcare providers to help share relevant patient information while respecting privacy laws. If one provider denies a request for assisted suicide, other local providers would be able to access information about the patient's history and reasons for denial if they were contacted for consultation.

Educating patients about the criteria and processes involved in assisted suicide would also help manage patient expectations and reduce the likelihood of individuals seeking alternative providers without understanding the underlying reasons for denial.

Physician Conscience Rights and Mandated Training

Given the ethical issues that can arise for medical professionals regarding MAiD and their call to "do no harm", physicians should be expressly permitted by law not to participate in the MAiD process if they so choose, either for reasons of religion, conscience or creed.

It is essential to mandate training and certification for physicians involved in Medical Assistance in Dying (MAiD). Worldwide, there is no universally mandated training program. The profession in Canada is largely self-managed and the providers performing assisted suicide have created their own association, Canadian Association of MAiD Assessors and Providers (CAMAP). In September 2023, the federal government allowed CAMAP to release their own training program.

The curriculum requires approximately 13 hours of online self-study and 14 hours of facilitated sessions. When MAiD providers develop their own training programs, there is a risk that personal biases and subjective interpretations of the law as well as personal ideologies may influence the content and delivery of training. This could result in providers being inadequately prepared to navigate complex ethical dilemmas or to assess patient eligibility accurately.

If providers create their own training without external validation or accreditation from recognized medical organizations or regulatory bodies, it becomes challenging to ensure that all practitioners are adequately qualified.

A standard government training and certification requirement will ensure that these professionals are thoroughly knowledgeable about the ethical and practical considerations necessary to fulfill all established

criteria. Additionally, it will address the intricate issues associated with concurrent organ donation and the role of artificial intelligence within the framework of MAiD.

Training programs that are not standardized may fail to prepare providers adequately for these complexities. For example, issues related to mental health assessments or determining whether a patient's suffering is intolerable can vary widely among individuals; thus, insufficiently trained practitioners might struggle with these nuanced evaluations.

Implementing Ethical Guidelines

Ethical considerations play a significant role in managing requests for assisted suicide. Hospitals and clinics should have ethics committees that review cases of both denied and approved requests for assisted suicide. These committees can provide guidance on how to handle such situations ethically and ensure consistent application of policies across different providers plus make ongoing recommendations to ensure transparency and standards are maintained.

Providing access to counseling services could help address underlying issues that may lead patients to seek assisted suicide. Mental health support can be critical in helping patients cope with their conditions rather than pursuing potentially harmful options.

Monitoring and Evaluation

Ongoing monitoring and evaluation of practices surrounding assisted suicide are vital:

Data Collection: Collecting data on requests for assisted suicide, including denials and subsequent attempts at obtaining assistance from other providers, allows authorities to identify patterns or trends indicative of doctor shopping.

Policy Review: Regularly reviewing policies related to assisted suicide ensures they remain effective in preventing abuse while still respecting patient autonomy. By implementing these strategies collectively, healthcare systems can significantly reduce the incidence of doctor shopping among patients denied access to assisted suicide while maintaining ethical standards and protecting vulnerable individuals.

Compliance Audits: Conducting regular audits to ensure compliance with established protocols and legal requirements.

Structured Intervention Process

The topic of assisted suicide often brings about complex emotions and ethical considerations, especially for family members concerned about the well-being of their loved ones. To address these concerns, a structured intervention process could be established, focusing on open communication, transparent processes, comprehensive assessments, and support systems. Family involvement in the evaluation process should be encouraged, allowing loved ones to voice their concerns and share their insights about the person's condition and wishes, and engage in facilitated discussions with healthcare professionals who are trained in palliative care and mental health.

These discussions should aim to address the loved one's pain management, psychological state, and overall quality of life, ensuring that their needs and preferences are thoroughly understood and respected.

Conclusion

It is essential that the Alberta Government directly address MAiD issues and process by implementing clear, concise policies and legislation to fill the current void, which is currently being addressed by AHS through its own internal policies apparently without direct government oversight.

The regulation of Medical Aid in Dying (MAiD) is crucial for several reasons, primarily focused on ensuring patient safety, preventing abuse, and maintaining ethical standards within the healthcare system. MAiD cases can often be complex due to varying medical conditions and psychological factors involved.

Regulations that differ across jurisdictions create risk with lack of standardization, potential bias, insufficient patient-centered focus, challenges in regulatory oversight, inadequate preparation for complex cases, and ethical implications surrounding accountability.

One of the primary concerns surrounding MAiD is the potential for abuse, particularly among vulnerable populations such as the elderly or those with disabilities. Heavy regulations can mitigate these risks by implementing strict eligibility criteria and procedural safeguards.

Furthermore, strict mandatory waiting periods and counseling resources could provide individuals with the opportunity to reflect on their choices and to consult with family members or support systems, thereby fostering a more informed decision-making process and the implementation of great social supports.

In addition to mental health evaluations, transparent reporting and oversight by an independent regulatory body with ultimate power to confirm or deny a MAiD request are critical to monitor the administration of assisted suicide. This body should regularly review cases in advance of the MAiD procedure, ensuring adherence to established guidelines while also having the authority to investigate complaints or incidents of potential abuse.

A mechanism should be implemented to assist with disputes and concerns of family members and interested parties who may be acting in the interests of protection of a vulnerable family member. Implementing an appeals process for individuals who feel they were unfairly denied access to assisted dying can also help bolster confidence in the system, providing a vital check against any potential discriminatory practices. An appeals process should also be in place for family members who are concerned about their loved one seeking assisted suicide.

Increasing public transparency by releasing anonymized data on the demographics of individuals who choose assisted suicide could effectively enhance accountability and highlight trends that deserve closer investigation. It is clear that ongoing data collection and statistical reporting are crucial for recognizing trends and addressing significant issues.

Community engagement efforts to educate the public about the implications of assisted suicide can also empower vulnerable populations, such as individuals with disabilities or those from marginalized backgrounds, ensuring that they are informed and have access to alternatives to assisted dying. These individuals may be at risk of making impulsive decisions about ending their lives due to temporary suffering or lack of support.

As such, specific protections must be established for those who may experience societal pressures, such as elderly individuals, the disabled, those with mental health issues and patients suffering from chronic illness. Clear legal provisions should safeguard against coercion, ensuring that individuals can make decisions free from external influences such as financial concerns or caregiver pressures.

By embracing a framework that prioritizes the health, dignity, and autonomy of all individuals, Alberta can responsibly navigate the complex landscape surrounding assisted suicide while mitigating risks to its most vulnerable populations.

Implementing training for medical practitioners regarding end-of-life care, various options in pain-free palliative care, and increased social and emotional supports can foster a more empathetic healthcare environment where some patients will not feel the need for ending their life.

The integration of support services, such as counseling and palliative care, is critical in addressing the psychological and emotional facets of patients considering assisted suicide. Furthermore, ongoing monitoring and evaluation of assisted suicide outcomes can inform policy adjustments, thereby ensuring that the regulations remain relevant and responsive to societal and medical advancements.

MAiD should be regulated to ensure patient safety and autonomy, prevent abuse and coercion, uphold ethical standards within healthcare practice, foster public trust in medical systems, and facilitate data collection for ongoing research. These recommendations can strengthen the integrity and ethical foundations of assisted suicide practices in Canada and ensure all human life is valued.