Thank you for having me. Today I will be sharing with you some of my experiences over the past 7 years of legalized euthanasia and assisted suicide in Canada.

In Canada the administration of a lethal dose of drug to intentionally end life is called 'Medical Assistance in Dying' – this includes both euthanasia, where a clinician administers the lethal drugs, and assisted suicide where the patient self-administers the lethal drugs. Almost all the cases of MAiD in Canada are euthanasia.

In 2016 Canada legalized MAID for those with a 'reasonably foreseeable death'. During the development of the legislation, Canadians were led to believe this would be for exceptional circumstances for a very few people who had intolerable suffering at the end of their lives. Over the next few years, we saw expansion of eligibility through acceptance of progressive interpretations of the legislation and court rulings. For example, a provincial Superior Court judge ruled that 'reasonably foreseeable death' criterion did not require a specific prognosis and a 77-year-old woman with osteoarthritis (OA) was approved, presumably based on her age, as OA is not a life-limiting condition.

In 2019, another provincial court struck down the requirement for reasonably foreseeable death as it approved euthanasia for 2 appellants with disabilities - cerebral palsy and post-polio syndrome. The Federal government did not appeal and in March 2021 amended the MAID to extend eligibility to those with a chronic illness, disability, or mental illness as a comorbid diagnosis, and as of March 2024, mental illness as sole diagnosis. At that same time they also removed a number of safeguards that had initially been put in place to minimize harm but were now seen as barriers to accessing MAID.

The current federal government has committed to further expansion of MAID in a staged approach including examining MAID for children and youth deemed capable of making their own medical decisions ("mature minors") and advance directives.

In terms of numbers, our most recent published national report is from 2021 data. In the 4.5 year period from 2016-2021, there were over 30,000 administered deaths and the numbers have increased annually by ~25-35%. The provincially reported numbers in Quebec and Ontario for 2022 show a similar increase of ~30% with Quebec MAID deaths in 2022 accounting for 6.1% of all deaths, up from 4.7% in 2021, more than any other jurisdiction in the world. The original picture painted of MAID being a rare event for very extreme circumstances has not been over reality.

At the outset of the Canadian euthanasia legislation, we were told that a "carefully designed and monitored system of safeguards" would limit harm and risk of wrongful death to vulnerable persons. Year after year there have been documented cases of non-compliance with safeguards and misapplication of both law and policy for MAiD. The Chief Coroner of Ontario, The End of Life Care Commission in Quebec, and the Correctional Investigator of Canada have all reported these issues. The head of the End of Life Commission in Quebec, Dr. Michel Bureau, recently stated that

"We're no longer dealing with an exceptional treatment, but a treatment that is very frequent" and that the Commission has seen a slight increase in the number of cases that violate the legislation. A report in the Canadian Journal of Bioethics recently concluded that the Canadian MAiD program "…has failed to provide Canadians with evidence to show that it is operating as mandated by the requirements of the law, regulations, and expectations of all stakeholders."

The revised 2021 Canadian MAID legislation established a second track for MAiD to end life for those with chronic illness and disability with a 90-day assessment period. But experts concerned that 90 days is wholly inadequate as suicidal ideation and depression peaks around 90 days after a diagnosis of a serious illness (and in most cases resolves over a 3-24 month period). Specialist care such as psychiatry, chronic pain and rehabilitation experts will take more than 90 days to access and see therapeutic improvements. Suicidality in chronic disease resolves over a 3-24 month period (often peaking at 90 days) but mental illness supports can take 5-6x longer to access than MAID.

We are seeing increasing numbers of Canadians asking and receiving MAID due to loneliness and depression from social deprivation and lack of access to supports needed for living. Including lack of access to adequate care, lack of access to parole for some prisoners, high costs of care, poor conditions at residential facilities, and fear of social isolation with COVID lockdowns. Former Minister for Disability Inclusion Carla Qualtrough stated to the House of Commons Justice Committee that "in some places in our country, it's easier to access MAID than it is to get a wheelchair."

MAID has been radically normalized as routine medical care. Some physician regulatory bodies and the new Health Canada Model Practice Standard for MAID are recommending that MAID be raised to all potentially eligible patients as one of the therapeutic options. But MAID is not just like any other option. It is irreversible and has significant ethical and professional implications. If a doctor offers unsolicited MAID as an option to a patient, this may be all that is needed to push a vulnerable patient to want to end their life. Patients take the recommendations of their doctors seriously due to trust in their expertise and that they have their best interests in mind.

Expressions of a desire to die are often expressions of grief, anger, loss and despair as a response to a devastating diagnosis or change in condition. This "lament" - often a cry for help – now often results in a MAiD consult before palliative care has been involved. Recently, a patient struggling with feeling they would be better off dead specifically asked to see the palliative care team but the MAiD team was sent instead.

Doctors are now facilitating suicide completion rather than suicide prevention. For example, an actively suicidal patient with all the high-risk indicators for suicide completion was seen in an oncology clinic and psychiatry was consulted. Rather than admitting the patient, as would have routinely been done, the patient was given the MAiD team phone number and told they would be eligible for MAID and it would be easier than doing it themself.

All healthcare facilities are expected to provide regardless of their philosophy or focus of care, eg hospices whose core palliative care philosophy includes not hastening death. The Irene Thomas hospice in British Columbia was shut down for refusing to provide MAiD onsite, even though patients could access MAiD next door at the hospital facility. And in Quebec, MAID legislation now requires all hospices and palliative care units to provide MAID. There are no euthanasia-free safe spaces.

MAID has completely changed the practice of medicine. There is no requirement for a patient requesting MAID to have tried any evidenced based medical therapies – even in the case of potentially treatable conditions – that may alleviate the suffering leading to the desire to die. In other international jurisdictions that allow euthanasia for those who are not dying - and there are only 3 – euthanasia is seen as a last resort when all other options have been exhausted. In Canada, death can be administered as a first line treatment for virtually any form of suffering.

What happens if a severely depressed person – assessed as capable of decision-making – refuses all available treatment and support measures and insists on obtaining MAID instead? How is mental health care and suicide prevention possible? I have seen this exact case where a patient had another underlying illness that qualified them for MAID but their suffering was driven by untreated acute onset major depressive episode. They received MAID the same day as their request with no other supports provided.

We have also seen a culture of silence evolve around concerns with MAID. Health care professionals who voice concerns about patient safety or advocacy for the necessary safeguards to prevent wrongful deaths have been dismissed as being 'anti-MAiD' or accused of trying to block access to MAiD. This is causing division and conflict within the medical profession and teams, on top of division already seen within many families over this issue.

We are in a difficult place in Canada. Healthcare professionals are regularly experiencing ethical or moral distress about MAiD and many colleagues – including nurses, social workers and physicians – have stopped practicing palliative care because of this. Legalizing MAID has changed everything.