Nova Scotia Health Ethics Network

Four MAiD Principles: Two Big Challenges

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MAiD Principle 1: Equity

- In the MAiD context, the responsibility of health care organizations and providers to identify and eliminate or reduce unfair disparities among individuals and groups in their **access** to legal, health-related interventions
- This involves the identification and removal of barriers that interfere with the making of a criteria-based request for, and subsequently having, a medically-assisted death

Challenge #1: How should *equity* be actualized?

- All Canadians living in rural, urban and mixed urban-rural settings should have reasonable access to MAiD services
  - If the relevant criteria are met, requestors should receive publicly-funded, medically-assisted deaths at the location of their choice, e.g., at home or in an acute or continuing care facility if the latter is where the request was made, and discharge to home is not desired by the requestor or is not possible due to medical and/or psychosocial circumstances

Related obligations of provincial health authorities and departments of health

- The allocation and use of appropriate health resources to build organizational and provider capabilities within rural, urban and mixed settings to provide MAiD services
- Potential pragmatic, interim mechanism:
  - The establishment of a portable/mobile **MAiD Team** within the health authority (or each subunit of the health authority) which provides services at home and in acute and continuing care facilities; where a local physician(s) is not available to join the team, a trained nurse practitioner team member could serve as the procedural provider

MAiD Principle 2: Non-abandonment and continuity-of-care

- Health care organizations and providers who have existing, therapeutic relationships with patients have an obligation to continue to provide them with health care services (within their organizational and professional purviews) after they have requested a medically-assisted death until such time as the patient or her/his substitute decision maker(s) decides otherwise

Practical implementation

- If the request is made while the patient is in a health authority facility and discharge to home is not desired or possible, the facility assumes responsibility for coordinating and delivering the service within the facility
- This could involve movement of the patient to another bed, e.g., to a private room within the same clinical unit; however, the established, attending health care provider team should continue to provide appropriate (other) care up until the patient's death
  - With a portable/mobile MAiD Team in place, transfer to another facility within or outside of a health authority is not warranted

MAiD Principle 3: Individual autonomy

- As a key component of *respect for persons*, all individuals have the right, and should have the opportunity, to make meaningful decisions about their health care and treatment
- In the MAiD context, this principle is inclusive of decision making about a 'death of one's choosing' that may include the making of a criteria-based request for a legal, medically-assisted death

MAiD Principle 4: Nonmaleficence and social justice

- The obligations of health care organizations and providers to work together to:
  - Do as little as possible **harm** to individuals
  - Pay particular attention to the perspectives, interests and needs of members of marginalized/disadvantaged sociocultural groups

Practical actualization

- In the MAiD context, this includes the development and implementation of a comprehensive set of regulatory and policy-based protections to:
  - Ensure that the decision-making of possible MAiD requestors is not subject to the manipulative or coercive influences of others
  - Prevent discrimination against, and abuse of, persons with disabilities and members of other marginalized/disadvantaged sociocultural groups

Challenge #2: the need for careful balancing

- A major challenge in the MAiD context: How to optimally balance the competing obligations that arise from concurrent consideration and application of these two foundational MAiD principles:
  - Individual autonomy (*P3*)
  - Nonmaleficence and social justice (*P4*)

What constitutes an optimal balancing of Ps. 3 & 4?' – the answer depends on the context

- There are 2 general types of MAiD circumstances:
  1. *Near-death paradigm circumstances*
     - 'Natural death' from the underlying health condition(s) is anticipated within a few days to a few weeks
     - The suffering is primarily physical in nature, e.g., shortness of breath, nausea, delirium, pain, with usual secondary psychosocial and relational elements

Two types of MAiD circumstances

2. *Non-paradigm circumstances*
   - The medical condition(s) is not in a terminal phase – 'natural death' could be years in the future, e.g., experience of profound suffering in persons with treatment-resistant depressive disorder, mid-stage Huntington disease
   - The suffering either arises directly from an intractable psychiatric disorder or is primarily psychoexistential in nature, e.g., perception of current or anticipated future loss of *self*, dignity, independence and/or social significance

Morally-relevant distinctions

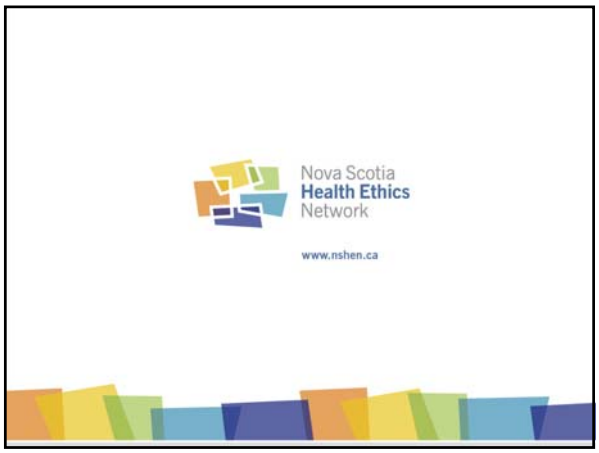
- In the ethical domain of 'consequences':
  - Interval of foreshortened life is usually considerably longer in *non-paradigm circumstances*
  - Existing 'imaginative public space for doubt and fear' is associated primarily with accounts of *non-paradigm circumstances* (it mostly results from the reporting of sensationalized euthanasia cases in Europe)
- In the ethical domain of 'proportionality':
  - It is more difficult to support a claim of proportionate benefit, i.e., that the 'good effect' of elimination of profound suffering outweighs the 'bad effects') in *non-paradigm* than in *near-death paradigm circumstances*

Implications

- Consideration of these morally-relevant distinctions could justify the development and implementation of different regulatory mechanisms and policy-based provisions for these two types of MAiD circumstances (on formal justice grounds)

Potential regulatory implications

- Possible regulatory/policy decision-making outcomes that recognize these morally-relevant distinctions:
  - In *near-death paradigm circumstances*:
    - Substituted decision making is permissible (as it is for continuous deep sedation at the end-of-life)
    - Retrospective reporting and periodic auditing are adequate
  - In *non-paradigm circumstances*:
    - Direct, informed consent of the capable requestor is mandatory
    - Administration of MAiD requires prospective approval
    - Medically-assisted deaths are closely monitored by a relevant government commission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