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MAID in Canada: A Multidisciplinary Conversation about End-of-Life Issues with David Guretzki, Kristin Harris, and Paul Blair

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Robert Dean: How did each of you get drawn into the conversation surrounding medical assistance in dying (MAID)?

David Guretzki: I was teaching at Briercrest when the Ontario cases surrounding physicians' conscience were being tried. I was called upon to do a couple affidavits on behalf of the claimants in terms of why effective referral might be contrary to an evangelical way of looking at the practice of medicine—especially to the practice of MAID. That's where I got pulled into it. I didn't really go looking for it, but God called me into it. I wasn't even really sure why God

[1] Special thanks to James Bensch who prepared a full written transcript of the original recording of the conversation.

called me into this, but it enabled me to do a bunch of research and I started writing about it.

Kristin Harris: As a Christian medical professional, I have had conversations with colleagues over the years as the MAID discussion has evolved in Canada. When Bill C-34 was introduced in Manitoba to protect conscience rights for medical professionals, I presented before the Legislature in support of conscience rights for those who do not feel comfortable providing or referring for MAID. I work both in a clinic and in a hospital, and I frequently have end of life discussions with patients. Usually, these conversations revolve around finding out how much intervention a patient might want to potentially save their life versus choosing more of a comfort care approach and limiting lifesaving interventions. Since MAID has become legal, and more so in the last year, an increasing number of patients are asking about MAID and some have requested it. I have had to figure out how to respond to these requests in a loving way, that also does not compromise my conscience and deeply held values.

Paul Blair: For me, I just can't avoid it. It's part of my job. I got into hospital chaplaincy shortly after the legislation passed in 2016. These days, I am probably involved with at least four or five cases a month. I had to decide early on how I was going to interact with these cases.

RD: For those who have not been following the legal developments here in Canada that closely, it might be helpful to them if you could outline the process of legalization of MAID and the changes of the law in recent years.

PB: In June 2016, the Parliament of Canada passed federal legislation allowing eligible adults to request MAID.[2] At that time, to be eligible, you had to have a terminal diagnosis with your death being

[2] For the official government of Canada website pertaining to MAID, see "Medical Assistance in Dying," Government of Canada, modified June 23, 2022, https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html.

reasonably foreseeable and you had to be experiencing unbearable suffering. Assessments were required from two separate physicians and there was a minimum ten-day waiting period, before MAID could be administered. After the ten days, MAID could be provided at any time, as long as the patient still possessed the ability to give active consent. At that time, psychological illness was not a candidate diagnosis.

Then the Supreme Court of Quebec challenged the constitutionality of the foreseeable death part of it, which was when the federal government modified things in March 2021. So now there are two tracks. In one track, you've got people whose deaths are foreseeable and have been given a terminal diagnosis, who follow the previous process, except that the ten-day waiting period has been eliminated. In the other track, you have people whose deaths are not foreseeable, and they have a ninety-day waiting period. In March 2023, mental or psychological illness will become a candidate diagnosis as well. They've also now instituted a pre-approved consent process, so that you no longer need to be able to provide active consent at the time of the provision of MAID.

KH: According to the new regulations, a MAID request has to be made in writing and it has to be signed by one independent witness (previously it was two). A paid professional personal or health care worker can act as independent witness. A person requesting MAID must be assessed by two separate physicians for eligibility. At least one of the physicians must have expertise in the medical condition the patient is suffering from, and if not, a practitioner with the expertise must be consulted. The patient must be informed of available and appropriate means to alleviate their suffering, including counselling, mental health disability support services, community services, and palliative care; must be offered consultation with professionals who provide those services; and the patient and practitioners must have discussed reasonable and available means to relieve the patient's suffering and agree that the patient has seriously considered those means.

RD: Cultural commentators sometimes look to Canada as the canary in the coal mine of Western societies when it comes to medical assistance in dying, as Canada now has some of the least restrictive laws surrounding MAID in the world. What are each of you are seeing in your respective contexts?

PB: This last amendment to the law has just sped everything up. I'm sometimes flabbergasted at how fast it happens because there's no required reflection period. Now it takes more time to file a marriage licence than it does to kill yourself. The law requires you to be more reflective about taking out a car loan than about ending your life. I have seen patients euthanized within less than twenty-four hours of asking for it—which is unprecedented in health care. There is no other health service you can access that rapidly

KH: It's shocking to me the emphasis that is placed on everyone having access to MAID. That same emphasis and urgency is not put into providing proper palliative or spiritual care for patients. Why is there no push to expand palliative care so everyone can have access to it, just like MAID? Why is more training not being provided so we can properly manage people's pain, discover their true fears and needs, and be able to engage with them in existential end of life discussions? It seems as if the latter interventions take much more time, money and manpower, which isn't always as attractive to those in leadership making decisions.

DG: What is also frightening is that there actually was an all-party agreement at the end of 2017,[3] that there should be a national strategy developed on palliative care. Even though that's already half a decade ago, less than 25% of Canadians actually have significant access or real access to palliative care.

[3] See Bill C-277, "An Act Providing for the Development of a Framework on Palliative Care in Canada," Parliament of Canada, December 12, 2017, https://www.parl.ca/DocumentViewer/en/42-1/bill/C-277/royal-assent.

KH: Oregon was one of the first states to legalize MAID, and when patients were surveyed about their reasons for requesting MAID: 92% said they feared losing their autonomy; 89% mentioned less engagement in activities that are enjoyable; 79% were concerned about loss of dignity; 48% referenced losing control of bodily functions. Interestingly, inadequate pain control (which is often cited by MAID advocates) was low on the list (25%).[4] These reasons are much more existential than physical.

PB: These days our understanding of pain management is so sophisticated that rarely anyone dies in the throes of agony as we tend to imagine. It's probably been ten years since I last saw a patient who was writhing and moaning on their way to death. Perhaps that's why the people in Oregon were not all that concerned about physical pain and suffering.

DG: In the 2020 federal report on MAID, only 57% of those who received MAID cited inadequate control of pain (or concern), and 50% inadequate control of symptoms other than pain (or concern). But 85% said the reason that they opted for MAID was loss of ability to engage in meaningful activities and 82% mentioned loss of abilities to perform daily activities.[5]

RD: I'm intrigued with the reasons that you've shared because there seems to be a disconnect between the public messaging and perception and the genuine reasons that people are engaging in MAID. At the popular level or when you hear politicians speaking it's about alleviating physical suffering. But as you are pointing out, that's not actually the reason that people are giving. What do you think lies behind this disconnect?

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[4] Charles Blanke et al., "Characterizing 18 Years of the Death with Dignity Act in Oregon," *JAMA Oncology* 3, no. 10 (October 1, 2017): 1403–6.

[5] "Second Annual Report on Medical Assistance in Dying in Canada 2020," Government of Canada, modified June 30, 2021, https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2020.html.

KH: I think that the majority of society these days struggles to see any value in perseverance or suffering. We want to be healthy and happy and any kind of suffering is perceived in a negative light. We forget that often those we most admire, we admire for how they have overcome adversity and trials. Our society has moved towards an individualistic world view. We often hear about "my rights," and "my truth." I think people have lost sight of our interconnectedness.

DG: I think you've nailed it. Suffering is seen as having no possible redeeming qualities whatever. And yet, as Christians, we know that Christ endured the cross. Hebrews 12:2 instructs us to fix our eyes on Jesus, "the author and perfector of our faith, who for the joy that was set before him endured the cross, despising shame" (ASV). Christ endured the cross of suffering, but he despised the shame. I think, for us today, suffering is viewed as shameful. It is not only something to be avoided, but it's shameful. One of the things I've been saying is that the church has to somehow come alongside those who are suffering and say, "Suffering isn't necessarily shameful." All the top reasons for requesting MAID that appear in these studies are rooted in shame. So alleviating suffering is intimately tied up with alleviating shame. I think there's a real connection there that hasn't always been understood.

Autonomy and independence is what we're taught from the earliest days of childhood and maturity is viewed in terms of being utterly independent. When one loses that independence, they find themselves on the wrong side of society's expectations. When we lose independence, when we lose bodily function, when we lose the ability to do the regular meaningful things that everyone else does, we recoil in shame. I think there's something there to be worked out.

KH: The psychiatrist and Holocaust survivor Viktor Frankl liked to say that "despair equals suffering without meaning."[6] He understood that we human beings can actually endure quite a bit, but if we don't perceive any meaning to it, that's when despair tends to set in. If we can help people find meaning in the midst of their suffering, we can help to combat the kind of despair that leads to MAID.

DG: And meaning is connected to other people. It's connected to caring family members; it's connected to our children or grandchildren; it's contributing to others; it's visiting; it's enjoying the hospitality together with others. So much of human meaning is tied up with our sociality. This points to a problem in our health care system. So many of our medical systems are designed to isolate people away from their social networks. Now there are some reasons for that, but when you channel people away from their normal, social communities of church and family and community, it's no wonder they lose meaning.

PB: I think we live in a culture that has trained us to look at life as a natural resource to be exploited. We milk life for what we can get out of it. Almost everyone you talk to on their deathbed who is despairing in that sort of way will say something like, "What do I have to live for?" I will often say to them, "You're right, nothing. You're done living, you're in your dying time now. Maybe instead of looking to see what you can get out of life, it is time to think about what you can give." In more traditional cultures, your dying time is when you prepare your legacy. This is where you focus on forgiveness and repairing relationships. This is where your dependence on others becomes an opportunity for them to love, to exercise charity. For most people, the idea that something would be asked of them on

[6] Viktor Frankl, "Finding Meaning in Difficult Times (Interview with Dr. Viktor Frankl)," YouTube, accessed July 12, 2022, https://www.youtube.com/watch?v=LlC2OdnhIiQ.

their deathbed just doesn't compute. We need to flip that situation on its head because dying is about giving, it's *kenosis*, pouring out.

DG: There's a great little book by a professor from P.E.I., Ian Dowbiggin, entitled *A Concise History of Euthanasia*.[7] Dowbiggin draws upon the language of *euthanasia*, which literally means 'good death' to explore how there was a symbiotic relationship between physicians and caregivers in the early Reformation age. Physicians were there to deal with symptoms and pain and suffering as best as they knew how in their era but dealing with suffering and pain wasn't an end unto itself. It was to enable the person as much energy as possible to focus on their spiritual life and their familial and community relationships. The physician and the priest stood on either side of the bed and saw themselves as true partners in this cause.

Another thing that should factor into the discussion is the role of economics and the quantification of life. The last year or months of life are the most expensive in terms of health care.[8] So when you start to crunch the numbers, MAID makes good economic sense. Nobody wants to talk about it that way. But there is a driver there, because we all know that health care is a significant part of the economy. But there's also a calculus of value that can commandeer our thoughts—what worth am I playing to my family now? How much is the burden on them to care for me? We are all taught to quantify our place in society, so through that lens it becomes easy to see what someone might say, "I've had a good life, but now it's just better for everyone if I go."

KH: The thing I worry about from a physician's perspective is that feeling of coercion. I think people are vulnerable; they're already feeling like a burden. I had a patient in hospital who was transferred

[7] Ian Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine* (London: Rowman & Littlefield, 2005).

[8] Tom Blackwell, "The Last Month of Life Costs Health-Care System $14K on Average," *National Post*, April 7-8, 2015, https://nationalpost.com/news/canada/last-month-of-life-costs-health-care-system-14k-on-average-report.

to our hospital from one of the bigger hospitals. He was quite sick and he said to me, "They came up to me and asked if I wanted MAID. They told me, 'We can get the team here,' and I didn't even ask for it. I don't even want it." The fact that it's being brought up without the patient even asking about it is disturbing because I think it automatically puts the thought in the patient's mind that they are an unnecessary burden.

I have heard of numerous instances where there has been quite a bit of liberty taken in interpreting MAID rules and eligibility. I believe that the lives of vulnerable people are being jeopardized. As physicians our job is to help, support, and heal people, not kill them. If it's that important for the government to have MAID available, why not train someone other than a physician to administer MAID? Patients should be able to come to their health care provider without having to question whether their provider might urge them along the path to ending their life. The insistence upon doctors providing an effective referral is equally baffling. Why can't they set up an accessible service that people can refer themselves to without a physician? I think Canada is the only country where an effective referral is being mandated in certain regions. There's no reason for it and it feels a lot like bullying.

DG: It's absolutely mystifying. I want to circle back to our earlier conversation about life. I think a really important issue is there's a deep Gnosticism in our society that dissociates life from *bios*, that dissociates life from the body. So the traditional protection of life is bodily—protection of the bodily, biological life. But life is no longer defined by biology, life is defined in a qualitative sense. I think that physicians and practitioners who are practicing euthanasia are not defining life biologically or bodily. They are defining it in terms of quality. *Do I have a particular quality of life?* And if you don't have that particular quality, then it's not worth living—not even that it's not worth living, it's just not life. So, someone lying in a hospital bed in excruciating pain with apparently no ability to get out of that pain, by definition, does not have life. Ending that person's existence is

not even viewed as the ending of the biological life, because their life is already over. I don't know how many times I've heard people use that language, "Well, my life is already over."

RD: I think one of the things that our conversation has been circling around is that MAID is, in some senses, symptomatic of an anthropological disease. Our culture lacks a shared conception of what it is to be a human being. How important is it to recover the place of a fully orbed theological anthropology or Christian understanding of the human person in our present cultural moment?

PB: When we don't have a common anthropology, we can't make rational legislation. What we're left with is basically legislation by feelings. I remember when I first did the bioethics training that the Winnipeg Regional Health Authority put together for the new MAID legislation back in 2016. When they presented the law to us, it was apparent that anyone with a first-year course in philosophy or logic would immediately recognize its utter incoherence and internal inconsistency. It was a compromised bill that tried to wedge together two or three radically incompatible views of life and death. It was just a matter of time before it was picked apart in the courts.

To get back to your question about anthropology, I think we need to develop or recover a thanatology. Our cultural discourse around death has largely evaporated. Look at how rare it is now for funerals to happen or for an obituary to be published. Most of the time they get a two-line death notice that says, *no service will be held*. We have no idea how to engage with death, what role it plays in our existence, and the like. I think this contributes to the normalization of MAID; we don't want to talk about death and we don't want to be in a state of dying. Stephen Jenkinson has suggested that euthanasia is an understandable response of a death-phobic culture to death.[9] Before you actually have to go through dying, you just stop it.

[9] Stephen Jenkinson, *Die Wise: A Manifesto for Sanity and Soul* (Berkeley, California: North Atlantic Books, 2015).

RD: Right. Perhaps one way of spinning it would be to bring Stephen Jenkinson into conversation with Stanley Hauerwas around their conviction that both the patient and the medical industry are united in the shared conspiracy of the denial of death. If we cannot cure those who are dying, Hauerwas says, "we then think it is the compassionate alternative to help them to their death. Euthanasia thus becomes but the other side of the medical and technological imperative to keep them alive at all cost."[10] Add that aspect together with the patient's fear of death or unwillingness to grapple with the reality of death, as Stephen Jenkinson has so clearly articulated, and you have the broad contours of our present crisis.[11] Both the health service industry and their patients are bound together in the denial of death. How then does the church witness to the Lord of Life in such a context as this? Changing legislation is difficult, because as we've talked about, it looks like an arbitrary position, because we have no agreed-upon basis for rational discourse. How do we go about witnessing to the Lord of Life in the face of MAID and the culture of death?

KH: I think we need to be proactive about building relationships in our circles because so many maladaptive tendencies (MAID, addiction, mental illness) come out of loneliness. We need to be intentional about getting together with people, having people over when we can, checking in on people, because if people have those connections, they are a lot less likely to proceed down that path of thinking they are not useful anymore. We need to tell people, "I value you. I like having you around."

DG: I think we need a deep recovery of pastoral care that is not just the task of the minister, but of the whole community. This will

[10] Stanley Hauerwas, *Dispatches from the Front: Theological Engagements with the Secular* (Durham: Duke University Press, 1994), 165.

[11] Jenkinson has observed that pain is not usually the presenting problem that he is confronted with when counselling palliative care patients. Rather, their physical pain has been alleviated, but they find themselves in great angst and existential terror because they are unwilling to face their death. Jenkinson, *Die Wise*, 278.

involve the classic disciplines of pastoral care which are active listening, prayer, and Scripture reading. If you want to talk about the Lord of the Living, we hear Him through the word. The word of God is active and living, able to discern the deepest thoughts and intentions of humans. Pastoral care does not ask the question, what is the solution to the presenting problem, but what is the word of God that this person needs to hear right now?

PB: I think one way we can bear prophetic witness is by recovering a lived theology of death. So that means, I think, in a very practical way, not hiding it from your kids anymore; not doing this thing where we refuse to take little Billy and Sue to see grandma, because she's just so awful, we don't want them to remember her like this. What a disservice! You'd be surprised at how many seventy- and eighty-year-olds I speak to on their deathbeds, and this is the first time they've been at one. I don't understand how that happens. Well, it's because we hide it. It's these kinds of things that I think make dying and death so terrifying, because we treat them as this horrendously taboo topic. So, it's no wonder people are terrified of the prospect of having to do it.

DG: Isn't it interesting that the euphemism of MAID avoids the word entirely?

PB: Exactly!

RD: What do you think is at stake in the euphemisms?

PB: I am a big fan of Confucius and Confucian philosophy. There's a famous line in the *Analects*—because Confucius was always trying to fix the government—at one point one of his students asks him, "Well Confucius, if you were made the minister of state, how would you fix everything? You've clearly got all the answers, so what's the first thing you would do?" And he says, "Fix words." The "rectifica-

tion of names" is a more accurate translation.[12] But he says, "I would fix words, because until we fix our words we can't speak about the realities, and until we can speak about the realities, we can't start fixing them."

I remember one case, there was a patient, we were talking with him about MAID—elderly fellow, end of life, so there's questions about delirium and stuff like that. He asks for MAID, gets approved for it. The day the MAID team is coming, we go to check on him: "MAID team's coming; do you still want to do this?" He looks at us and says, "No, the room's clean, it's fine the way it is." This threw everyone for a loop, because now everyone wonders if he knows what he's consented to. The MAID team got there, and they seemed to think that they managed to clarify the situation and they went ahead with it, and he was dead within the hour.

DG: We tend to think of medicine as sanitary, as clean, as professional. The euphemisms themselves lend to that. There is a sanitization of MAID, because it is associated with the medical. As Kristin said earlier, there really is no reason why a physician is required to end someone's life.

PB: Right, and the language and structures are dressed up to make this look like what it isn't. Because deep down everyone knows that this is, at the very least, a bit controversial, if not wrong. So, we use language that makes it seem like it's not what we're doing. It keeps up the facade of gentility, that this is all part of normal life.

RD: CBC aired a townhall discussion on MAID a little while ago.[13] Several people asked about when they were going to be able to achieve their right to MAID and I found myself wondering why they didn't just take their own lives? It's easy enough to do. But I think

[12] Confucius, *Analects*, 13.3.

[13] Ghazala Malik, "Medical Assistance in Dying: What the Government, Experts Say about Proposed Changes to MAID Law | CBC News," CBC, July 21, 2020, https://www.cbc.ca/news/health/town-hall-assisted-dying-maid-legislation-1.5491824.

you're right, there's something that gives it moral authority if it takes place under the supervision of a doctor. The presence of a physician lends the whole thing moral credence.

KH: Some of the studies coming out of Oregon compared outcomes between those given medication to take at home and those that had the medication administered directly by a physician. There was much higher completion rate for death administered by a physician than among those who were given lethal medication to self-administer.[14] The desire to die among the terminally ill is often transient and studies have shown that over the span of twelve hours 30% of people change their minds and over thirty days 60-70% change their minds.[15] This is significant when we realize that people can now in some cases have MAID administered within twenty-four hours of requesting it.

PB: When the latest changes came out that implemented the second track for those whose deaths were unforeseeable, I remember sitting down with someone and saying, "We don't have language to describe this." What do you call an administered death for someone who's not foreseeably going to die? We would normally call that killing.

DG: It is interesting that the MAID legislation is technically a change of the definition of homicide in the criminal code. All it did was make an exception for medical professionals.[16]

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[14] For example, in Oregon where physicians write a prescription for patients to self-administer only 57% of patients prescribed lethal medication in 2021 went on to ingest it. Admittedly, there are some gaps in the data. See "Oregon Death with Dignity Act: 2021 Summary," Oregon Health Authority Public Health Division, February 28, 2022, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf.

[15] H. M. Chochinov et al., "Will to Live in the Terminally Ill," *Lancet (London, England)* 354, no. 9181 (September 4, 1999): 816–19.

[16] See Bill C-14, "An Act to Amend the Criminal Code and to Make Related Amendments to other Acts (Medical Assistance in Dying)," Parliament of Canada, June 17, 2016, https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent.

Maybe one thing I'll just add on the pastoral side: if the church would look at that chart where the federal government lists reasons why people chose MAID, they will see that of the twelve reasons given, about five of them are medically related and about seven of them are things that the church could actually contribute to. So, loss of ability to engage in meaningful activities; they probably just need someone to—I don't want to oversimplify it—but if they just had help, if someone came alongside, they could engage in activities. Perceived burden on families, well, if someone could come alongside so that families wouldn't feel so burdened. One of the things we've been seeing is that one of the primary responses to legalized euthanasia is palliative care. It's not going to solve everything, but I think that pastorally, in the absence of a change of law, the church needs to say, *okay, here are the factors; how do we step up and serve here and prevent people from making MAID their last option or last lonely option?*

PB: On top of that, churches need to start challenging the conspiracy of silence around death within their own congregations. If we give people a way to orient themselves and locate their own death in relation to God, maybe then dying isn't going to be something that has to be avoided at such costs. In the late medieval, early Reformation era, there was a whole genre of literature called the *ars moriendi*, the art of dying.[17] The whole of Christian life is supposed to be preparation for a good death, but you don't generally see that in parishes. Our entire life should have been lived in the service of preparation for a good death, for entering into that final, great mystery.

RD: Paul's comment sparked another question for me. Part of the conspiracy surrounding death that I mentioned earlier is that we have to keep people alive, maybe to the point that they don't know that

[17] For a thoughtful attempt to recover the *ars moriendi* for the contemporary church, see, Allen Verhey, *The Christian Art of Dying: Learning from Jesus* (Grand Rapids: Eerdmans, 2011).

they're dying. Is there a distinction to be made between allowing to die and putting to death?

PB: I think so. I think a lot of the suffering that people are wrestling with at the end of their life in palliative care is iatrogenic—it's oncology that doesn't know when to stop. People who, under other circumstances would have died quite a while ago but weren't allowed to because the system told them they couldn't give up yet. For most people—and you're slowly starting to see some changes in this regard— but for the most part, no one comes to palliative without having exhausted treatment options. And that leaves them exhausted for a big final task—the task of dying.

KH: Yeah, I agree. People are alive longer because we're keeping them alive longer, so they develop many chronic conditions that cause morbidity and pain and suffering. But the alternative is you would have died of a heart attack at age fifty. So, you either live to be eighty and you get chronic health conditions, or you die young and maybe don't 'suffer' as long. So, it's tricky finding that balance. At some point people tend to shift to focusing on comfort and quality of life, rather than quantity of life.

DG: I do believe there's a big difference between putting to death and allowing to die. Just because we can do something medically or technologically doesn't mean it's a good thing. I think we are going to increasingly face this challenge. Life will just be extended further and further, and as Kristin mentioned, it will probably in some ways increase the suffering, which will just reemphasise why MAID is supposedly a good thing. We need to remember that from a Christian perspective, death is not the worst thing that can happen for a Christian. Now that's a bit of a paradox because that's also what the MAID lobby is saying. But we have a different reason why it's not the worst thing, because there is hope beyond it. Death does not have the last word.