

# INTERPRETING ELIGIBILITY UNDER THE MEDICAL ASSISTANCE IN DYING LAW: THE EXPERIENCES OF PHYSICIANS AND NURSE PRACTITIONERS

*Thomas McMorrow, Ellen Wiebe, Ruchi Liyanage, Sabrina  
Tremblay-Huet & Michaela Kelly\**

This study examines the experiences of physicians and nurse practitioners interpreting the statutory criteria determining patient eligibility for Medical Assistance in Dying (MAiD). The *Criminal Code* sets out what qualifies as “a grievous and irremediable medical condition”, which includes the requirement that a patient’s “natural death has become reasonably foreseeable” (NDRF). The Superior Court of Quebec struck down the provision as unconstitutional and the government responded by introducing Bill C-7 which now deploys the NDRF criterion in new ways. Ambiguity and controversy

Cette étude se penche sur les expériences vécues de médecins et infirmières-praticiennes qui interprètent les critères légaux déterminant l’admissibilité d’un patient à l’aide médicale à mourir. Le Code criminel requiert que la personne souhaitant recevoir l’aide médicale à mourir soit « affectée de problèmes de santé graves et irrémédiables » ce qui requiert entre autres que sa « mort naturelle [soit] devenue raisonnablement prévisible ». La Cour supérieure du Québec, jugeant la disposition inconstitutionnelle, l’a annulée. En réponse, le gouvernement a présenté le projet de loi C-7 afin de résoudre la non-conformité de la

---

\* Thomas McMorrow, D.C.L., is an Associate Professor of Legal Studies and Undergraduate Program Director of Liberal Studies in the Faculty of Social Science and Humanities at Ontario Tech University. Ellen Wiebe, M.D., is a Clinical Professor in the Department of Family Practice at the University of British Columbia. Her primary areas of practice are assisted death and women’s health. Ruchi Liyanage is a physician who completed her Family Practice Residency at the University of British Columbia. Sabrina Tremblay-Huet is a PhD candidate at the Faculté de Droit, Université de Sherbrooke. Michaela Kelly is a researcher and an MSc candidate at the University of London.

© Thomas McMorrow et al. 2020

Citation: Thomas McMorrow et al, “Interpreting Eligibility Under the Medical Assistance in Dying Law: The Experiences of Physicians and Nurse Practitioners” (2020) 14:1 McGill JL & Health 51.

Référence : Thomas McMorrow et al, « Interpreting Eligibility Under the Medical Assistance in Dying Law: The Experiences of Physicians and Nurse Practitioners » (2020) 14:1 RD & santé McGill 51.

have attached to the phrase since the Government introduced Bill C-14 before Parliament in 2016. From January to March 2019, we conducted semi-structured interviews with twenty-four Canadian MAiD assessors and providers to find out how they interpret the relevant federal and provincial legislative provisions. Respondents included 9 doctors from Quebec where the provincial-law differs from the Criminal Code. The article identifies differences in the eligibility regimes, while providing a detailed analysis of how health care practitioners interpret and apply the statutory requirements to determine patient eligibility for MAiD. Our findings shed new new light on Truchon and Bill C-7, while offering insight into the on-the-ground experiences of health care professionals in this changing field of law.

loi. De janvier à mars 2019, nous avons eu des entretiens avec 24 professionnels de la santé pouvant évaluer un patient pour déterminer son admissibilité à l'aide médicale à mourir afin d'obtenir leurs interprétations des articles établissant les critères pour l'aide médicale à mourir. Parmi les professionnels que nous avons interrogés dénombraient neuf médecins du Québec, endroit où la loi provinciale se distingue du Code criminel. Cet article soulève les différences dans les régimes d'admissibilité tout en analysant en détail la manière dont les professionnels de santé interprètent et appliquent les critères prévus par la loi pour déterminer l'admissibilité à l'aide médicale à mourir. Nos résultats nous permettent de tirer plusieurs conclusions de Truchon et le projet de loi C-7 tout en offrant au lecteur un aperçu des expériences de terrain des professionnels de la santé dans ce domaine juridique.

---

<b>INTRODUCTION</b>	<b>53</b>
<b>I. BACKGROUND</b>	<b>59</b>
<b>A. Outlining 241.2(2) and Related Issues</b>	<b>59</b>
<b>B. Reviewing the Rationale for the Legislative Provision</b>	<b>65</b>
<b>II. STUDY METHODS AND RESULTS</b>	<b>69</b>
<b>A. How Assessors Interpret the MAiD Eligibility Requirements</b>	<b>71</b>
<b>B. Differences in Québec versus the Rest of Canada</b>	<b>97</b>
<b>CONCLUSION</b>	<b>105</b>

---

## INTRODUCTION

In light of the Superior Court of Québec's decision in *Truchon c Procureur général du Canada*<sup>1</sup>, and the federal government's subsequent introduction of Bill C-7<sup>2</sup>, the law governing medical assistance in dying (MAiD) is destined to change by 18 December 2020.<sup>3</sup> Neither *Truchon* nor Bill C-7 fully acknowledges how clinical interpretation of the statutory rules governing MAiD eligibility has evolved since the practice was legalized. The present qualitative study aims to address this gap. We asked MAiD providers to describe how they apply the statutory rules determining patient eligibility for MAiD and to share their perceptions of the law. We discovered that the law does not just have an impact on the work of health professionals; the interpretive work of health professionals also shapes the meaning and effect of the law.<sup>4</sup> The present study offers insight into how the current statutory regime in Canada functions and highlights features of the clinical landscape in which legal change ends up playing out in daily life.

The Supreme Court of Canada's 2015 decision in *Carter v Canada* (Attorney General) initiated a seismic shift in that landscape, by declaring that

the prohibition on physician-assisted dying ... void insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability) that causes

---

<sup>1</sup> 2019 QCCS 3792 [*Truchon*].

<sup>2</sup> Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), 2nd Sess, 43rd Parl, 2020 (Committee reporting the Bill with amendments in the House of Commons 25 November 2020) [Bill C-7].

<sup>3</sup> See Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, (assented to 17 June 2016), SC 2016, c 3 [Bill C-14]; *Truchon c Procureur général du Canada*, 2020 QCCS 2019 (extending the period of suspension for the declaration of constitutional invalidity).

<sup>4</sup> See Roderick A Macdonald, & David Sandomierksi, "Against Nomopolies" (2007) 57:4 N Ir Leg Q 610 (elaborating on a constructivist account of legal normativity that exceeds the purview of the present study, stressing the active, creative role that legal subjects play in law's construction).

enduring suffering that is intolerable to the individual in the circumstances of his or her condition.<sup>5</sup>

The Court agreed with the plaintiff, Gloria Taylor, that by imposing “the ‘cruel choice’ between killing herself while she was still physically capable of doing so, or giving up the ability to exercise any control over the manner and timing of her death”, the law unjustifiably infringed her rights to life, liberty and security of the person.<sup>6</sup> The Court suspended its declaration of constitutional invalidity from taking effect for one year, stating that “Parliament must be given the opportunity to craft an appropriate remedy.”<sup>7</sup> Subsequently, the Court extended that suspension by four months.<sup>8</sup> During the extension, however, the Court began permitting patients access to physician-assisted dying: patients in Québec were deemed eligible in accordance with the province’s *Act Respecting End-of-Life Care*,<sup>9</sup> while patients in the rest of the country had to apply to the superior court of their jurisdiction to determine their eligibility based on the parameters set out by the Supreme Court in *Carter (2016)*.<sup>10</sup> Parliament subsequently amended the *Criminal Code* to permit physicians and nurse practitioners to provide MAiD.<sup>11</sup> Bill

---

<sup>5</sup> 2015 SCC 5 at paras 4, 127 [*Carter*].

<sup>6</sup> *Ibid* at paras 13, 56. The impugned statutory provisions, sections 241(b) and 14 of the *Criminal Code* RSC 1985, c C-46, provide that everyone who aids or abets a person in committing suicide commits an indictable offence, and that no person may consent to death being inflicted on them.

<sup>7</sup> *Ibid* at para 125.

<sup>8</sup> See *Carter v Canada (Attorney General)*, 2016 SCC 4 at para 7 [*Carter 2016*].

<sup>9</sup> CQLR c S-32.0001 (on June 5th, 2014, the National Assembly of Québec passed the *Act Respecting End-of-Life Care*, eight months before the Supreme Court of Canada handed down its landmark decision in *Carter*. Even though the federal *Criminal Code* prohibited voluntary euthanasia and assisted suicide, the provincial legislation acknowledged the provision of voluntary euthanasia, or “medical aid in dying”, as part of its comprehensive end-of-life care framework. Nevertheless, in light of the criminal ban, the Québec government did not cause the *Act* to enter into force until 10 December 2015, 10 months after the Court in *Carter* declared the blanket criminal prohibition of voluntary euthanasia and assisted suicide constitutionally invalid).

<sup>10</sup> See *Carter 2016*, *supra* note 8.

<sup>11</sup> See Bill C-14, *supra* note 3.

C-14 was legislated as s. 241.2 of the *Code*, establishing criteria – not stipulated in *Carter* – to determine what qualifies as “a grievous and irremediable medical condition”.<sup>12</sup>

One statutory requirement is that a patient’s “natural death has become reasonably foreseeable” (NDRF).<sup>13</sup> From the outset, the precise meaning of the phrase has been unclear and its inclusion in the law controversial.<sup>14</sup> While litigation over its constitutional validity was ongoing,<sup>15</sup> and no consensus on whether to expand access to MAiD forthcoming,<sup>16</sup> we undertook qualitative research to identify how the current eligibility

---

<sup>12</sup> *Ibid*, s 241.2(1)(c).

<sup>13</sup> *Ibid*, s 241.2(2)(d).

<sup>14</sup> See Thomas MJ Bateman & Matthew LeBlanc “Dialogue on Death: Parliament and the Courts on Medically-Assisted Dying” (2018) 85:2 SCLR 387; Eleni Nicolaides & Matthew Hennigar, “*Carter* Conflicts: The Supreme Court of Canada’s Impact on Medical Assistance in Dying Policy” in Emmett Macfarlane, ed, *Policy Change, Courts, and the Canadian Constitution* (Toronto: University of Toronto Press, 2018) 313 at 319.

<sup>15</sup> See *Truchon*, *supra* note 1.

<sup>16</sup> See Council of Canadian Academies, “State of Knowledge on for Mature Minors, Advance Requests, and Where a Mental Disorder Is the Sole Underlying Medical Condition: Summary of Reports” (2018) at 27, online (pdf): *Council of Canadian Academies*, <[cca-reports.ca/wp-content/uploads/2018/12/MAID-Summary-of-Reports.pdf](http://cca-reports.ca/wp-content/uploads/2018/12/MAID-Summary-of-Reports.pdf)> [perma.cc/C4VU-6CL3]; The Expert Panel Working Group on Advance Requests for MAiD, “The State of Knowledge on Advance Requests for Medical Assistance in Dying” (2018) at 176, online (pdf): *Council of Canadian Academies* <[cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf](http://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf)> [perma.cc/9GUG-FJ7G]; The Expert Panel Working Group on MAiD Where a Mental Disorder Is the Sole Underlying Medical Condition, “The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition” (2018) at 36, online (pdf): *Canadian Council of Academies* <[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](http://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)> [perma.cc/MQ5N-5637]. The *Council of Canadian Academies*’ mandate was to provide a synthesis of relevant research, not to make law or policy recommendations. Nevertheless, a single set of recommendations arising from any of the three reports would have been unlikely anyway, given that each report acknowledges its expert authors expressed disagreement over crucial issues.

requirements actually work in practice.<sup>17</sup> From January to March 2019, we conducted semi-structured interviews with 24 Canadian MAiD assessors and providers, including nine physicians in Québec, to find out how they were interpreting the relevant legislative provisions.

In September 2019, Justice Baudouin of the Superior Court of Québec in *Truchon* ruled that the NDRF requirement, along with the “end of life” criterion in Québec’s provincial legislation, were unjustified infringements of the plaintiffs’ section 7 and section 15 *Charter* rights.<sup>18</sup> She suspended her declaration of invalidity for six months.<sup>19</sup> Amidst the ensuing federal election campaign, both the federal and provincial governments announced that they would not appeal the decision. Just before the declaration of invalidity was set to take effect in March 2020, the federal government introduced Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*<sup>20</sup> and the court agreed to grant a four-month extension.<sup>21</sup>

Bill C-7 removes the requirement that a patient’s “natural death has become reasonably foreseeable” but explicitly rules out eligibility for patients suffering exclusively from a mental illness.<sup>22</sup> Although Bill C-7 removes NDRF as an essential condition of accessing MAiD, it continues to treat NDRF as a threshold for determining which set of

---

<sup>17</sup> See Thomas McMorrow, “MAiD in Canada? Debating the Constitutionality of Canada’s New Medical Assistance in Dying Law” (2018) 44:1 *Queen’s LJ* 69 at 115 (noting that “[w]hen this case actually comes before the Supreme Court of Canada...evidence of how the access regime is actually working will be crucial”); Hamish Stewart, “Constitutional Aspects of Canada’s New Medically-Assisted Dying Law” (2018) 85 *SCLR* (2nd) 435 at 436 (observing that “full assessment of the constitutionality of Bill C-14 will require the development of a substantial evidentiary record from which a court can draw inferences about the extent to which the new regime both affects the constitutionally-protected interests of individuals and achieves its own purpose”).

<sup>18</sup> See *Truchon*, *supra* note 1 at paras 734–35.

<sup>19</sup> See *ibid* at para 744.

<sup>20</sup> See Bill C-7, *supra* note 2.

<sup>21</sup> See *Truchon c Procureur général du Canada*, 2020 QCCS 772 at para 26.

<sup>22</sup> Bill C-7, *supra* note 2 at cl 1(1) and cl 1(2).

safeguards applies<sup>23</sup> and which patients may waive their right to give contemporaneous consent when receiving MAiD.<sup>24</sup> Since the bill does not include a definition of NDRF, evidence of how clinicians have been interpreting the eligibility criterion provides the strongest indication of how they will continue to do so, if Bill C-7 is passed in its current form.

The bill assumes, as Justice Baudouin concluded in *Truchon*, that the NDRF requirement “clearly prohibits eligibility for medical assistance in dying for every person who is not near to death”.<sup>25</sup> Our findings challenge this conclusion, as our interviews with MAiD assessors reveal a significant discrepancy between the standard clinical interpretation of NDRF in Québec and the rest of Canada. Because clinicians in Québec have been interpreting the federal eligibility criteria in conjunction with the legislative regime unique to that province, theirs has been a more restrictive interpretation than the one that has evolved in the rest of the country. Like Julia Lamb – whose *Charter* challenge in British Columbia was adjourned on the consent of the parties after the government-appointed MAiD assessor determined she was eligible – the plaintiffs in *Truchon* probably would have had their MAiD requests granted had they been making them somewhere else in Canada other than Québec.<sup>26</sup> There is another reason that the meaning of NDRF continues to

---

<sup>23</sup> See *ibid* at cl 1(3), 1(7). Those whose natural death is not reasonably foreseeable must wait 90 days following their first assessment to receive MAiD unless their assessors are both of the opinion that their loss of capacity to consent to the procedure is imminent. Conversely, those whose natural death is reasonably foreseeable are no longer required to wait ten clear days after making their request to receive MAiD (see cl 1(5)).

<sup>24</sup> See *ibid* at cl 1(7).

<sup>25</sup> See *Truchon*, *supra* note 1 at para 511.

<sup>26</sup> See Kelly Grant, “B.C. woman drops challenge of MAiD law after learning she qualifies for assisted dying”, *The Globe and Mail* (18 November 2019), online: <[www.theglobeandmail.com/canada/article-bc-woman-challenging-reasonably-foreseeable-clause-in-maid-law/](http://www.theglobeandmail.com/canada/article-bc-woman-challenging-reasonably-foreseeable-clause-in-maid-law/)> [perma.cc/79Y8-FRYY] (reporting on why *Lamb v Canada (Attorney General)*, 2017 BCSC 1802 did not proceed to trial). Following the enactment of the MAiD law in 2016, Julia Lamb, a 25-year-old B.C. woman with spinal muscular atrophy, and the B.C. Civil Liberties association, challenged its constitutionality, arguing inter alia that the reasonably foreseeable natural death requirement would impede her

be relevant. Bill C-7 stops short of fully embracing Justice Baudouin's reasoning in *Truchon*, since it expressly excludes patients whose sole underlying medical condition is a mental illness from being eligible for MAiD.<sup>27</sup>

Our study aims to shed light on how clinicians interpret the NDRF criterion – which as a matter of form and substance still plays a role in Bill C-7 – as well as the other eligibility requirements, which all remain in the proposed legislation. A study of how clinicians interpret and apply MAiD legislation has the potential to inform understanding of, and deliberations over, the role of law in governing MAiD. Thus, the present paper examines how providers and assessors interpret and apply the statutory criteria that determine if a patient has “a grievous and irremediable medical condition”<sup>28</sup> and is therefore eligible to receive MAiD,<sup>29</sup> subject to age, residency, capacity, and consent requirements.<sup>30</sup> Part I situates the rationale for the study, by discussing the ambiguity of the *Criminal Code*'s definition of eligibility for MAiD. Part II offers a provision-by-provision breakdown of section 241.2(2) of the *Criminal Code*, presents respondents' interpretations of these provisions, and

---

from accessing MAiD once her suffering was no longer tolerable.

<sup>27</sup> Bill C-7, *supra* note 2 at cl 2.1. (“For the purposes of paragraph (2)(a), a mental illness is not considered to be an illness, disease or disability.” Concluding that the statutory provision requiring a reasonably foreseeable natural death was an infringement on the section 7 and section 15 rights of the plaintiffs, the Court also ruled that these infringements are not justified under section 1 of the Charter.)

<sup>28</sup> Bill C-14, *supra* note 3.

<sup>29</sup> For a list of bibliographic references to the growing Canadian research literature on MAiD, see Hemlock AID in Dying <[hemlockaid.ca/?page\\_id=198](http://hemlockaid.ca/?page_id=198)> [perma.cc/PP9U-7SEB].

<sup>30</sup> See *ibid*, s 241.2 (1). A person may receive medical assistance in dying only if they meet all of the following criteria: (a) they are 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) they are at least 18 years of age and capable of making decisions with respect to their health; (c) they have a grievous and irremediable medical condition; (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.



highlights differences between the MAiD legislative regimes in Québec and the rest of Canada. Part II further identifies the interpretive aids—including people and documents – that the MAiD assessors rely upon when interpreting the eligibility criteria. Part II also outlines how the participants view the criteria, how their interpretations have changed since the law was introduced, which criteria they find most challenging to interpret, and whether (and why) they think any aspects of the law should be modified. Part III presents our general findings. Nearly all of the respondents note that their interpretation of the MAiD eligibility requirements has evolved since they began doing assessments in 2016. Overall, respondents describe all four statutory criteria that define a grievous and irremediable medical condition, including NDRF, as having sufficient flexibility for them to pursue their MAiD practice in a patient-centred way. Québec’s additional legislative framework makes the experience of MAiD assessors and providers in this province stand out in certain respects. The article’s Conclusion expands on these and other findings, while suggesting potential avenues for future research.

## I. Background

### A. Outlining 241.2(2) and Related Issues

In addition to prescribing procedural rules for the provision of MAiD,<sup>31</sup> the *Criminal Code* requires a person to have a grievous and irremedi-

---

<sup>31</sup> Other requirements include the 10 clear days between the request and administration of MAiD: “Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must [...] (g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or – if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent – any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances”; *Criminal Code*, RSC 1985, c C-46, s 241.2(3).

able medical condition. Section 241.2 (2) states that

[a] person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.<sup>32</sup>

Thus, only if the patient is in an “advanced state of irreversible decline in capability...[and] their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining” will they qualify as having a “grievous and irremediably medical condition”.<sup>33</sup> As noted, in *Carter* the Court never mentioned these characteristics of a grievous and irremediable medical condition. The phrase “natural death has become reasonably foreseeable” (NDRF) was not an established clinical term when Bill C-14 introduced it.<sup>34</sup>

After Parliament passed Bill C-14 in June 2016, the Ministry of Justice published a *Legislative Background* expanding on the meaning of the

---

<sup>32</sup> Bill C-14, *supra* note 3, s 241.2 (2).

<sup>33</sup> *Ibid*, ss 241.2(2)(b)–(d).

<sup>34</sup> See Jocelyn Downie & Kate Scallion, “Foreseeably Unclear: The Meaning of the ‘Reasonably Foreseeable’ Criterion for Access to Medical Assistance in Dying in Canada” (2018) 41:1 Dal LJ 23 at 25–26 (discussing why critics have described the criterion as “unfamiliar and unclear”).

novel phrase, “natural death has become reasonably foreseeable”:

The criterion of reasonable foreseeability of death is intended to require a temporal but flexible connection between the person’s overall medical circumstances and their anticipated death. As some medical conditions may cause individuals to irreversibly decline and suffer for a long period of time before dying, *the eligibility criteria do not impose any specific requirements in terms of prognosis or proximity to death* (e.g., a six month prognosis as the U.S. states’ medical assistance in dying laws require). *The medical condition that is causing the intolerable suffering does not need to be the cause of the reasonably foreseeable death either.* In other words, eligibility is *not limited to those who are dying from a fatal disease. Eligibility needs to be assessed on a case-by-case basis, with flexibility to reflect the uniqueness of each person’s circumstances, but with limits that require a natural death to be foreseeable in a period of time that is not too remote.* It should be noted that people with a mental illness or physical disability are not excluded from the regime, but will only be able to access medical assistance in dying if they meet all of the eligibility criteria.<sup>35</sup>

Neither the *Criminal Code*, nor the *Legislative Backgrounder*, specifies what constitutes “a period of time that is not too remote” when determining whether a patient’s natural death has become reasonably foreseeable. In addition, the legislation states that a prognosis as to a specific length of time does not need to be made at all.<sup>36</sup> Furthermore, as the *Legislative Backgrounder* emphasizes, the condition from which the patient is suffering need not itself be fatal; age and overall health may factor into the assessment of whether a patient’s natural death has become reasonably foreseeable. Consequently, it is up to physicians and nurse practitioners – the legislation requires two assessors – to answer

---

<sup>35</sup> Department of Justice, *Legislative Background: Medical Assistance in Dying* (Bill C-14), Catalogue No J4-41/2016E (Ottawa: Justice Canada, 2016) at 10 [Legislative Backgrounder] [emphasis added].

<sup>36</sup> Bill C-14, *supra* note 3, s 241.2(2)(d).

this question when a patient requests MAiD.<sup>37</sup>

Downie and Chandler highlight a set of problems with the legislation's ambiguity, arguing that uncertainty in the MAiD legislation means eligibility "may be determined too broadly or too narrowly, and there may be arbitrary inequality of access when the various MAiD assessors and providers interpret the law differently."<sup>38</sup> Identifying the meaning of "natural death has become reasonably foreseeable" is not only essential to establishing a consistent baseline for access,<sup>39</sup> but also for determining whether the provision is a constitutional restriction on access to MAiD.<sup>40</sup> Downie and Scallion argue that amending the *Criminal Code* would dispel uncertainty, while sparing patients and providers undue litigation.<sup>41</sup> They recommend the following definition for NDRF:

In the professional opinion of the health care provider, it is not far-fetched to forecast an assessment of the future course of a patient's medical circumstances (including age and frailty) to natural death, based on knowledge of the course of such medical circumstances in other patients together with the general health, age, and sex of the patient (not necessarily including any prediction of the length of time the patient has remaining).<sup>42</sup>

They argue that this definition "is consistent with the only court decision we have on the issue, which rejected a temporal proximity neces-

---

<sup>37</sup> While the *Criminal Code* applies to all of Canada, as criminal law is of federal jurisdiction in this country, note that the Québec legislative context as concerns MAiD renders the NDRF moot. Section VI will detail the more restrictive legislative framework under which Québec practitioners operate.

<sup>38</sup> Jocelyn Downie & Jennifer A Chandler, "Interpreting Canada's Medical Assistance in Dying Legislation" (2018) at 31, online (pdf): *Institute for Research on Public Policy* <[irpp.org/wp-content/uploads/2018/03/Interpreting-Canadas-Medical-Assistance-in-Dying-Legislation-MAiD.pdf](http://irpp.org/wp-content/uploads/2018/03/Interpreting-Canadas-Medical-Assistance-in-Dying-Legislation-MAiD.pdf)> [perma.cc/G7ZJ-XJAT].

<sup>39</sup> Downie & Scallion, *supra* note 34 at 26.

<sup>40</sup> See McMorrow *supra* note 17 at 83; Stewart, *supra* note 17 at 436.

<sup>41</sup> Downie & Scallion, *supra* note 34 at 56.

<sup>42</sup> *Ibid* at 53.

sary condition”.<sup>43</sup> The decision of the Ontario Superior Court of Justice in *A.B v Canada (Attorney General)*<sup>44</sup> demonstrates that a court may declare – based on the evidence before it and as a matter of statutory interpretation – whether a person’s natural death has become reasonably foreseeable within the meaning of section 241.2(2)(d) of the *Criminal Code*. Justice Perell concluded: “There may be cases of doubt about the ambit of s 241.2(2)(d), but AB’s case of an almost 80 year old woman in an advanced state of incurable, irreversible, worsening illness with excruciating pain and no quality of life is not one of them.”<sup>45</sup> The decision confirms that a patient must be “on a trajectory toward death”<sup>46</sup> due to natural causes, but also that no statute, court judgment, or professional guideline defines any temporal limit.

As the court did not specify a period of time, and the legislation says a prognosis as to length of time is not required, Downie and Scallion affirm: “Natural death has become reasonably foreseeable” means that, in the professional opinion of the medical or nurse practitioner, taking into account all of the patient’s medical circumstances, how or when the patient’s natural death will occur is reasonably predictable.<sup>47</sup>

Thus, according to Downie and Scallion, for a patient’s natural death to be reasonably foreseeable, either one or the other condition must be met: the cause of death must be predictable or its timing relatively prox-

---

<sup>43</sup> *Ibid* at 54–55.

<sup>44</sup> 2017 ONSC 3759 [*AB v Canada (AG)*].

<sup>45</sup> *Ibid* at para 87.

<sup>46</sup> *Ibid* at para 83.

<sup>47</sup> *Supra* note 34 at 56. They then give these examples: “Eligible (if s. 241.2(2) (a) through (c) met) Patient with Amyotrophic Lateral Sclerosis, Parkinson’s, Huntington, Spinal Muscular Atrophy, or Alzheimer’s; Patient with intractable anorexia; Patient with locked-in syndrome who refuses artificial hydration and nutrition. Ineligible (even if s. 241.2(2) (a) through (c) met) 40-year-old patient with incurable cancer for which suffering can be controlled by means acceptable to the patient[;] 25-year-old patient with paraplegia resulting from a car accident but no other health conditions 60-year-old patient with spinal stenosis but no other health conditions[;] 45-year-old patient with chronic pain but no other health conditions [;] 50-year-old patient with schizophrenia but no other health conditions”, at 57.

imate.<sup>48</sup> In other words, there is a causal and temporal dimension; satisfying either suffices. However, the government stated in its response to Julia Lamb’s lawsuit that “[t]o have become ‘reasonably foreseeable,’ a natural death must be reasonably anticipated to occur by one of a range of predictable ways, *and* within a period of time that is not too remote.”<sup>49</sup>

The MAiD policies of the provincial and territorial medical professional regulatory bodies vary in the specificity with which they address NDRF. None offers a comprehensive definition. The College of Physicians and Surgeons of Nova Scotia offers the most detailed definition, articulating a standard consistent with Downie and Scallion’s argument:

[N]atural death will be reasonably foreseeable if a medical or nurse practitioner is of the opinion that a patient’s natural death will be sufficiently soon or that the patient’s cause of natural death has become predictable.<sup>50</sup>

The *Canadian Association of MAiD Assessors and Providers* (CAMAP) is a professional association of MAiD providers that provides guidelines for its members. CAMAP has published the following “clinical interpretation of reasonably foreseeable”:

Once the patient’s death and its manner has become reasonably predictable (as far as the factors leading to it are concerned) then it can be said to be reasonably foreseeable. Reasonably predictable does not mean that the clinician is confident that death will definitely ensue in this way, only that predicting

---

<sup>48</sup> See *Ibid* at 56.

<sup>49</sup> *Lamb v Canada (Attorney General)* (27 July 2016), Vancouver, BCSC No S-165851 (Response to Civil Claim at Part 1, para 36) [*Lamb v Canada*] [emphasis added].

<sup>50</sup> “Professional Standard Regarding Medical Assistance in Dying” (8 February 2018) at 5, n 9, online (pdf): *College of Physicians and Surgeons of Nova Scotia* < [cpsns.ns.ca/wp-content/uploads/2018/12/ProfessionalStandard\\_Medical-AssistanceInDying\\_Dec2018.pdf](http://cpsns.ns.ca/wp-content/uploads/2018/12/ProfessionalStandard_Medical-AssistanceInDying_Dec2018.pdf) > [perma.cc/L4QA-NZG3] .

that it will do so is reasonable...

A clinician should decide:

1. Is it reasonable to predict that death will result from the patient's medical conditions and sequelae, taking into account age and other factors?
2. Is it likely that death will be “remote” or in the “too distant future” in the ordinary sense of these words?

If the answer to the first question is Yes, and the second question is No, then it is CAMAP’s view that the criterion of a reasonably foreseeable natural death is satisfied.<sup>51</sup>

Notably, the CAMAP definition stops short of reproducing the language that Downie and Scallion recommend and that the Nova Scotia College of Physicians and Surgeons has adopted. The CAMAP document states that “[s]ome medical health authorities, particularly those which regulate the provision of MAiD within facilities, have adopted time limits to prognosis. For example, some provincial and regional organisations automatically rule ineligible any patient with a prognosis of more than one year.”<sup>52</sup> The CAMAP document thus eschews strict time limits but acknowledges a temporal dimension to determining NDRF.

## B. Reviewing the Rationale for the Legislative Provision

The Department of Justice’s *Legislative Backgrounder* states that the law only recognizes those patients “approaching a natural death” as eligible for MAiD, in order to avoid “undermining suicide prevention initiatives and normalizing death as a solution to many forms of suffering”.<sup>53</sup> It also notes, “that people with a mental illness or physical disability are not excluded from the regime, but will only be able to access medical

---

<sup>51</sup> Canadian Association of MAiD Assessors and Providers, *Clinical Practice Guideline: The Clinical Interpretation of “Reasonably Foreseeable”* (June 2017), online: <[camapcanada.ca/wp-content/uploads/2019/01/cpg1-1.pdf](http://camapcanada.ca/wp-content/uploads/2019/01/cpg1-1.pdf)> [perma.cc/NZ5Q-TSJJ].

<sup>52</sup> *Ibid.*

<sup>53</sup> *Legislative Backgrounder*, *supra* note 29 at 6.

assistance in dying if they meet all of the eligibility criteria.”<sup>54</sup> Supportive of the NDRF requirement, Trudo Lemmens argues that it is necessary to prevent “individual physicians strongly committed to promoting wider access... alter[ing] a practice and provid[ing] increasing access in situations where patients are vulnerable.”<sup>55</sup> The idea is that, over time, a suffering person, who still has a long life ahead of them, may change their mind about wanting to receive medical assistance in dying; restricting eligibility to those on the trajectory to natural death is meant to reduce the chances of a suffering patient acting on what may turn out to be a transient wish.<sup>56</sup>

In its response to Julia Lamb’s statement of claim, the government argued that

The legislation is intended to support rather than weaken suicide prevention initiatives to the extent feasible under the criminal law. It does so by maintaining strict limits in relation to those who would participate in the death of another person while recognizing that for individuals who wish to die but whose natural death is not reasonably foreseeable, suicide prevention is better achieved through the offer of help and

---

<sup>54</sup> *Ibid* at 11.

<sup>55</sup> Trudo Lemmens, “Charter Scrutiny of Canada’s Medical Assistance in Dying Law and the Shifting Landscape of Belgian and Dutch Euthanasia Practice” (2018) 85 *Supreme Court Law Review* (2nd) at 533. But see Justine Dembo, Udo Schuklenk & Jonathan Reggler, “‘For their own good’: A response to popular arguments against permitting medical assistance in dying (MAID) where mental illness is the sole underlying condition” (2018) 63:7 *Can J Psychiatry* 451.

<sup>56</sup> See Dianne Pothier, “The Parameters of a Charter Compliant Response to *Carter v Canada* (Attorney General), 2015 SCC 5” (20 March 2016) [unpublished], online: SSRN <[ssrn.com/abstract=2753167](https://ssrn.com/abstract=2753167)> at 8. But see *Carter v Canada* [2015] 1 SCR 331 (Factum of the Intervenor the Alliance of People with Disabilities who are Supportive of Legal Assisted Dying Society at para 25) (arguing that the law should respect “the capacity and right of each individual to make a subjective evaluation about his or her quality of life”, and not restrict the freedom of people with disabilities).



treatment rather than the threat of criminal sanction.<sup>57</sup>

The purpose of the present study is not to argue the defensibility of this claim or advance a position on the current eligibility requirements under Bill C-14. Rather, the purpose is to see how the providers we interviewed interpret and regard these legislative criteria in the course of their clinical practice involving MAiD. Besides, in *Truchon*, the court concluded the NDRF and end of life requirements were unconstitutional.<sup>58</sup> While acknowledging that “protect[ing] vulnerable persons from being induced to request medical assistance in dying in a moment of weakness” is a “laudable” legislative objective, Justice Baudouin stressed that the court’s job is not to ensure Parliament’s objectives are fulfilled but to examine whether the legislative means it has deployed to accomplish them are “consistent with the *Charter*.”<sup>59</sup> In her view, denying MAiD to patients who are not “at the end of life”, even though they satisfy the other eligibility criteria, has less to do with verifying their “true consent” than with “the social acceptability of offering this assistance to dying people.”<sup>60</sup> According to Justice Baudouin, “a legislative regime within which suffering takes a back seat to the temporal connection with death” unjustifiably infringes the plaintiffs’ *Charter* rights by “ignoring their individual decision-making autonomy.”<sup>61</sup> For the state to be “prepared to recognize the right to autonomy” only once “death approaches” is discriminatory.<sup>62</sup> Respect for “the autonomy of competent people”<sup>63</sup> and their “right to a dignified and serene death”<sup>64</sup> demands they be able to choose MAiD. Justice Baudouin emphasized a bright line distinction between MAiD and suicide, affirming the ability

---

<sup>57</sup> *Lamb v Canada*, *supra* note 49 at para 10.

<sup>58</sup> *Truchon*, *supra* note 1 at paras 734–35.

<sup>59</sup> *Ibid* at para 688.

<sup>60</sup> *Ibid* at para 689.

<sup>61</sup> *Ibid* at para 678.

<sup>62</sup> *Ibid* at para 678.

<sup>63</sup> *Ibid* at para 679.

<sup>64</sup> *Ibid* at para 633.

of physicians to grasp its application in practice.

The Court accepts from the evidence that physicians are capable of assessing, with the necessary diligence:

1. the capacity, lack of ambivalence and deep convictions that motivate a person to request medical assistance in dying, on a case-by-case basis;
2. the presence of any possible coercion or external pressure on the patient;
3. the advanced state of irreversible decline in capability;
4. that presence of enduring intolerable suffering related to the person's condition that cannot be relieved under conditions that the person deems acceptable;
5. that the person who made the request is suicidal with or without an underlying psychiatric condition.<sup>65</sup>

Now, neither a “lack of ambivalence” nor evidence of “deep convictions” is a statutory prerequisite for MAiD, although they may speak to the voluntariness of the patient's request. As we will see, the NDRF criterion does figure in how clinicians interpret a “grievous and irremediable medical condition”, which includes determining “the advanced state of irreversible decline in capability” and “presence of enduring intolerable suffering”.<sup>66</sup> Certainly, these statutory requirements contribute to defining what constitutes lawful MAiD.

Legalizing MAiD permits doctors and nurse practitioners – as well as pharmacists and other parties who would have otherwise been prohibited from aiding a person to die by suicide – to not only support but effectuate a patient's decision to terminate their life. In comparison to suicide, MAiD is not only a more predictable and reliable, but also a less solitary and more socially validated, way to end one's life.<sup>67</sup> It therefore renders the choice to terminate one's life more legitimate.

---

<sup>65</sup> *Ibid* at para 619.

<sup>66</sup> Bill C-14, *supra* note 3, ss 241.2(2).

<sup>67</sup> See Wiebe et al, “Suicide vs medical assistance in dying (MAiD): a secondary qualitative analysis” (2020) 44:12 *Death Studies* 802 at 806.

Bostwick and Cohen argue that where a patient's decision to end their life does not stem from a form of psychopathology, health care professionals should accept it.<sup>68</sup> Of course, it is important to recognize that law itself, including statutory eligibility requirements for MAiD, is involved in the social construction of the difference between legitimate and illegitimate forms of self-initiated death. Indeed, awareness of this fact informs and motivates both those who advocate and those who object to extending MAiD access to patients whose sole underlying medical condition is a mental disorder.<sup>69</sup>

The eligibility criteria in Bill C-14 leave MAiD clinicians with considerable room for interpretation as to whether a patient has a grievous and irremediable medical condition and is therefore eligible for MAiD. We designed the present qualitative study to identify and explain how clinicians interpret the MAiD eligibility criteria prescribed by section 241 of Bill C-14 and section 26 of Québec's *Act respecting end-of-life care*.

## II. Study Methods and Results

We conducted a qualitative study with semi-structured interviews and thematic analysis. We used abductive reasoning, first looking at the whole set of interview responses, then analyzing the transcripts in more detail to discover themes.<sup>70</sup> The interviews were transcribed verbatim

---

<sup>68</sup> See John Michael Bostwick & Lewis M Cohen, "Differentiating suicide from life-ending acts and end-of-life decisions: a model based on chronic kidney disease and dialysis" (2009) 50:1 *Psychosomatics* 1 at 5.

<sup>69</sup> See The Expert Panel Working Group on Advance Requests for MAiD, *supra* note 16. Cf The Halifax Group, *MAiD Legislation at a Crossroads: Persons with Mental Disorders as Their Sole Underlying Medical Condition IRPP Report* (Montreal: Institute for Research on Public Policy, 2020) and Expert Advisory Group on MAiD, *Canada at a Crossroads: Recommendations on Medical Assistance in Dying and Persons with a Mental Disorder—an Evidence Based Critique of the Halifax Group IRPP Report* (Toronto: EAG, 2020).

<sup>70</sup> See Martin Lipscomb, "Abductive reasoning and qualitative research" (2012) 13:4 *Nurs Philos* 244. Also, see Lisa Webley, "Chapter 38: Qualitative Approaches to Empirical Legal Research" in Peter Cane and Herbert Kritzer eds, *Oxford Handbook of Empirical Legal Research* (Oxford: Oxford University Press, 2010); Anselm Strauss & Juliet Corbin, *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (Thousand Oaks: Sage, 1998).

and French interviews were translated into English for analysis. The research team met repeatedly to discuss and agree the major themes. Initial participants were recruited from the Canadian Association of MAiD Assessors and Providers (CAMAP) listserv. Additional clinicians joined the study after hearing of it through word-of-mouth.<sup>71</sup> The research ethics boards at the University of British Columbia and Ontario Tech University approved this study. A total of 24 interviews were conducted between January and March 2019: two in written format and the rest by audio or video. Twelve men and 12 women were interviewed. Twenty-one respondents were physicians, and three were nurse practitioners. Seventeen worked in an urban setting, four worked in a rural setting, and three worked in mixed rural/urban settings. Their ages ranged from 32 to 81 and the (mean) average age was 54 years. Respondents came from across the country, representing five provinces: British Columbia, Manitoba, Ontario, Québec, and Nova Scotia. Nine respondents were from Québec. Most had provided MAiD since it was legalized.

What follows highlights how physicians describe the way they interpret the MAiD eligibility criteria and thereby contributes to a fuller picture of what the legal eligibility requirements mean in practice. Clearly, we did not interview every MAiD assessor and provider in the country. In 2019, according to the Canadian Institute of Health Information, there were 91,375 physicians in Canada and 6,159 nurse practitioners.<sup>72</sup> Only a fraction of this number has administered MAiD and among those who have, there appears to be a small number of health care professionals for whom MAiD figures as a prominent part of their practice. Since we recruited through the CAMAP listserv, our findings reveal the views of some subscribers to that listserv – not Canadian health care professionals as a whole. In fact, on several occasions, respondents speculated as to how other physicians and nurse practitioners with different clinical experiences and areas of specialty, as well as patients, their families and most Canadians, perceive the law. Notably, however, several of the

---

<sup>71</sup> See Chaim Noy, “Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research” (2008) 11:4 *Intl J of Soc Research Methodology* 327 at 334 (on the snowball method incorporated into recruitment for this study).

<sup>72</sup> “Physicians in Canada” (2020), online: *Canadian Institute for Health Information* <[www.cihi.ca/en/physicians-in-canada](http://www.cihi.ca/en/physicians-in-canada)> [perma.cc/YR7F-KXFP]; “Nursing in Canada, 2019” (2020), online: *Canadian Institute for Health Information* <[www.cihi.ca/en/nursing-in-canada-2019](http://www.cihi.ca/en/nursing-in-canada-2019)> [perma.cc/MC27-Y3V7].

research participants reported having assessed, and provided MAiD for, hundreds of patients. As a whole, our respondents had participated as either provider or assessor in a significant number of MAiD cases since the practice became lawful in Canada. In total, they reported completing over 3,000 MAiD assessments or provisions, deeming 200 patients ineligible for MAiD. We do not know in how many instances two participants were actually referring to the same patient. An official figure on the number of MAiD deaths that had occurred in Canada by the time our interviews concluded at the end of March 2019 is not available. According to Health Canada, there were 5,631 cases of MAiD reported in 2019, accounting for 2% of all deaths in Canada and an increase of 26.1% over the number of death with MAiD in 2018.<sup>73</sup> In the interviews, we asked respondents to discuss how they interpret the relevant statutory requirements.

### A. How Assessors Interpret the MAiD Eligibility Requirements

We organize our findings with respect to the four criteria that – under the *Criminal Code* – a patient must satisfy in order to have “a grievous and irremediable medical condition” and therefore be eligible for medical MAiD. We compare and contrast how assessors in Québec interpret the corresponding provincial eligibility criteria, which require the patient to be suffering from a serious and incurable illness, to be in an advanced state of irreversible decline in capability, to be experiencing constant and unbearable physical or psychological suffering, which cannot be relieved in a manner the patient deems tolerable, and to be at the end of life.<sup>74</sup>

#### (1) *They have a serious and incurable illness, disease or disability;*

Respondents reported that a wide variety of health conditions satisfy this criterion, including evidence of frailty. (Meanwhile, as discussed

---

<sup>73</sup> See Health Canada, “First Annual Report on Medical Assistance in Dying in Canada, 2019” (2019) (pdf) at 5, online: *Government of Canada* <[www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf](http://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf) > [perma.cc/VC5T-V7AK]. In 2019, 571 of the 7,336 requests for MAiD were denied on the basis of ineligibility.

<sup>74</sup> The order has been altered here from the way it appears in the statute for ease of analysis. The end-of-life criterion is in fact listed first in the Québec law. In addition, to be eligible for MAiD, a patient must also be an insured person

below, MAiD assessors in Quebec noted that the absence of any reference to “disease or disability” in the provincial legislation restricts the kinds of medical conditions that qualify.) Respondents did not indicate that they rely on a predetermined list of qualifying illnesses, diseases, or disabilities. They emphasized that they determine eligibility on a case-by-case basis. The patient may be dealing with a single disease, illness, or disability, or with a constellation of health issues. Assessors noted that a terminal illness would obviously qualify as “a serious and incurable illness, disease, or disability”, but so too would many other conditions.

[A]lmost everyone that we get referred has some form of cancer that is not curable or some form of chronic, neurologic, cardiac, or pulmonary disease which is progressive and there are not really any treatment options, like they’re not eligible for transplant etcetera. So that’s sort of the vast majority of cases are pretty straight forward.<sup>75</sup>

Another respondent echoed this sentiment, noting that it is more difficult to approve patients whose condition is not terminal.

[I]f they have terminal cancer that’s easy. That’s easy. The other ones, it’s a little bit difficult, but they say disease, disability, or illness, and that covers a whole spectrum of things... I think I have become a little bit more empathetic to people that have diseases that are affecting their quality of life that are not necessarily terminal malignancy.<sup>76</sup>

Similarly, another assessor states: “it doesn’t have to be cancer, it doesn’t have to be something that I consider less serious if the patient considers it serious. It has to be something that destroys their lives.”<sup>77</sup> Respondents noted how their appreciation of qualifying conditions had changed over time in light of the specific cases they encountered. Diabetes, persistent genital arousal disorder, rheumatoid arthritis, quadriplegia, and other non-fatal conditions were cited as examples of conditions that – along

---

within the meaning of the Health Insurance Act, be of full age and capable of giving consent to care. See *Act Respecting End-of-Life Care*, *supra* note 9, s 26.

<sup>75</sup> Participant 13 (36-year-old MD, ROC) [Participant 13].

<sup>76</sup> Participant 7 (60-year-old MD, ROC) [Participant 7].

<sup>77</sup> Participant 8 (65-year-old MD, ROC) [Participant 8].

with satisfaction of the other three statutory requirements – had rendered a patient eligible for MAiD.

One potentially crucial factor is evidence of frailty. Frailty is a syndrome that is marked by loss of function, strength, physiologic reserve, with increased vulnerability to morbidity and mortality.<sup>78</sup> Various tools have been used to assess frailty; the tool most commonly mentioned by our participants was the Canadian Study of Health and Aging Clinical Frailty Scale.<sup>79</sup> There is evidence supporting an association between frailty and increased mortality.<sup>80</sup> For example, in a study on frailty following 5,993 older men (65 years and older) for 4.7 years, the authors found that the frail men were over eight times as likely to die as the “robust” men.<sup>81</sup> Although it is not a disease, MAiD assessors were using frailty to decide if someone meets the criteria of being “in an advanced state of decline in capability” and that their “natural death is reasonably foreseeable”.

Indeed, frailty was noted as particularly important in assessments where a terminal or life-limiting diagnosis was absent.

I have a patient right now who his primary medical issue is frailty. He's 99 and he can't look after himself anymore and he lives alone and it's intolerable for him and unacceptable

---

<sup>78</sup> See Alfred L Fisher, “Just What Defines Frailty?” (2005) 53 *J American Geriatric Society* 2229; Robert C McDermid and Sean M Bagshaw, “Chapter 28: Physiological Reserve and Frailty in Critical Illness” in Robert D Stevens, Nicholas Hart, & Margaret S Herridge, eds, *Textbook of Post-ICU Medicine: The Legacy of Critical Care* (Oxford: Oxford University Press, 2014) 303.

<sup>79</sup> See Canadian Study of Health and Aging, Revised 2008, “Clinical Frailty Scale” (2009), online (pdf): *Dalhousie University* <[thehub.utoronto.ca/family/wp-content/uploads/2016/12/E\\_Clinical-Frailty-Scale-June\\_2016.pdf](http://thehub.utoronto.ca/family/wp-content/uploads/2016/12/E_Clinical-Frailty-Scale-June_2016.pdf)> [<https://perma.cc/4AAY-RH9Y>].

<sup>80</sup> See Arnold Mitnitski et al, “Relative fitness and frailty of elderly men and women in developed countries and their relationship with mortality” (2005) 53 *J American Geriatric Society* 2184.

<sup>81</sup> This figure is the unadjusted rather than multivariate result. See Peggy M Cawthon et al, “Frailty in Older Men: Prevalence, Progression, and Relationship with Mortality” (2007) 55:8 *J Am Geriatr Soc* 1216 at 1221 (presence of three or more of the following five criteria indicated the man was frail: shrinking/sarcopenia, low activity weakness, slowness, or low energy; if none of the criteria was present, the man was deemed robust).

for him to go to a nursing home and receive palliative care because he values, so highly, his independence, so although I have no diagnosis that would cause his foreseeable death, I think it's reasonable to assume that his chances of dying in 6–24 months are extremely high. And so I don't really have a good answer there, but I feel that looking at this picture, and thankfully the wording on the criteria is in the context of their overall health as a person. It's not related to a specific illness.<sup>82</sup>

Where a patient's natural death is temporally proximate, it need not be the consequence of a specific illness, disease, or disability. The length of time assessors referenced when discussing temporal proximity varied from 6–24 months, as seen above, to 10 years, as evidenced below:

There was one fellow who had more of a chronic lymphoma picture, but he also had a few comorbidities and was also in his nineties, so I found him eligible based on age and comorbidities even though statistically his lymphoma probably was his most critical illness and his prognosis from that standpoint, according to various actuarial tables and whatnot, was still pretty close to 10 years. And that one was probably, he's probably the one that I think I could stand to be challenged on, but basically I asked myself would I be surprised if he had an event in the next year that killed him, like an infection. And no. Would I be surprised if he were actually alive 10 years from now given his prognosis of CLL, usually a 10-year prognosis, but I'd actually be surprised if he was alive 10 years from now because he's 90 and no one in his family lived over 100 and even though he had reasonably good – he was still living independently, he was – his frail scale had increased, so there was deterioration, so that one was pretty much the only one that I approved that I thought could be debatable. I have not had very many people apply who didn't have a clear life-limiting illness.<sup>83</sup>

Respondents in Québec noted that one way in which the provincial law differs from the federal one is that it only refers to “illness”. Unlike the *Criminal Code* amendment, no reference is made to “disease” or

---

<sup>82</sup> Participant 12 (32-year-old NP, ROC) [Participant 12].

<sup>83</sup> Participant 10 (47-year-old MD, ROC) [Participant 10].



“disability”.<sup>84</sup> One physician pointed out that the narrower formulation of the provincial statute can give rise to spirited debates among physicians:

[As] for the grave and incurable illness, yes, we’ve had discussions that were rather animated on what is a grave and incurable illness. The Canadian criterion that talks about an illness, a condition, appears to me larger than just the term grave and incurable illness.<sup>85</sup>

Another physician provides further illustration of these types of disagreements: “Is a stroke a terminal illness, four people say ‘Yes, yes, yes,’ all of a sudden there’s a neurologist who says: ‘Come on, that’s not a terminal illness.’”<sup>86</sup> The legislation does not use the phrase “terminal illness” but the proximity of death is undoubtedly treated as an essential factor:

For me, a physician that has done a lot of MAiD, I wouldn’t administer MAiD to someone with arthritis or fibromyalgia or a spinal stenosis, because those aren’t illnesses that will kill them, those aren’t illnesses that will result in them dying short-term within a year, you understand.<sup>87</sup>

How the Commission on End-of-life Care might view one’s decision to deem a patient eligible for MAiD factors into assessor determinations. One physician recounts efforts to convince the Commission that his patient’s illness satisfied the legislative criteria:

I had a problem one time with a person who was quadriplegic because he had a serious illness, but not incurable. In the sense that it was a stable lesion. He had been quadriplegic for 35 years, and there were complications with his mobility. At some point he was less and less capable of going in his wheelchair, so he developed fragility fractures, he developed bladder stones, repetitive infections, fever, etc., and needed

---

<sup>84</sup> Participant 20 (72-year-old MD, PQ) [Participant 20]. See *Act Respecting End-of-Life Care*, *supra* note 9

<sup>85</sup> Participant 24 (35-year-old MD, PQ).

<sup>86</sup> Participant 18 (69-year-old MD, PQ) [Participant 18].

<sup>87</sup> Participant 17 (62-year-old MD, PQ).

antibiotics. He developed major intestinal problems, chronic pain, etc. And, we know these people still have a shorter life expectancy than average, so I had to fight a little to defend that this patient, even if he didn't have an incurable illness, or at least that was progressive, he was a victim of the consequences of his immobilization, that it would get worse and worse.<sup>88</sup>

Although most MAiD requests come from patients suffering from a life-limiting illness, the narrower language in the Québec legislation, plus the *ex post facto* review function exercised by the Commission, limits the range of illnesses that qualify in that province. In the rest of Canada, some participants noted that evidence of frailty can bear decisive weight. Respondents did not describe frailty as an “illness, disease or disability” *per se*, but discussed it as a potentially important part of the patient's overall medical condition.

**(2) *They are in an advanced state of irreversible decline in capability***

Differences arise in how assessors interpret this criterion. Two main approaches stand out, so too does the significance of perspective when determining if this criterion is met. How assessors gauge whether a patient has reached an “advanced state of irreversible decline in capability” appears to depend above all on the reference points they use. For example, according to some providers, whether the state of decline is advanced depends most upon the patient's prior level of capability. This approach focuses on the patient “not being able to do their activities of daily living that they used to do”,<sup>89</sup> paying particular attention to evidence of decline that has already taken place.

The other approach places greater emphasis on the progression of the illness, disease, or disabling condition. As per this approach, whether “[the patient is] in an advanced state of irreversible decline in capability” depends on the stage they have reached, given the typical trajectory of the illness. For example, one provider described having denied MAiD to a patient with chronic lung disease because “she wasn't on

---

<sup>88</sup> Participant 19 (62-year-old MD, PQ).

<sup>89</sup> Participant 2 (37-year-old MD, ROC).

oxygen and could have lived for a few years”.<sup>90</sup>

Another respondent noted that when it comes to establishing decline, “there’s some controversy about whether it has to be gradual or sudden”<sup>91</sup> – in other words, continuous or instantaneous deterioration in the individual’s condition. This provider stressed patient experience over illness trajectory: “It doesn’t have to be an ongoing decline, but they have to have declined from a former healthier state.”<sup>92</sup> Thus, a sudden stroke may cause a person to reach an advanced state of irreversible decline in capability, presumably so long as a full recovery remains improbable.

No respondent parsed each word in this statutory provision – for example, by defining “irreversible”. One noted that if it is “something that’s likely to get better in a short period of time, then no”.<sup>93</sup> This kind of answer reflects a pattern in the research participants’ responses: many start out by delimiting easy cases first. Moreover, the fewer the number of MAiD cases a provider had assessed, the smaller their percentage of refusals. Those who had given MAiD to the most people, had also received the most requests and were therefore more likely to receive requests that had been refused by other providers.

Four findings may be drawn from responses related to this criterion. First, even though the same wording is used in the federal and provincial statute, “an advanced state of irreversible decline in capability” is not interpreted uniformly by MAiD assessors outside and inside Québec.<sup>94</sup> As one Québec physician noted, “an advanced state of irreversible decline” is equated with the terminal phase of a fatal medical condition: “for me the end of life starts when the person starts to have aspiration...

---

<sup>90</sup> Participant 4 (72-year-old MD, ROC).

<sup>91</sup> Participant 5 (38-year-old MD, ROC).

<sup>92</sup> *Ibid.*

<sup>93</sup> Participant 3 (age unknown MD, ROC).

<sup>94</sup> See *Act Respecting End-of-Life Care*, *supra* note 9 at s 26(5). As noted below, in the section addressing the unique legal regime in the province of Québec, the reference to a “serious and incurable illness” in the provincial legislation, *Ibid* at 26(4), is not as compendious as the phrase “illness, disease or disability” in Bill C-14, *supra* note 3.

when you choke on your food or your own saliva.”<sup>95</sup> The interpretation is different in the rest of Canada.

Second, few respondents reported this criterion as a major sticking point when interpreting the law, since it would appear most requests are made by patients burdened by serious medical conditions from which they will never recover anyway. When determining if a patient has entered an advanced state of irreversible decline in capability, the responses of some MAiD assessors reveal a tension between basing judgments on what objectively constitutes an advanced stage of a given disease or illness and the patient’s subjective experience of an advanced state of irreversible decline in capability. Reflecting the latter position, one respondent noted “I think it has to be significant from the point of the patient, that’s more important than whether or not it’s significant to me.”<sup>96</sup>

Furthermore, many of the assessors indicated that they would consider patients who are no longer able to perform daily tasks or are experiencing a marked decrease in their quality of life as satisfying this criterion. According to one respondent, this may range widely:

I think that it basically means that you can no longer do things that you used to be able to do. That can be pretty broad. For us, it would include people that are still quite functional but can no longer do some of the things that they used to be able to do. So we’re pretty broad with our interpretation of that here.<sup>97</sup>

As another respondent stressed, however, a patient-centred assessment will still rely on objective reference points for determining satisfaction of the criterion:

I have one patient that was a chronic pain issue and I did three assessments over a four-month period on him. And he was able to document with me that – well the first time I came to see him, I asked him when you go for a walk, how far do you walk. And he told me five or six blocks. So that’s pretty good actually because he could hardly move at all. But the next time I came back, it was two blocks, and the next time it was kind

---

<sup>95</sup> Participant 21 (57-year-old MD, PQ) [Participant 21].

<sup>96</sup> Participant 13, *supra* note 75.

<sup>97</sup> Participant 11 (51-year-old MD, ROC) [Participant 11].

of to the end of the sidewalk and back. So that was obviously a state of decline but his actual condition, which was based on advanced arthritis, we didn't have x-rays, I didn't have any way to determine that that had actually gotten worse, but his health certainly did.<sup>98</sup>

Another respondent explains the requisite change this way:

So basically that is to be able to demonstrate that over a period of time, be that three, six months to a year or two, the patient has gone from A to B. A is a state of active participation in society in an independent fashion and a more robust physical health, to B where they have now lost independence, have lost weight, have lost physical abilities, maybe they can't walk whereas they could before, they've increased in frailty.<sup>99</sup>

When seeking objective evidence for an advanced state of irreversible decline in capability, clinicians often seek medical opinions from their specialist colleagues.

So I try and do my due-diligence when doing assessments so I try to find secondary assessors that are specialists in the area of the disease that the patient has, and so I consulted this with the respiratory service and said if this patient finds BiPAP [assisted breathing] intolerable, she doesn't like that treatment, would her death be reasonably foreseeable, if we were to discontinue BiPAP. And the response I got was, "well the only way to find out is to discontinue it and see if she dies". And so, you know, true enough, that is not looking at the patient as a person.<sup>100</sup>

Other respondents also conveyed the opinion that specialists may fixate on the objective progression of the illness rather than how the patient is experiencing its impact.

She [a patient with a neurological disorder] could still walk, she could still talk. And this disturbed the other assessors, that she could still walk and still talk, that she wasn't far enough

---

<sup>98</sup> Participant 14 (57-year-old NP, ROC) [Participant 14].

<sup>99</sup> Participant 1 (56-year-old MD, ROC) [Participant 1].

<sup>100</sup> Participant 3, *supra* note 93.

down the road of her disease, but I happened to look at her resume. She happened to have a recent resume because of a slight change in her job, she'd had to put it together for some reason or another, so I looked at that and thought, she has come so far, so far from where she was a couple of years ago, and so I talked to her family doctor, I talked to one of the other assessors and I talked to her neurologist...her neurologist was upset with the idea that she was going to have MAiD because he really believed that she was not eligible and thought I was doing the wrong thing. I explained how I dealt with each of those issues, like why I considered her advanced – you see as a neurologist, he didn't consider her advanced. Advanced is when you can't move and you can't talk. And I said, but look where she was, and where she's come to. So then I provided for her.<sup>101</sup>

Assessors also employ various clinical scales to help determine MAiD eligibility such as the Walter Prognostic Scale, e-prognosis calculator, Frailty Scale, Palliative Performance Scale and Charlson Comorbidity Calculator. The respondents recalled relying much more on these types of tools when they started out performing MAiD assessments and used them less as they acquired clinical experience in this domain. Many noted that while these objective tools are useful, decision making regarding MAiD eligibility often comes down to clinical judgement:

There's a number of tools that I think I used when I first started to do this work. The charts and the life span predictors and stuff like that. I don't look at that stuff much more anymore, I really use frailty and the frailty scale to kind of guide the assessment, and all the collateral information and that kind of thing.<sup>102</sup>

Another stated:

There are some conditions – I had a patient where I did an assessment and they had rheumatoid arthritis (RA) and I called in my resources and support people and said 'help me find some documentation because my gut tells me that –' and she'd had it for 35 years, she was very very frail, very unwell, but

---

<sup>101</sup> Participant 8, *supra* note 77.

<sup>102</sup> Participant 6 (60-year-old NP, ROC) [Participant 6].

relatively young and had no other comorbidities, like none. And so without the RA, life would be great, but meanwhile she was in a scooter and dependent on other people for almost all her – so I said to people, help me find documentation that says RA shortens your life span because her rheumatologist told me it didn't, but we did find it, and I just had to look in the right places, and I didn't know where to find it, but my gut told me that it likely did. And once I had that documentation I was able to say it would shorten life-span by 10-15 years, therefore, when I look at her age and add that, then that kind of changes her reasonably foreseeable.<sup>103</sup>

Evidently, there is a tension between what a medical specialist regards as an advanced state of an illness and what a patient experiences as an irreversible decline in capability. Thus, some respondents reported conflicting assessments over this issue, resolved through further discussion with the second assessor or obtaining approval from a third.

Respondents reported occasions of conflict over patient eligibility arising sometimes among assessors, as well as between MAiD providers and disease specialists. Seeking out specialist consultants who support MAiD and selecting second assessors with extensive clinical experience are strategies these respondents adopt to avoid conflict in complex cases. Assessors indicate they try to take a proactive approach to clinical care. They stress the importance of supporting communication among patients and their families. They also ensure patients know that if they do not yet qualify for MAiD, they may request again in the future and be deemed eligible if their medical circumstances have changed. Respondents recounted stories where patients they approved as eligible ended up changing their minds about receiving MAiD. They also reported instances where patients they had deemed ineligible were nevertheless approved by other colleagues.

Finally, one respondent's remark captures a common refrain among the assessors we interviewed: "I think we have to respect what people want out of their quality of life."<sup>104</sup> Evidence of a person's decline, as well as evidence that any reversal through treatment the patient deems acceptable remains improbable are both crucial factors, but the phases of decline associated with an illness, disease or disability may play a role

---

<sup>103</sup> Participant 14, *supra* note 98.

<sup>104</sup> Participant 7, *supra* note 76.

too. Deference to the patient in interpreting this legislative provision appears to be a function of how strongly an assessor is inclined to accord the patient's perception of the intolerability of their situation decisive weight in determining eligibility for MAiD.

***(3) That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable***

More respondents expressed an opinion as to the wording of this provision than they did in reference to the previous criteria. Many providers stressed that it is the patient who is in the position to determine if the suffering they are enduring “is intolerable to them”. For example, one respondent said:

if the patient tells me that they feel that their symptoms, that their quality of life, that their experience of their state of being, their health, however you want to say it, is that they are suffering and it is intolerable to them, then they meet that criteria. And that has never changed for me. That I understood right from the get-go, that it was always the patient's subjective expression of that.<sup>105</sup>

As another provider relates, “I always would write down, ask and write down, what constituted their suffering. But I don't need to assess that in terms of whether it's bad enough. As far as I'm concerned, it's only what they consider.”<sup>106</sup> And yet, more than one respondent argued that no patient who is managing to put up with their suffering without a suite of analgesics fogging their capacity is actually enduring intolerable suffering. Two said that, taken literally, the phrase “intolerable suffering” would establish an unattainable threshold, since any person experiencing suffering is by definition tolerating it. Furthermore, some providers noted that they relied on this criterion when denying eligibility – more specifically, by telling patients that they would have to wait. For example, where a patient kept pushing back the date they were to receive MAiD, the assessor saw this as evidence their suffering was not “intolerable”; therefore, the person would not be eligible until they

---

<sup>105</sup> Participant 14, *supra* note 98.

<sup>106</sup> Participant 8, *supra* note 77.



had chosen a date. It was not clear from the responses whether MAiD assessors perceive an obligation to perform another assessment if too much time has elapsed since a request has been approved. Many acknowledged that for a considerable number of patients, their suffering is anticipatory in nature. Many are quite matter of fact about it, noting that it is the patient's call. Others see this as a problem with the wording of the legislation that needs to be corrected to become more transparent.

Several respondents acknowledged – including one provider who otherwise felt the law as a whole is “not that difficult to interpret”<sup>107</sup> – that patients may not feel their suffering has yet become intolerable when they are making their request. When patients are seeking approval for their MAiD request, they often have not yet reached the point of intolerable suffering. Thus, some saw a discrepancy between the threshold that the statutory provision's wording creates and the actual circumstances in which patients seek MAiD. For this reason, one respondent noted that they interpreted intolerable suffering to encompass anticipated suffering, saying that doing so was “in the spirit of the law”.<sup>108</sup> Still others specified that the sense of anticipation – or perhaps more specifically, the dread that attends the prospect of future suffering – was itself a form of suffering, rendering the patient eligible on this point.<sup>109</sup> Most, but not all providers, accepted the idea that intolerable suffering includes anticipated suffering:

[W]e are comfortable approving people that have primarily anticipatory suffering, so they may not have a lot of current suffering, but they're very concerned about what the future holds including natural death and what that may entail. And

---

<sup>107</sup> Participant 15 (59-year-old MD, ROC) [Participant 15]. “I don't think it's right that they have to say that their suffering is intolerable at the point that they sign the form. That's implying that they are imminently about to die, and that's not in the spirit of the law.”

<sup>108</sup> *Ibid.*

<sup>109</sup> Participant 8, *supra* note 77. “I'll say, the unbearable suffering that you have is the fear of future suffering, and that is acceptable. And so it's acceptable for me that they have – why do they want the MAiD papers done? It's because they have an extreme fear of future suffering and when you have metastatic cancer, that is a reasonable fear.”

we are fairly comfortable calling that intolerable suffering.<sup>110</sup>

Since ten clear days must pass between the request and provision of MAiD, taken literally, the law would require patients to bear intolerable suffering for that whole period.<sup>111</sup> Thus, one respondent objected to the wording of the intolerable suffering criterion:

That has been the trickiest part of the law for me and the reason is that a person who fills out their patient request form here has to take a vow that says “I’m having intolerable suffering”. And then it says now you’ve got 10 days to wait and you cannot shorten the 10 day wait period for suffering. You can shorten it for loss of capability or you can shorten it for imminent death, but basically people look at – I’ve had a number of people who’ve received the patient request form, looked it over, wanted to apply for MAiD, but wanted to do it sort of as in the future this is what I want, and they couldn’t tick the box that they were suffering intolerably.<sup>112</sup>

Some providers talked about how the requirement of intolerable suffering may have an impact on capacity to consent and may cause increased suffering. One stated:

In some ways, I have felt like I’ve been causing suffering by requiring this and often their families will be like ‘Oh, the doctor’s coming and so we can’t give you your (opioid analgesic) because you have to be able to tell her’. And that, I find really – I find that almost unethical. But I know it’s true that if they had their (analgesic) they probably wouldn’t be able to speak coherently for themselves. So, in that way, it has been a part of the suffering, part of the procedure that has caused suffering rather than relieved it. That’s hard.”<sup>113</sup>

Most prominent in the interview responses addressing this criterion was that it is up to the patient to define suffering. Interpreting the legislative provision to encompass anticipated suffering, the majority of assessors

---

<sup>110</sup> Participant 11, *supra* note 97.

<sup>111</sup> Participant 10, *supra* note 83.

<sup>112</sup> *Ibid.*

<sup>113</sup> *Ibid.*

identified intolerable suffering as a straightforward clinical question to answer since it relies on patient self-assessment.

And yet, some providers stressed that a patient saying that their suffering is intolerable is not always a sufficient basis for satisfying this eligibility criterion. For example, one respondent noted:

[I]t's hard to figure out if it's intolerable for patients not totally aware of all the means available to address it. So you know, wrapped in this idea of intolerability is what are the various means of addressing something to make it tolerable again. Those could be medications, those could be just sort of counselling, they could be any number of different things, but I think it's really hard to determine if suffering is intolerable unless you've really tried everything to address it already.<sup>114</sup>

Most respondents did not identify assessment of this criterion as the point of departure for discussing the nature of treatments and supports the patient had received to alleviate their sufferings. Nevertheless, they did acknowledge such communication as an essential part of their role as assessors:

Well, our job is to explore all of the aspects, like have they considered this, have they considered that, have they considered the other. And do they know about this treatment or that treatment. We have to do that. That is part of our job. And so certainly I have said things like I need you to explore this. You need to see a neurologist to discuss treatment. You don't have to take the treatment, but you do need to actually get the information directly about this treatment. So for example

---

<sup>114</sup> Participant 13, *supra* note 75. Here are the sentences preceding this quotation: "So I mean for me that's really at the root of why I think MAiD is appropriate for some patients. It's this idea that despite everything else, there's some form of suffering, be it physical somatic suffering, be it existential, be it social suffering, some form of suffering that cannot be addressed by any means that the patient finds to be acceptable. In our local practice we have a fairly good relationship with palliative care and I think almost every patient that I've assessed has already had palliative care involved by the time they are referred to us and the times they haven't been, I've actually referred them to palliative care. I think that's important because palliative care services are difficult to access sometimes and patients might not realize all of the means available to address their suffering and therefore,"

there are people that get a diagnosis of cancer and they say, I'm never going through cancer treatments. I saw my aunt go through this, I'm never doing that. And I say no, no, no you have got to see the oncologist and actually get the details about what your treatment will look like and what that will be. And then when you say I'm not willing to accept that, then fine. Not just globally, I will accept no cancer treatments because you know there are these direct treatments that are oral and you take at home, that have practically no side effects. It's not all like your aunt's. But another person I wouldn't say that to. So for example, I had a patient who got breast cancer. She had a biopsy and it was an aggressive tumor. She was 50 years old. And she said absolutely no treatment at all. And she did not go through finding out what treatments were available. She had a biopsy that said it was aggressive and so it was very high risk. So she knew, we all knew, that the treatment would be surgery, radiation, and chemo therapy. That's just what we do with aggressive tumours. The reason I didn't ask her to even find out what they were is, well first of all, I knew the answer because I know breast cancer reasonably well. The other reason was she had MS. And the reason she wanted MAiD was the MS not the cancer. So I wouldn't say I'm persuading people against. I'm refusing people or I'm putting up conditions sometimes, and that doesn't feel good. I much prefer to just say "whatever you want", but I can't. I can't do that in this case. I can't do it for legal reasons, and I can't do it for protecting myself for personal reasons, and I can't do it because I discovered that I actually must be convinced, personally, on every case.<sup>115</sup>

Sometimes patients do not offer a full picture of why they are seeking MAiD. One respondent recollected a patient conveying to the second assessor—but not to her—that the patient “couldn't stand living with her husband anymore.”<sup>116</sup> Even though the patient met the criteria, it turned out that there were “a lot of steps that could have been taken” to improve her quality of life.<sup>117</sup> Consequently, the second assessor refused and the first assessor made the relevant referrals, including provision of

---

<sup>115</sup> Participant 8, *supra* note 77.

<sup>116</sup> Participant 14, *supra* note 98.

<sup>117</sup> *Ibid.*

palliative care.

Respondents stressed the significance of psychological suffering:

Well, intolerable suffering is what people say it is. . . . A lot of the suffering I see is psychological. It's existential. They know their life is coming to an end. They don't want their dying process prolonged. They have lost any enjoyment that they have in life. They don't want to be a burden on their family. They also don't want their family to see them sort of waste away in a bed and just die slowly.<sup>118</sup>

This was less pronounced among assessors in Québec, where patients must be at the end of life to be eligible for MAiD and the statute provides the patient must “experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable”.<sup>119</sup> Nonetheless, physicians in Québec did note a shift over time in the weight placed on the patient perspective when judging whether the suffering threshold had been met:

And in fact, we thought [at the beginning] that there had to be symptoms that we couldn't control for the patient to be eligible, but finally it just had to be symptoms that the person considers intolerable. It's her point of view, not ours. That's what we, what we understood afterwards.<sup>120</sup>

Thus, it would seem that under both statutory regimes, assessors treat the patient's view as to the intolerability of their suffering as definitive.

***(4) Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining***

In discussing this criterion, respondents noted that the natural death has become reasonably foreseeable criterion in the federal statute is not interpreted in the same manner as the end of life requirement in the Qué-

---

<sup>118</sup> Participant 6, *supra* note 102.

<sup>119</sup> *Act Respecting End-of-Life Care*, *supra* note 9 at s 26(6).

<sup>120</sup> Participant 21, *supra* note 95.

bec legislation.

The MAiD assessors and providers identified the requirement that “natural death has become reasonably foreseeable” as the most difficult part of the law to interpret. They spoke of “reasonably foreseeable” meaning that natural death is temporally proximate (the patient is going to die soon) or the cause of natural death has become predictable (there is a high degree of probability the patient will die in a particular manner), or both. Thus, respondents framed and addressed the relationship between causality and temporality in different ways.

For example, one assessor stated that, compared to the other provisions in the section of the *Criminal Code*, the wording of the NDRF criterion is “probably the most confusing because reasonably foreseeable is not a medical term and even as a legal term, when you look at it, it has more to do with causality, like whether or not a consequence is reasonably foreseeable due to an action as opposed to a timeframe or anything like that.”<sup>121</sup> Given that the legislative provision specifies that no prognosis is necessary, most assessors eschew any strict timeframe. Instead, a central question appeared to be: *but for* the patient’s current medical condition (inclusive of all factors and circumstances, including age and frailty as well as disease, illness and disability) would the patient’s natural death be farther off than it currently is? If the answer is yes, and all other eligibility criteria are met, a number of MAiD assessors seemed prepared to declare the patient eligible.

Here is one respondent’s reasoning on the matter:

Yeah, and who knows what reasonably foreseeable is. Is it a year or is it 5 years, is it 10 years? That’s the problem. Everyone is going to die eventually, but most people don’t know what they’re going to die of, right. Whereas if you have something that could potentially kill you, like COPD [Chronic Obstructive Pulmonary Disease], that’s what I would interpret it

---

<sup>121</sup> Participant 13, *supra* note 75.

as.<sup>122</sup>

Similarly, another assessor noted,

I certainly don't put any rules on the prognosis. I probably have a rough idea of 5 years in my head. Maybe if it's longer than that, I'd be really seriously thinking if they were in an advanced state of decline or not.<sup>123</sup>

Consistent with this outlook, another health care professional described their approach as "holistic", noting their assessment

will depend on the age of that person as well as the overall frailty of that person and multiple other things wrong with that person. Reasonably foreseeable does not mean that we have to set any particular time. I see this as a person who is on a trajectory towards death with no particular time. So, we make a judgement on a case-by-case basis.<sup>124</sup>

Another respondent stressed that individual assessments therefore require extensive knowledge of the patient's medical background:

[E]very illness that they have, whether that be something that doesn't seem to contribute to their suffering, you want to know everything that they have. And then I just make up a chart in my mind. For these factors I think their death is foreseeable, for these factors it's not. What outweighs what. And most importantly, I think the benefit of the doubt goes to the patient. We are not able to predict the future.<sup>125</sup>

Furthermore, the way assessors reach their understanding of the phrase NDRF differs. Some responses displayed a more detailed analysis of the statutory provision, demonstrating familiarity with themes in the legal academic literature on the subject; for instance, one assessor sum-

---

<sup>122</sup> Participant 4 (72-year-old MD, ROC).

<sup>123</sup> Participant 15, *supra* note 107.

<sup>124</sup> Participant 3, *supra* note 93.

<sup>125</sup> Participant 1, *supra* note 99.

marized their approach this way:

So there are the two tests, and I feel like if your patient meets the criteria on either one of those two grounds, either reasonably foreseeable by time or reasonably foreseeable mechanism of death, then I consider them to be reasonably foreseeable. But I look at both because it's not always clear which one it is.<sup>126</sup>

One respondent expressly referenced the work of Jocelyn Downie, noting:

I was influenced a lot by one of the articles that she wrote that if a person is on a trajectory towards death, then that's kind of enough. So if they have a disease that's going to kill them, then that's kind of enough.<sup>127</sup>

Another assessor—notably one who had only participated in a handful of cases, all of which involved patients at the terminal phase of their condition—expressed a skeptical, even dismissive view of the NDRF criterion:

Every one of us has a reasonably foreseeable natural death, so basically I kind of just roll my eyes at that one and, you know, I base my decisions mostly on the decline in capability and the suffering because to me, yeah, to me it really has no meaning.<sup>128</sup>

Along these lines, another respondent suggested that the NDRF requirement imposed a formalistic legal encumbrance on intuitively sound clinical practice:

[I]t's a terrible thing in my mind that our gut often says this person should qualify for MAiD and then we have to go look-

---

<sup>126</sup> Participant 13, *supra* note 75.

<sup>127</sup> Participant 4, *supra* note 122.

<sup>128</sup> Participant 10, *supra* note 83.



ing for resources to be able to justify that.<sup>129</sup>

Consequently, clinical experience, professional judgment, personal intuition, and *ex post facto* rationalizations are at play in interpretations of the NDRF provision, as well as academic reading, consultation with colleagues, discussions with legal experts, and the legislative wording itself. Some respondents expressed disapproval of the current legal regime, while others came across as more ambivalent, pleased with the degree of flexibility the law permitted MAiD providers in determining eligibility.

In Québec, with its civilian legal tradition and more stringent standard of eligibility, such flexibility raises the specter of uncertainty and unpredictability. Some respondents in Québec and the rest of Canada expressed the view that no such end of life or “natural death has become reasonably foreseeable” requirement should figure as part of the law (especially since the Court made no reference to such a threshold in *Carter*). Other respondents remarked that the law, in practice, reflects the legislation’s stated purposes well. Moreover, one respondent noted that absent the NDRF criterion, it would become difficult to distinguish MAiD from the facilitation of suicide for anyone who wished to die.

As one respondent noted, the NDRF requirement ensures that MAiD provision mirrors their work in intensive care “where people are a little bit closer to death physiologically so having these discussions is a bit simpler.”<sup>130</sup> This respondent saw legalizing MAiD as extending to “anyone who had profound declining capacity, life-limiting illness and suffering” the same opportunity to ask a physician to end their lives as members of “this very small select group who happened to have the right kind of disability that landed them on life-support...It just sort of made it more fair.”<sup>131</sup>

Based on the interviews, it is evident that NDRF can function as a means of distinguishing those cases that assessors are willing to provide for and those they are not. Respondents recognized it as part of the line they must not cross to stay on the right side of the law. In addition, some pointed to how the requirement may spare them from assessing pa-

---

<sup>129</sup> Participant 14, *supra* note 98.

<sup>130</sup> Participant 13, *supra* note 75.

<sup>131</sup> *Ibid.*

tients as eligible for whom they would not themselves feel comfortable providing. The NDRF criterion helps limit the possibility of a patient changing their mind about ending their lives. The case of the patient who satisfies the NDRF criterion is that of a person who the assessor anticipates (reasonably foresees) will not waver in this decision, whether they receive a medically assisted death or not. Thus, one respondent stated: “basically I have to reassure myself that the person is not asking for this out of severe depression or as a symptom of suicidality.”<sup>132</sup> Thus, a distinction is drawn, in the legislation and in clinical practice, between medical assistance in dying and suicide. In other words, the criterion facilitates a distinction between a legally legitimate versus an illegitimate way to initiate one’s own death.<sup>133</sup>

One provider suggested that whether a health care professional is perceived to be medically supporting a patient’s death or helping a person to kill themselves depends on whether “these are people who are going to die anyway.”<sup>134</sup>

We don’t want to be helping people to kill themselves, we want to be medically supporting someone’s death for people who choose to not have to live with the suffering that they’re experiencing. Are those different? I think that they are... I think often when I’ve talked to other care providers and people in the community about what MAiD is, these are people who are going to die. So if we completely take out reasonably foreseeable, then we can’t say that anymore. So that’s the part that makes me uncomfortable.<sup>135</sup>

Since any form of ending a life is by definition but a hastening of the inevitable, assessors must make a determination minus an explicit time-frame.

Some assessors referred to how plotting the life expectancy of patients whom either the government or the courts had declared eligible—such

---

<sup>132</sup> Participant 10, *supra* note 83.

<sup>133</sup> See Margaret P Battin, “Could Suicide Really be a Fundamental Human Right? A Triple Threat” in Sebastian Muders, ed, *Assisted Death and Human Dignity* (Oxford: Oxford University Press, 2017) 199 at 200.

<sup>134</sup> Participant 15, *supra* note 107.

<sup>135</sup> *Ibid.*

as the 89-year-old Kay Carter who did not have a terminal illness and could potentially have survived another five to six years – widens the temporal range of reasonable foreseeability. In *AB v Canada* (AG), Justice Perell declared an “almost 80-year old woman” eligible.<sup>136</sup> She had been suffering intolerably from an untreatable form of degenerative osteoarthritis for more than two decades.<sup>137</sup> Such a condition is not by itself fatal and a person of that age who does not have a terminal illness may, statistically speaking, live for another 10 years.<sup>138</sup> Knowledge of these declarations, as well as of the ensuing discussions, academic commentary and practice among colleagues has had a demonstrable impact on the approach of most MAiD assessors, and certainly on all of the providers with the most extensive experience.

Nevertheless, the phrase’s ambiguity was said to pose problems particularly for those with limited experience:

Right now, as an experienced MAiD provider, I am comfortable with how things are worded because over time I have learned how to make that useable in my practice and interpret it a little more broadly, but for sure during my first 10 provisions it was very scary...I think that over time my comfort level with the wording of that has grown, whereas novice providers – that’s why it’s so hard to find new providers, it is terrifying.<sup>139</sup>

Nonetheless, evidence of its flexibility is the primary reason that respondents cited when voicing support for keeping the NDRF require-

---

<sup>136</sup> *Supra*, note 44 at para 17. See also Michelle McQuigge, “Ontario woman dies after lengthy fight for medically assisted death”, *The Globe and Mail* (10 August 2017), online: <[www.theglobeandmail.com/news/national/ontario-woman-dies-after-lengthy-fight-for-medically-assisted-death/article35954750/](http://www.theglobeandmail.com/news/national/ontario-woman-dies-after-lengthy-fight-for-medically-assisted-death/article35954750/)> [perma.cc/6LX6-TBHE] (reporting that the woman was 77 years old).

<sup>137</sup> See *AB v Canada*, *supra* note 44 at paras 17–19.

<sup>138</sup> See “Life expectancy at various ages, by population group and sex, Canada”, online: *Statistics Canada* <[www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310013401](http://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310013401)> [perma.cc/9TGF-L8FF].

<sup>139</sup> Participant 12, *supra* note 82.

ment in the law.

I know there's a push to have reasonably foreseeable death removed, I think that given the evolution and interpretation of that, I think it allows us now to provide for most people that I would want to provide for.<sup>140</sup>

Most respondents who spoke approvingly of the NDRF criterion, did so while acknowledging there had been a shift in its interpretation.

At the beginning of this work, we were wanting patients' deaths to be predictable, in the next year or so. We were being quite conservative at the beginning, including using the surprise question. Would you be surprised if this patient died in the next year? If their primary health care provider said "no I wouldn't be surprised", we were comfortable saying that their death was foreseeable, but we have definitely shifted. We now are comfortable or more comfortable approving patient's whose death is years away. So MS, for instance, we didn't approve anybody with MS unless they were quadriplegic and tube-fed, and now we'll approve patients that could live many years but have progressive MS and are dependent for care. We've become more comfortable with saying that people that are totally dependent on care, without which they would die, meet the criteria of their death being reasonably foreseeable even if with that care they could live for many, many years. By virtue of needing that level of care, without which they would die, their death is foreseeable even if they could live for decades with care.<sup>141</sup>

Driving the development, says this respondent, is:

I think a desire to help people. You would meet people and your heart would ache because oh my gosh, if I was in the same situation, I would probably want the same thing...But I think the ongoing conversation across Canada helped us feel that there's an evolving standard of practice for MAiD that has included an expanded interpretation of reasonably foreseeable

---

<sup>140</sup> Participant 11, *supra* note 97.

<sup>141</sup> *Ibid.*

death that we have gone along with.<sup>142</sup>

Relief of patient suffering is the critical concern driving the manner in which interpretation of NDRF has broadened:

So I mean for me that's really at the root of why I think MAiD is appropriate for some patients. It's this idea that despite everything else, there's some form of suffering, be it physical somatic suffering, be it existential, be it social suffering, some form of suffering that cannot be addressed by any means that the patient finds to be acceptable.<sup>143</sup>

Indeed, another MAiD provider observes:

A lot of the suffering I see is psychological, it's existential. They know their life is coming to an end. They don't want their dying process prolonged. They have lost any enjoyment that they have in life. They don't want to be a burden on their family. They also don't want their family to see them sort of waste away in a bed and just die slowly. They would rather gather them all around and be present in the moment with them that they say goodbye.<sup>144</sup>

Interpretations of MAiD eligibility have broadened, as the practice has evolved and opportunities for professional exchange developed, including the Canadian Association of Medical Assistance in Dying Assessors and Providers' (CAMAP) listserv, workshops and conferences.

The most obvious impact of the NDRF requirement is its exclusion of people whose suffering derives exclusively from a mental disorder. Several respondents indicated that on balance they thought this was positive:

If that clause was to be removed, [a patient whose personality disorder severely complicated the eligibility assessment] would be eligible and there are several other patients like him that I would not be comfortable providing MAiD for. . . I'm not sure how I would be comfortable providing for mental illness

---

<sup>142</sup> *Ibid.*

<sup>143</sup> Participant 13, *supra* note 75.

<sup>144</sup> Participant 6, *supra* note 102.

as a sole medical condition, which really if the foreseeable death piece was removed would open it up to mental illness because that's often the only criteria that they don't meet.<sup>145</sup>

It was evident that assessors who endorse a more restrictive approach to MAiD access, as well as those who advocate for a more permissive MAiD access regime, have a vested interest in a rule-based regulation of the practice. For example, one respondent expressed concern that a physician might perform MAiD before the standard ten clear day waiting period expires due to their own private interest.

[Y]ou know, I meet somebody and I think it's so bad that rather than the 10 days of reflection, it should be three days from now. And is that three days from now because I'm going fishing, or is it three days from now because the patient really is that badly off?...[W]e have never done an accelerated provision here but it sounds like a lot of people are doing them. I don't always get that. There was a bit of a dust up on the list-serv this week about that because I think somebody was saying basically "I'm just going to be involved in civil disobedience. I think it's a lot of crap that we have to wait 10 days and I'm going to do it my own and I'll just fudge the paperwork." And a number of other people...said "listen, we've got to follow the law here because you're going to make it bad for all of us".<sup>146</sup>

Notwithstanding the phrase's ambiguity – or providers' objections to its inclusion in the legislation in the first place – only one respondent ever suggested dispensing with the NDRF criterion in their assessments. Significantly, that comment was made by someone who had only received their handful of requests from patients who had terminal illnesses anyway.

The NDRF requirement helps to demarcate the kind of medical conditions for which MAiD provision is the clinically appropriate response to

---

<sup>145</sup> Participant 2 (37-year-old MD, ROC).

<sup>146</sup> Participant 9 (66-year-old MD, ROC) [Participant 9].

a patient's request for MAiD:

There's lots of conditions where people have intolerable suffering, severe disability, and perhaps if they're not dying, then with some time and with some support, they actually find that their quality of life is pretty good and they would potentially regret not having that chance at life later on. So I'm not saying that I totally object to getting rid of it, but I think that in those cases where you would not be using that as a criterion, you have to be even more careful with the other criteria.<sup>147</sup>

None of the respondents working outside of Québec who had done more than a handful of assessments described the NDRF criterion as a strict end-of-life requirement; on the contrary, the accounts of those clinicians who had done the most assessments indicate that the reasonably foreseeable natural death requirement lends the requisite gravity for a patient's condition to be grievous and irremediable. There is interpretive flexibility to be found in each eligibility criterion in C-14, including NDRF. If the manner and timing of the patient's natural death is more predictable on account of their particular medical condition, it qualifies as reasonably foreseeable. That factor rounds out and lends gravity to the rest of the eligibility criteria, which it appears the most experienced clinicians judge as a whole.

### **B. Differences in Québec versus the Rest of Canada**

It is necessary to examine further Québec's distinct regulatory context for the provision of MAiD. Québec physicians also must report to a specific regulatory body created for this purpose – the *Commission on end-of-life care* – created by section 38 of the *Act Respecting End-of-Life Care*.<sup>148</sup> Its broad mandate is “to examine any matter relating to end-of-life care.”<sup>149</sup> Once a Québec physician administers MAiD, he/she must submit a notice to the Commission within 10 days,<sup>150</sup> in order for the body to assess its compliance with the *Act*'s requirements for

---

<sup>147</sup> Participant 4, *supra* note 122.

<sup>148</sup> *Ibid*, s 42.

<sup>149</sup> See *Act Respecting End-of-Life Care*, *supra* note 9, ss 38–39 (for the composition of the Commission).

<sup>150</sup> *Ibid*, s 46.

providing MAiD.<sup>151</sup>

One physician mentioned that he perceived the notice to be submitted to the Commission as a burden: “In the ten-page report we are under the obligation to send to it, the CSFV [*Commission on end-of-life care*] always requires the numerical prognosis failing which we will receive an inquisitive letter (44% of doctors who practiced MAiD received one or more letters from the CSFV, about the prognosis but also about various different ‘other violations of the law.’)”<sup>152</sup>

Another physician also deplored the tighter deadline imposed by the Commission: “Canada gives a month to fill it out, Québec gives ten days. That’s constraining, ten days. If you do a MAiD before going away on vacation, or whatever, well you have trouble completing it in ten days.”<sup>153</sup>

Another physician expressed his opinion on the limitations to the Commission’s role, objecting that it is strictly retrospective and does not provide prospective help to providers:

And I asked the *Commission on end-of-life care* if we could submit situations that are at the limit, to somewhat get absolute (laughs) before doing it, but it seems complicated, they didn’t give me a clear answer about that. But I think we should, when we aren’t that sure and that we fear being blamed, to maybe be able to present the case to know if, if it’s acceptable, or if it’s declined, well in fact the blame of having denied is shared and maybe more acceptable for the patient and for the physician who denies.<sup>154</sup>

While the Québec respondents generally agreed that the Commission’s supervisory role is important, most of them expressed dissatisfaction with how it operates, deeming it excessive. Some physicians said that they felt the Commission’s members did not fully understand the complexity of the demands on MAiD providers, which was reflected in the

---

<sup>151</sup> *Ibid*, s 47.

<sup>152</sup> Participant 16 (81-year-old MD, PQ) [Participant 16].

<sup>153</sup> Participant 18, *supra* note 86.

<sup>154</sup> Participant 19 (69-year-old MD, PQ).



design of the notice form and issuance of *post facto* inquiries.

While Québec physicians were pioneers in the provision of MAiD in Canada, the approach in Québec is now more cautious and restrictive than in other provinces. This is not solely due to the differences in the criteria set out in the *Act respecting end-of-life care* and section 242.2(2) of the *Criminal Code*.<sup>155</sup> The unique reporting requirements and review powers of the relevant regulatory body in Québec have an impact on interpretative practices in that jurisdiction. Interpreting the law restrictively is the surest way to avoid adverse consequences in both contexts.

Among the 15 doctors we interviewed outside of Québec, the vast majority said that they had supported legalization of MAiD. One spoke about certain personal and clinical experiences she had had shortly before MAiD was legalized, which led her to change her opinion. Many respondents outside Québec said that they had started to support the idea of MAiD after seeing the way loved ones had died and not wanting to let themselves, or anyone else for that matter, have to endure the same fate. Others cited patients who had expressed the wish to die, including some who had ended their lives themselves. Certain respondents emphasized respect for patient choice. One respondent expressed how his political beliefs about the right to medical assistance in dying informed his sense of professional obligation to provide it:

I was very passionate about MAiD or voluntary euthanasia for a long time... It's very much in line with my overall clinical, career trajectory of working with marginalized populations and just ensuring that no one gets left out of health care because the people who are so sick they can't even control the

---

<sup>155</sup> One exception is the *Criminal Code*'s 10-day mandatory waiting period. It is not found in the Québec legislation, but due to the overlap of jurisdictions, Québec physicians nonetheless observe this requirement. Conversely, another difference between the two statutory regimes results in nurses not serving as MAiD assessors or providers in Québec. The *Act Respecting End-of-Life Care*, *supra* note 9, does not permit nurse practitioners to assess or provide MAiD in the province. Some of the interviewed physicians did not see a problem with nurse practitioners participating in MAiD in the future, under the condition that a physician be involved, while some others indicated that it should remain an act reserved to physicians. Some of them expressed doubts as to whether nurse practitioners would actually want to be involved in the assessment and provision of MAiD, alluding to the burden (either emotional, administrative or both) that they associate with these acts.

trajectory of their own death and die the way they want to... [they] are definitely the most vulnerable and those we have to support...I felt very much a moral imperative to assist if no one else was willing to because it had to happen. If there had been a slew of other doctors that would have done it, I probably wouldn't have gotten involved. I would have been busy enough, but no one else was coming forward. I felt the need to.<sup>156</sup>

Of all the providers we interviewed outside of Québec, only one spoke to having had reservations about the legalization of MAiD:

I was a bit concerned because I was worried about the impact on people who were vulnerable. I work a lot with people who have multiple disabilities and I'm a generation away from people who lived in Europe where a lot of people got killed in facilities who had disabilities, so I was very, very concerned about this possibility and I was very concerned about how I would teach this, if this became legal, to our students because I'm very involved in the teaching program.<sup>157</sup>

Meanwhile, among the nine Québec providers we interviewed, the proportion of people who had originally opposed MAiD was higher. Two stated that before the law changed, they were against MAiD. A third said: "I was in agreement, but not in every case."<sup>158</sup> A fourth noted that they had come round to supporting the practice as a result of reading the various studies and reports involved in the lead-up to the National Assembly's Select Committee on Dying with Dignity tabling the *Act Respecting End-of-Life Care*.<sup>159</sup>

Whereas certain Québec providers described being persuaded through the consultation process that produced the provincial law on end of life care, none of the providers we interviewed in the study ever mentioned that the Supreme Court's decision in *Carter* had convinced them to support MAiD. For the Québec practitioners, conversations with colleagues, as well as the guidelines and oversight of the CMQ, all played a

---

<sup>156</sup> Participant 5, *supra* note 91.

<sup>157</sup> Participant 3, *supra* note 93.

<sup>158</sup> Participant 17 (62-year-old MD, PQ).

<sup>159</sup> *Act Respecting End of Life Care*, *supra* note 9.

role in the interpreting patient eligibility. They did not refer to case law outside of Québec, given the distinction between end-of-life requirement in the Québec legislation and the review powers of the *Commission on end-of-life care*. Besides, they are not interpreting the *Criminal Code*. They are interpreting the *Act Respecting End-of-Life care*, whose purpose “is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy”.<sup>160</sup> For physicians and nurse practitioners in the rest of Canada, they are not interpreting provincial health legislation concerned with patient care at the end of life; they are interpreting the statutory eligibility criteria carving out an exemption to the offence of murder.<sup>161</sup>

Furthermore, the statutory language itself is different: “end of life” is used rather than “reasonably foreseeable natural death.” Nevertheless, the definition of “end of life” is reported as one of the most difficult to interpret by the Québec physicians. It is interesting to note that while the Québec law has not been amended since its adoption, the interpretation of the implicit length of time characterizing end of life has expanded over time. One physician mentioned that at the very beginning, end of life was interpreted by some as to mean a maximum of two weeks left to live. In *Truchon*, the MAiD provider called as an expert witness by the government indicated that he had originally restricted eligibility to “the terminal stage (death within one month) of the illness” but that now he was “comfortable administering...where the prognosis [was] six months or less.”<sup>162</sup> The MAiD provider testifying for the plaintiffs indicated that he had administered MAiD to patients whose prognosis was twelve months and that the longest prognosis he had established was eighteen months.<sup>163</sup> Justice Baudouin notes that the government witness acknowledged that “a rapid decline of the illness makes patients with a prognosis of up to eighteen months eligible.”<sup>164</sup>

The Collège des médecins du Québec (CMQ) published internal practice and pharmacological guidelines on MAiD; its most recent version,

---

<sup>160</sup> *Ibid*, s 1.

<sup>161</sup> The victim’s consent to “have death inflicted on them” is still no defence to culpable homicide. See *Criminal Code*, *supra* note 6, s 14.

<sup>162</sup> *Truchon*, *supra* note 1 at para 168.

<sup>163</sup> *Ibid* at para 161

<sup>164</sup> *Ibid* at para 168.

from April 2018, does not provide a specific length of time for calculating end of life.<sup>165</sup> However, our respondents suggested there was an implicit clinical norm that end of life should now be interpreted as a death that is foreseeable within the next 12 months. With few illnesses offering such a predictable trajectory, respondents noted the difficulty making such a precise prognosis. They also distinguished between the end-of-life criterion and the reasonably foreseeable natural death criterion, with most highlighting that the reasonably foreseeable natural death criterion is considerably more flexible than the end of life criterion.

Several Québec-based physicians stressed that applying the requirement that a patient must be “capable of giving consent to care” is difficult to do in practice. Section 26 specifies that “[t]he patient must request medical aid in dying themselves, in a free and informed manner, by means of the form prescribed by the Minister. The form must be dated and signed by the patient.”<sup>166</sup> Section 29 adds that the physician must make “sure that the request is being made freely,” must make “sure that the request is an informed one,” and must verify “the persistence of suffering and that the wish to obtain medical aid in dying remains unchanged.”<sup>167</sup> Several respondents underscored a tension between requiring patients to be competent to receive MAiD but only allowing them to do so at the end of life.

Indeed, one physician described the rule that a patient have capacity right up until MAiD is provided as “medically unacceptable”, an “injustice,” and “anxiety-provoking”; he called it “totally unjustified”, saying it “leads patients to refuse their treatment aimed at providing comfort (analgesics, anxiolytics, sedatives)”.<sup>168</sup> Another physician said that this is an area in which “there’s been damage done”.<sup>169</sup> Yet another stated that a refusal solely on this basis can be very difficult for families to accept if a patient has deteriorated within a short period of time while

---

<sup>165</sup> Collège des médecins du Québec, “Medical Aid in Dying – Updated 04/2018 – Practice and Pharmacological Guidelines” (2018) at 18, online (pdf): <[www1.otstcfq.org/wp-content/uploads/2018/09/medical\\_aid\\_in\\_dying.pdf](http://www1.otstcfq.org/wp-content/uploads/2018/09/medical_aid_in_dying.pdf)> [perma.cc/3SQ3-E9N4].

<sup>166</sup> *Act Respecting End-of-Life Care*, *supra* note 9, s 26.

<sup>167</sup> *Ibid*, s 29.

<sup>168</sup> Participant 16, *supra* note 152.

<sup>169</sup> Participant 20, *supra* note 84.

waiting to be provided with MAiD. A physician also underlined that capacity can be challenging for providers to assess, considering that psychiatric factors can confuse what would otherwise be a clear, lucid consent and could lead to discrepancies among psychiatrists' and providers' medical opinions on a patient's capacity to consent.

Among respondents in the rest of Canada, most of their criticism of the current law centred around the requirement that the patient have the capacity to consent to MAiD right up until the performance of the procedure as well. There was no consensus among either group of providers, however. Saying he thought the law in this respect should "probably" be changed, one provider from outside Québec stated:

I've had a couple people where we have lightened up on their analgesia and sedation so that we were sure they were awake enough to give final consent and so I think there probably should be some way of saying today, 'I'll be ok with this tomorrow', and if they need Ativan or more morphine or whatever it is, that they can have it. It seems a little bit cruel to me to deny people the best palliative care in their final hours. I don't like that that much.<sup>170</sup>

Most respondents who, like this one, expressed concerns with the contemporaneous consent requirement were also quick to draw a distinction between situations where a patient loses capacity (and therefore eligibility) after their MAiD request has been approved, and other cases of advance requests for MAiD. Unlike the provider quoted above, most did not reference a particular time limit.

Outside of Québec, a considerable range of intervals appears to arise between approval of a patient's request and delivery of MAiD. Although one assessor said that "[i]n general I feel like if someone isn't ready to set a date, then their suffering is not intolerable,"<sup>171</sup> another indicated that in some cases, they anticipated that the patient would not go through with MAiD for some time after receiving approval:

For example, somebody with an ALS diagnosis that wants to put all their paperwork in place but they want to just follow along and wait until a moment where they feel that things have

---

<sup>170</sup> Participant 9, *supra* note 146.

<sup>171</sup> Participant 4, *supra* note 122.

changed enough for them that now they're suffering intolerably and now they want to proceed, so I think that is something that we do in practice. So even though I see somebody who may have been diagnosed with ALS for a year or two and they're still functioning not too badly, so their death might even be a few years away, I would still approve somebody like that.<sup>172</sup>

Evidently, the types of medical conditions determined to qualify as "grievous and irremediable" may vary widely; so too may the length of time patients have remaining and the chances of them losing capacity before they are able to have their approved MAiD request fulfilled at the time of their choosing. That the most vociferous objection to maintenance of capacity came from a provider in Québec is unsurprising. Due to the statutory scheme operating in Québec, including the establishment and function of the Commission and the fact, for related reasons, the ruling in the Ontario case of *A.B.* had virtually no impact, physicians deal exclusively with end of life cases; thus, in this province, there is likely a larger proportion of patients who are losing eligibility (due to loss of capacity) while waiting to become eligible (based on the end of life requirement).

The suggestion that "there probably should be some way of saying today, 'I'll be ok with this tomorrow', and if they need Ativan or more morphine or whatever it is, that they can have it",<sup>173</sup> may be instructive when it comes to defining a temporal limit on a patient's expression of consent in advance to receiving MAiD. As evidenced in a story that the same respondent recounted, establishing the patient's own informed, voluntary consent to MAiD remains a crucial safeguard in the statutory scheme:

One of the glioblastoma patients that I had, he had a degree of competence when I first met him, and he just wasn't ready. He was a lifelong Toronto Maple Leaf fan and he thought this was the year that they were going to do well and he wanted to enjoy their success. His suffering was from his brain tumour and from the Maple Leaf's lack of success. He had that, and there was a grandchild that was going to be born. So we did the assessment and as far as I was concerned he was a good

---

<sup>172</sup> Participant 6 *supra* note 102.

<sup>173</sup> Participant 9, *supra* note 146.

candidate for it. He was ready to die, just not yet. And unfortunately, as time went on, he lost capacity. And his wife was distraught with the burden of looking after him. And I lived in [rural location] and he lived in [other rural location] and so we couldn't be driving back and forth. And so we spoke on the telephone every week. And his conversations made less and less sense, but her conversations were increasingly sad and frustrated and she was sort of saying 'we need to get this over with because he's not going to make it'. And I said 'but he doesn't want to die yet'. And so she was advocating for her husband's death, not because there was anything in it for her other than the fact that watching him die was slowly killing her. And every week we'd have that conversation and I'd have to say that he's the one who has to consent and he doesn't want to die yet, so we're not going to do this.<sup>174</sup>

### Conclusion

Based on these interviews, there is evidence that over time the interpretation of each criterion has broadened (even though a small minority of respondents claim they always understood the criteria the way they understand them now). Assessors recount drawing on a variety of sources to interpret and apply the legal criteria. They describe their interpretation of the MAiD eligibility requirements evolving after discussing their clinical practice experiences with colleagues (or reading the exchanges between colleagues recounting their experiences and opinions on the CAMAP listserv). They cite CAMAP conferences and workshops, court decisions and scholarly papers as informing the way their perspectives have changed. Rarely did any respondents consult lawyers. All but one lamented the lack of valuable assistance from the Canadian Medical Protective Association legal counsel. The lawyers they consulted urged a cautious and restrictive approach, emphasizing the risk of running afoul of the criminal law. Only one provider spoke of legal counsel as a valuable resource, noting however that the MAiD team benefited from a longstanding professional relationship with legal counsel.

Although providers across the country risk criminal liability for running afoul of the eligibility criteria, it is where the *Criminal Code* alone serves as the sole governing legislation that interpretation is most flex-

---

<sup>174</sup> *Ibid.*

ible and access to MAiD the widest. Several respondents said they have the impression that other health care professionals and members of the public think the MAiD eligibility criteria are more restrictive than they are and express concern that, consequently, access to MAiD may be uneven. As the Government of Canada acknowledges in its 2019 MAiD report, the data on formal requests does not provide a full picture of how physicians and nurse practitioners respond to their patients' questions about their eligibility for MAiD.<sup>175</sup> The NDRF criterion doubtless enables health care providers to tell patients that MAiD is not available among their treatment options. Without it, one respondent suggested the other requirements (or at least how they are currently assessed) may not be enough.

The criminal law provisions do not by themselves produce a clear, predictable, nuanced, or standardized set of reference points for clinical determinations of MAiD eligibility. Certain assessors described consciously applying the NDRF criterion after they were satisfied the patient was eligible, in order to justify their decision to provide MAiD. In their view, the provision mattered most when it came to demonstrating that they had complied with the law. That assessors do seek to justify and provide evidence for their conclusion that a patient's condition qualifies as "grievous and irremediable" shows that the law is providing an authoritative baseline. In other words, seeking to "be seen" to act properly may be evidence of ambivalence toward the substantive legitimacy of the law (more an acknowledgement of its force and decision to avoid its negative consequences), but it may also evince an attitude of respect and recognition for the law's role in legitimating one's actions. So while the CAMAP listserv is a forum that has likely contributed to an expansion or broadening of interpretations of the C-14 criteria, it has also served as a means of holding participants accountable, to demonstrate that their clinical assessments are justified in light of the law (rather than saying "to hell with it").

Each of the four statutory criteria comprising "grievous and irremediable medical condition" establishes a verifiable standard. Verification depends on the patient's subjective experience, most of all when it comes to "suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable". When it comes to having a "serious and incurable illness, disease or disability" and being in "an advanced state of irreversible decline in capability" these

---

<sup>175</sup> See Health Canada, *supra* note 73 at 16–17.



depend (to a lesser but still substantial extent for the majority of our respondents) on an individualized, patient-centred basis as well. It appears that there are more and less patient-centred approaches to interpreting the NDRF criterion – and that for the most part our respondents subscribe to a flexible standard and want their colleagues and the public to know that NDRF has this flexible meaning.

While MAiD providers apply the statutory criteria in the course of their clinical practice, their interpretations are shaped by their perception of what their role and duties are as health care professionals and MAiD assessors and providers. They are both motivated by, and statutorily obligated to consider, a patient's intolerable suffering. Identifying and redressing the variety of factors (beyond the psychopathological) that may contribute to a patient's informed and voluntary decision to receive MAiD do not figure among their clinical duties.

Respondents expressed varying views about the law, including whether and how it should be changed. Some voiced objections to specific wording in the legislation, either due to its effects on their clinical practice (i.e., obliging them to reduce pain medication and therefore increase suffering so patient maintains competence up until the end) or because ambiguity presumably results in uneven access. Several respondents said the MAiD provider community knows eligibility standards are more flexible than the wider medical community and Canadian public tend to think, and there is evidence of differing ideas among providers about which circumstances warrant the provision MAiD. Further studies are required to adequately address these topics. Our aim here is not to advocate for any position vis-à-vis the law; it is to advance understanding of how the law is being interpreted on the ground.

How does criminal law govern the assessment of MAiD eligibility? In the first section, we identified what the law states, how the courts have interpreted it, how scholars have weighed in and what relevant professional bodies have stated in their policies. Evidently, it is MAiD assessors and providers whose interpretations are serving to define what the law means in practice. Their interpretation is informed by the exchanges on the confidential CAMAP listserv, discussions with colleagues, reading the relevant academic literature, and speaking with experts at related conferences. Respondents reported rarely seeking the advice of legal counsel and then only for difficult cases.

The NDRF requirement remains, with Bill C-7, an important legal and clinical element in determining eligibility for MAiD. Our study reveals

