

# MAiD in Canada: Ethical Considerations in Medical Assistance in Dying

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Résumé de l'article

L'aide médicale à mourir (AMM) est unique dans l'arsenal des thérapeutiques médicales, mais elle nous renvoie à un dilemme qu'Hippocrate a abordé il y a 2400 ans. Elle apporte un soulagement bienvenu aux patients souffrants et à leurs familles, mais l'AMM n'est pas un suicide – elle invite à l'homicide. Il s'agit davantage d'un rituel de mort que d'une procédure thérapeutique. Contrairement aux interventions médicales, l'AMM ne guérit aucune maladie et un véritable consentement éclairé ne peut être obtenu. Elle sépare le corps de l'âme et les erreurs des médecins perçus sont passibles de poursuites pénales. S'il est mal administré, il pourrait saper la confiance dans la profession médicale. Les prestataires risquent également d'être victimes de remords tardifs. Au fur et à mesure que les critères d'inclusion de l'AMM s'assouplissent, les médecins qui décident actuellement des candidats à l'AMM devraient avoir accès à des panels établis pour les guider. Ces groupes devraient comprendre des spécialistes du droit et de l'éthique.

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TÉMOIGNAGE / PERSPECTIVE

# MAiD in Canada: Ethical Considerations in Medical Assistance in Dying

William Robert Nielsen<sup>a</sup>

## Résumé

L'aide médicale à mourir (AMM) est unique dans l'arsenal des thérapeutiques médicales, mais elle nous renvoie à un dilemme qu'Hippocrate a abordé il y a 2400 ans. Elle apporte un soulagement bienvenu aux patients souffrants et à leurs familles, mais l'AMM n'est pas un suicide – elle invite à l'homicide. Il s'agit davantage d'un rituel de mort que d'une procédure thérapeutique. Contrairement aux interventions médicales, l'AMM ne guérit aucune maladie et un véritable consentement éclairé ne peut être obtenu. Elle sépare le corps de l'âme et les erreurs des médecins perçus sont passibles de poursuites pénales. S'il est mal administré, il pourrait saper la confiance dans la profession médicale. Les prestataires risquent également d'être victimes de remords tardifs. Au fur et à mesure que les critères d'inclusion de l'AMM s'assouplissent, les médecins qui décident actuellement des candidats à l'AMM devraient avoir accès à des panels établis pour les guider. Ces groupes devraient comprendre des spécialistes du droit et de l'éthique.

## Mots-clés

suicide assisté, éthique du suicide, serment d'Hippocrate, aide médicale à mourir, thanatique

## Abstract

Medical assistance in dying (MAiD) is unique among the arsenal of medical therapeutics though it does return us to a dilemma Hippocrates addressed 2400 years ago. It provides welcome relief for suffering patients and their families, but MAiD is not suicide – it is invited homicide. It is more like a death ritual than a therapeutic procedure. Unlike medical interventions, MAiD cures no diseases and true informed consent cannot be obtained. It separates the body from the soul and perceived doctors' errors are punishable through criminal prosecution. If badly administered, it could undermine trust in the medical profession. The providers are also at risk for delayed remorse. As the inclusion criteria for MAiD become more relaxed, doctors who currently decide on candidates for MAiD should have access to established panels for guidance. The panels should include legal and ethical specialists.

## Keywords

assisted suicide, ethics of suicide, Hippocratic oath, medical assistance in dying, thanatics

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Most medical discoveries do not determine who lives and who dies. There are exceptions. I especially remember one gnarly old-timer at Toronto General Hospital in 1980, Gus. He was in for a sore hip. As a youth, Gus barely survived the roaring twenties. He later became a cliff diver in Acapulco. Partially deaf, his voice would echo across the ward, booming out merry tales of his enormous leaps into the tropical Pacific. He let me in on a trade secret that summer too – in his day, the highest Acapulco cliff divers never hit the water headfirst.

“We always had a man on the rocks below, timing our dives,” Gus told me. “At the last second the man'd shout ‘NOW!’ and that's when we'd tuck, too fast for the spectators to see, and hit the water ass first.” Then with a twinkle in his eye, he hollered “And when you hear ‘NOW!’ you don't say ‘Eh!’” Gus let that sit for a minute then smiled slyly, cupping his good ear with his hand and hollered again “You don't say EH!” laughing uproariously in his hospital bed. He was an extroverted risk taker – one dangerous trait that saved his life when he was fourteen. You see, back in 1922, Gus became the second patient ever to go on insulin for diabetes. That tale really resonated with me.

He suddenly became sick and skinny around ninth grade and was placed on a medical ward surrounded by other young men. The trouble, as he saw it, was they were all dying. They suffered from sugar diabetes and there was no cure. They were the worst of the worst. Luckily for him a young surgeon from London, Ontario, Dr. Fred Banting, and his summer student Charlie Best, had just figured out how to get potent, brown goo out of canine pancreases. They were pretty sure their mucky extract had kept one diabetic dog alive for 71 days and wondered if it could do the same for a boy.

My hip patient recalled how those doctors politely, almost apologetically asked if he wanted to try the stuff. He looked around at his gasping, ketotic and comatose roommates and thought, “What do I have to lose?” Now was his only chance to survive, and when you hear “Now!” you don't ask “Eh?” Gus jumped at the opportunity to have the experimental goo injected under his skin every day.

Fifty-eight years later, Gus was limping proof that a universally fatal disease could be tamed overnight, not by a miracle, but by a molecule. Dr. Banting named the extract Insulin because it came from the islet cells of the pancreas. To speed its development and distribution, Banting gave up the priceless patent for one dollar. He changed the world immensely for the better, won a Nobel Prize, and then donated the money from his Nobel Prize to medical research. The unselfish clinician also chose to share his Nobel honours with three associates. Not a bad model of altruism for aspiring physicians.

I learned a lot that first semester of med school – the hidden virtues of brown goo, humility in victory, and the benefits of tucking before you hit the water.

Fast-forward forty years: today a lot of my patients still endure a world of hurt. Two thirds of them are elderly and half of those have spreading cancer. Their final descents are not always graceful. They suffer cruelly from more than malignant pain. The uncertainty of all things death-related erodes the soul and hangs heavily on family. When the endgame becomes grim, some cry “No More!” if only to purchase peace. Doctors have been assigned the task of assisting death. Medical assistance in dying (MAiD) is a reassuring option but has unexpected negative potential. Walking the tightrope between its mercies and mayhem, MAiD is much more involved than simply writing a prescription that the patient self-administers. Since MAiD is here to stay we should discuss its awkward ramifications. As a surgeon, I do not perform MAiD procedures, but quite a few of my patients have benefitted from them. Nonetheless, I want to share some of the misgivings that jump to mind when I contemplate doctors actively ending their patients’ lives.

Nobody wants to die alone or in pain. Those frightening apprehensions are as old as medicine itself. Accordingly, physician assisted suicide is an ancient practice that predates the Roman Empire. For our society, however, it marks a sea change in the role of the modern physician as we drift back toward Classical sensibilities around the meaning of life. In the ancient world, suffering patients sometimes got poison even though this practice violated the Oath of Hippocrates. Hippocrates also coined the mantra “First, do no harm.” It may seem curious he emphasized the importance of not hurting patients, but medicine, as we know it did not even exist prior to Hippocrates.

Around 500 BCE, people still believed diseases were punishments conjured up by witches or angry gods. When you contracted the plague or the pox or even influenza, friends and relatives who feared catching the same disease might shun and avoid you. Forget about viral pandemics and plague. Nobody wanted a vengeful deity to strike them down for taking your side. Men and women saw themselves as easy targets for supernatural mischief. Medicine was magical and magic was medicine, so supplication and spells augmented a physician’s stock in trade.

Then came Hippocrates, the father of scientific healing. Hippocrates studied the biological courses of all ailments, from bladder stones to heart failure. He also established an ethical code that defined the moral responsibilities that accompany the privilege of medical practice. His cultural legacy still affects our feelings toward the sanctity of life and the role of physicians. Because Hippocrates influenced Western medicine so dramatically, we have to talk about the innovations of that foremost Greek physician to understand assisted suicide today.

Hippocrates raised the medical mindset out of its credulous depths once and for all. He dismissed the occult and separated the domain of physicians from the cabal of shamans and soothsayers. His clinical success persuaded a superstitious world that diseases have natural causes and will respond to biological cures. His impact on all technological aspects of civilization, not just medicine, is incalculable because he was the first to prove that science really works. And due to an auspicious literary innovation, the vowel, his method spread far and wide. It may sound mad, but vowels made science possible. That’s right – vowels!

Initially, hieroglyphics and ancient alphabets were inefficient and complicated. This limited literacy to a small class of priests and professional scribes – you know the type – always focused on esoteric spiritual and metaphysical issues. As a result, a community’s knowledge of popular culture and practical magic remained cached in personal memories, shared exclusively by conversation. Around 700 BC, basic phonetic innovations dramatically changed history. The acquisition of a simple, flexible alphabet comprising twenty-five or thirty letters compared to thousands of complex symbols, suddenly made literacy achievable for all Greek speakers. Now, anyone could learn to read and write in a couple of years.

As the new literacy spread it allowed an eyewitness to become the recorder and distributor of discoveries that benefitted natural arts like biology and medicine. The Greek alphabet was the Internet and smartphone of its day. Facts and insights could be immediately recorded in ink, then copied and shared with foreign practitioners and future generations. Once written history had arrived, direct and accurate observations were recorded at the patient’s bedside. Reproducible discoveries spread throughout the eastern Mediterranean and inspired practitioners to give up mythical healing techniques. It is fortunate that Hippocrates and literacy co-existed. They made each other great. At last, the art of medicine did not have to be reinvented in every village with every generation but could grow into international libraries of accumulated experience. Shortly after Hippocrates’ pioneering work, Aristotle, whose father was also a physician, took up the torch of science and applied it to biology, physics and ecology.

The Oath of Hippocrates affirms commitment to every patient’s life and health and describes the sorts of improprieties physicians must avoid. In a nutshell, the oath guarantees your doctor will stick with you, even if the gods are against you, which they aren’t. His vision freed patients from shame and the fear of magical reprisal. This gained their trust, which is key to a successful therapeutic relationship. For twenty-three centuries physicians have sworn this oath and enjoyed their patients’ complete confidence. The excerpt from the oath relevant to MAiD translates into English as:

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. Neither will I administer a poison to anyone when asked to do so, nor will I suggest such a course.

These sentiments imply Hellenic physicians were perplexed by the idea of assisting death. What is clear is that Hippocrates stood defiantly against medically assisted death and Western medicine has followed this dictate for literally thousands of years.

Now fewer doctors take the Hippocratic oath, and physician assisted suicide is gaining momentum. It has been legalized in some European countries, some U.S. states and in Canada. These jurisdictions support the individual's right to control their own bodies and grant the competent individual full authority over end-of-life decisions, including suicide.

Recently in my surgical practice I saw a Pastor in consultation. After the office visit, I asked him his view of MAiD. He described the conflict as a clash between the head and the heart. In Divinity school, he had studied how life itself is so sacred under the law of God that doctors should never end it. That argument expresses an important theological position – *Thou shalt not kill* (Exodus) includes suicide. On the other hand, the Pastor remembered when his own mother was confined to a hospital bed in the room beside their kitchen, dying of cancer. Her pain was poorly controlled and she would cry at night, imploring God to release her from her misery. She could neither die nor be cured. But the most painful memory the Pastor recalled was of his desperate father, chain-smoking in the shadowy kitchen. Those last lonely evenings they were beside themselves, drowning in helplessness.

The rules against suicide say God knows best. Common sense sympathy says help her to go quietly and quickly. Given that choice, what can you do? Which way best serves a relative during a painful passing? Exodus exudes authority and forbids assisting death. But times change, as reflected in Ecclesiastes, composed following the Babylonian exile and seven hundred years after the Ten Commandments:

There is a season for everything, a time for every occupation under heaven:  
 A time for giving birth,  
 A time for dying,  
 A time for planting,  
 A time for uprooting what has been planted,  
 A time for killing,  
 A time for healing.

This passage allows compassionate choices. It is strangely fitting that killing and healing together form the final poetic couplet.

Practically speaking, half of medical costs today are incurred in the last two years of life. In private medical systems, assisted death is inexpensive. An early exit strategy minimizes suffering and avoids futile medical heroics. Limited resources can be redirected to patients who will truly benefit. And let's face it; modern diagnostic techniques are pretty good at recognizing when the death is imminent. MAiD provides predictability that spares families the frightening anticipation of missing a deathbed vigil, especially in times of COVID. It is no wonder more than half of medical professionals and an even higher percentage of lay people agree with MAiD in the right conditions and with proper safeguards. But misuses are already happening.

To minimize abuses in Canada there are strict inclusion criteria before thanatics (life-ending drugs) may be legally administered. The law recognizes a patient's right to request death if the following criteria are met:

1. The patient is over eighteen years of age.
2. The patient suffers a grievous and irremediable medical condition, according to two independent MD's. This specifies intolerable suffering with no hope of cure.
3. The request for suicide is voluntary and not influenced by external pressure.
4. The patient gives informed consent to receive medical assistance in dying after having been informed of available means to relieve suffering, including palliative care.
5. Finally, a ten-day waiting period and repeat consent immediately before death is mandatory.

These five criteria are a rough summary of a more detailed document. Our Canadian approach is strongly slanted toward preventing sinister manipulation. It is purposely vague (grievous and irremediable are undefined terms) so it can be applied to many unique situations, but each case can be argued many ways. The rules appear strict enough to protect society. Doctors oversee the process because we are trusted to understand medical specifics and advocate what is best for the patient. So, what are the problems with assisting suicide? What apprehensions might Hippocrates still entertain? Recognizing his medical experience and depth of understanding, you have to wonder about his absolute ban on poisons. What might he have foreseen that would still apply today? Let's discuss medical, legal and ethical issues Hippocrates dealt with and consider their present relevance.

In Greece twenty-five hundred years ago, "First do no harm" was also a position that protected physicians from revenge. It was easy for people in the ancient world to purchase poisons from physicians or pay medical men to covertly administer the lethal drugs. Sworn opposition to any and all killing raised Hippocratic doctors above suspicion and reproach. It insulated them from avenging advocates who suspected foul play.

The scientific method was based on observation of what we call the natural history of the disease. Hippocrates was mapping uncharted medical waters, so he did not know what the next stage of each disease might bring. Some flesh rotted, some bodies convulsed, some patients recovered unexpectedly, and most did not. Prognoses were elusive and treatments were experimental. Mercy killing interfered with the natural history of the disease under observation, so assisted death compromised

clinical discovery. How could the physician help the next person with a particular disease without knowing the entire course of the ailment?

Legally, in Greek democracies a citizen could charge anybody with murder. Conviction resulted in execution or banishment. Since trials were argued in front of the local landowners, physicians in these small communities had to be squeaky clean and wrinkle free, legally speaking. There were licit reasons for physicians to keep a low profile and stay out of the death business.

Then there was Greek piety. Though Hippocrates could argue persuasively that jealous gods did not cause diseases, his medical success did not erase morality from the Hellenic consciousness. Knowing that the gods can't cause diseases doesn't justify ending lives. Fate still judged killers harshly and doctors were still supposed to do what the gods wanted (which was what society expected), which was to heal people.

People have come to expect doctors to be devoted exclusively to health and life. Most patients open up immediately and trust automatically. Some are naturally more circumspect. I met a young mom with a very painful kidney stone; she had never seen me in her life yet was keen to hand her feeding infant to her husband and get to the operating room as fast as possible! The sort of trust that let her put her life entirely in the hands of strangers comes with the title "Doctor." This phenomenal trust persists through the centuries because of the ethical foundation created by Hippocrates. Our traditional role binds us to respect that trust by uncompromised patient advocacy. Doing no harm does not mean minimizing pain by ending the sufferer's life. Patients may become even more circumspect when they are assigned a doctor that has been known as a finisher. MAiD may very well change the trust doctors have earned over the centuries.

Why should an MD be uncomfortable performing MAiD if suffering can be erased with a simple drug cocktail? This is because the physician's daily focus is to diagnose and heal, so the practitioner sees pain as a secondary issue that is extremely well controlled with modern drug combinations. Medically assisted death no doubt relieves suffering, but also elevates the status of comfort above the status of life itself. Assisted death desanctifies life and will eventually complicate trust issues toward doctors, especially in old people who tend toward suspicion anyway.

But I think that Hippocrates knew more. He understood that mercy killing opens a morally defensible avenue to dispose of anybody, not just the ill. It's all a matter of degree, but once suffering becomes reason enough to invoke death, utilitarianism starts sniffing around. It is only one logical step further to argue that if something about you bothers me, and my torment is worse than your painless death would be, you have to go. You could claim it is I who should go because I am the one suffering, but the fact we are having this argument at all shows the sanctity of life is diminished. Once medically instituted death becomes commonplace, be wary if you are the wrong ethnicity, the wrong religion, or a powerless individual whose life is worth little to society.

It is still too soon to predict all MAiD's long-term consequences, but the tally of misadventures is sure to accumulate quickly. The current process almost always ensures correct decisions are reached, yet the wrong people sometimes die. I have seen it happen a few times recently. For example, I saw a man with a small bladder cancer that was situated in a tight corner and could not be removed with a scope. The cancer was easily curable by two or three other common techniques, but technically, it was "unresectable," which was the quoted reason for MAiD. The surgeon only learned of the assisted death when the patient missed his follow-up appointment. Understand: the man had a painless curable condition. Now he is dead from MAiD. Shortly after, in the same town, a lady orchestrated a memorable and romantic MAiD party, complete with a new white dress and a house full of guests. Her grievous disease: gout and advancing deafness.

What do these cases say about the selection process? Did the safeguards simply fail, or were alternate forces at play? Maybe the doctors felt the patient has the right to suicide, so why not just help them? Maybe these old people consented to lethal injection by mistake, or maybe they had agendas of their own and knew exactly what they were about. Perhaps they were lonely and fading and this was their last shot at being the centre of attention. Should someone report the MAiD doctor for wrongful death? Am I abetting criminal acts (inappropriate MAiD is prosecuted in criminal court) by not reporting?

On the other hand, modern treatments distort the natural history of diseases and stretch lives far past their natural expiration dates in ways Hippocrates could not have anticipated. For example, a friend of mine underwent an appropriate MAiD last winter. She had an abdominal cancer diagnosed about five years before and would have died back then without high tech treatment. Even a year ago she was relatively well after two major operations and several courses of chemotherapy. The cancer had been beaten back and was progressing very slowly but remained incurable. The surgery and chemo weakened her and now she couldn't eat, had significant pain and no energy. Down to ninety pounds, all she could do was lie on the couch and wait for death. She had lived for five extra years, but her quality of life finally ran out. Her body was a scarred and damaged battlefield from the war between chemo and cancer. Modern medicine put her into this distressing limbo, so it seemed fair that modern medicine should release her from her unnatural vigil. MAiD was a tearful relief after her five-year battle.

What about MAiD for conditions when death is not imminent or even foreseeable? Late stages of common degenerative and neurological diseases are scary. Should MAiD be a recognized treatment earlier in these cases? And what about MAiD for dysphoric teenagers? Or MAiD for the still competent seventy-year-old who is slowly slipping into Alzheimer's? His estate is settled, and he is ready to face God today. He wants to enjoy life as long as he can, then end it all when he becomes fully demented in the near future but won't qualify once he becomes legally incompetent to give the final consent.

Should suicide drugs be available through the Internet? Will great candidates avoid a medical career because they do not want to be caught up in a job that sometimes promotes killing and would change them into accepting or at least abetting it? How should a doctor investigate and interpret the layers of motivation in a MAiD application? Imagine trying to assess the risk/benefit equation of a death request. Dying wishes are private intrigues that can be wrought in despair, anger, self-doubt or financial fear, but not everyone who wants a ticket out is actually dying. Under pressure from confusing psychological influences, heirs, and finances, otherwise content old people will be subtly influenced to opt for a modified martyrdom. Elders have enough challenges already. Some feel humiliated every day by their need for personal care. Others just hate being institutionalized. Some want to die sooner to leave more money to relatives and be remembered more fondly. Some people don't want to be a burden and others simply dislike their family. There are many reasons to tuck before you hit the water.

Once we become a MAiD society, MAiD will lose the status as a last-ditch intervention for uncontrollable pain in imminently dying patients. Sick people will begin to see themselves as easily erasable and as excess human specimens. The conviction that it is a wonderful and divine thing to exist will be hollowed out by notions of a life that strives for societal convenience.

Landmark breakthroughs come from drugs like insulin for diabetes and platinum for cancer and vaccines for measles, tetanus, smallpox, polio, diphtheria – all apocalyptic reapers – and now relegated to the graveyards of antiquity (as long as the anti-vaccination lobby can be suppressed). There are currently fourteen new disease modifiers in the pipeline for multiple sclerosis. Blood banks are working to make all transfusions interchangeable. One never knows what fatal diseases will soon be curable. It is impossible for doctors to keep current with all the medical research and drug trials around the world. MAiD assessors working alone in their practices can't be expected to stay current with every novel treatment for every fatal disease. As Hippocrates himself expressed "Life is short, the art so long to learn; opportunity fleeting, experience fallacious, judgment difficult." All those insights remain true today and epitomize why Hippocrates never condoned mercy killing.

The MAiD process has been compressed into a few forms for doctors but is still emotionally ponderous and time-consuming. The psychic energy required to perform the procedure can be intense for borderline cases, which will become more common as the criteria for MAiD become less exclusive. In the future, this could scare away discerning doctors, leaving only enthusiasts for the procedure who will uncritically do it for everyone who asks. As the unquestioned sacredness of human life fades, the importance of other human rights could be eroded.

MAiD is a new big deal with uncharted hazards and unclear borders. So, whoever does it, whatever impacts it elicits, wherever the fee is set, it will be impossible to administer a prejudice-free system. As you have probably sensed from the tone of this paper, I believe that the MAiD process is excellent for some patients. But soon it will be sterilized, industrialized, advertized and performed on the wrong patients despite the best of intentions. Currently the coroner's service in British Columbia reviews all the MAiD procedures to identify mistakes, but since they review the forms submitted by MAiD practitioners, their purview is intrinsically biased. Someday, Right to Die groups will sue doctors for refusing to kill patients on purpose, instead of for killing patients not on purpose.

Consider life insurance. How do you collect on some policies post-MAiD, especially if the death certificate specifies the cause of death as gout and deafness? Imagine the legal complexities and probate paperwork that could be generated by a third-party protest. How do you handle the distraught family member, left out of the will, who disagrees with the process after the fact?

Sifting through these uncertainties makes me wonder how the practice of assisting death will stress the physicians and nurses who accommodate the lethal drugs. Usually, the procedure relieves suffering and restores dignity to the patient. The clinician gleans satisfaction from knowing they helped the patient and the patient's family. But if I did these procedures, would there be delayed impact on my self-concept? Medically aided death, we should remember, is not suicide. It is invited homicide. Ethically, I am responsible for the death if I gave the drugs. Will I feel some of the contested cases were morally wrong in retrospect? Delayed remorse could cause guilt or anger as I question what sort of person I have become. We all make mistakes in judgment. MAiD practitioners will be no different, except the effect of those actions is irreversible.

Another insight from "First, do no harm" hints at a different class of injury – unknowable harms. Sure, I can calculate what my patient is risking in this life, but my calculus only considers physical and psychological factors. Could I possibly be dispatching an unsuspecting soul into an unfriendly afterlife? What does happen after death? Many people anticipate judgment in the next world. Does the acceptance of MAiD indicate belief in the afterlife is dying?

Ironically, the afterlife also raises a conundrum about informed consent. The required form for MAiD includes the declaration: "I determine the patient has been fully informed of: The probable outcome/result of taking the medicine to be prescribed." How can I possibly inform patients of death's outcomes? The goal of MAiD is to send people into the afterlife, yet we have no idea what happens there. Isn't one's afterlife affected by deeds and intentions in this life? I don't know much about life after death, but I am pretty sure Judgment does not defer to precedents in Canadian law.

Doctors can claim we are not responsible for our actions if we could not have known their consequences, but that is a legal defense, not a moral justification. We cannot be sued for complications we have disclosed ahead of time, but we still are responsible for them, no matter how rare or unexpected. When you cut into darkness, anything can bubble up. Hippocrates' mantra "First, do no harm" reminds doctors of their infinite ignorance and need for constant humility.

Medical aid in dying is unique among the arsenal of modern therapeutics. In some ways it is more like a religious sacrament or a phase-shift initiation than a medical procedure. It is a life choice. It cures no disease and true informed consent cannot be obtained. It separates the body from the soul and its effect lasts longer than herpes. Errors in MAiD are punishable through criminal prosecution. It could undermine trust in the medical profession and change our children's ethical views in ways we cannot yet imagine. And as long as humans do it to other humans, it can be misused.

So how do we resolve MAiD's controversies today? Like most new medical interventions, MAiD will evolve through three stages. Initial acceptance will be rapid, and it will be over-prescribed. As I was writing this text, Parliament was finalizing a bill to extend MAiD to those whose deaths are not foreseeable imminently. After a few unsavory retrospectives, a limited negative rebound movement will claim it should never be done at all. Experience will refine MAiD's indications and it will be considered an excellent option in certain defined situations. It is my opinion this will happen sooner and with less risk for abuses if legal and ethical experts become involved in the process.

The request for MAiD is not always a medical decision. Applications involve societal ethics, personal psychology, competency and issues based on morality, law, probate, insurance and family dynamics. Clearly, those are not medical considerations. The Sawbones' craft does not navigate these minefields adeptly. There are too many loose threads in a dying man's tapestry to leave all cases for medical practitioners to decide, once the criterion of imminent death is abolished. Often the patient and family generate so much pressure to have MAiD, their physician cannot be unbiased. Performing those injections is not the sort of responsibility I want, but I know some great doctors who are comfortable doing it. Yet if they, or even a family member senses conflict in any given case, there should be preordained professional backup.

The government has breezily instituted a difficult and deadly process through a few forms and a modest stipend in the doctors' fee code. To make matters worse for doctors, alleged errors are redressed through criminal courts. It will be a grim sight indeed when the first MAiD physician gets dissected and sentenced in a criminal prosecution. Clearly, more needs to be done to properly establish and govern this service.

Each health authority needs a formal administrative fixture for MAiD. Perhaps an ethicist and a magistrate should oversee the process. They would review the submissions, be aware of precedents, rule on the matter in a timely manner and advise the patient on inheritance, insurance and sundry legal and moral issues. Standard dose thanatics would be administered in a home or hospice setting to provide dignified and loving relief for the suffering patient. Nobody should be vulnerable to future recriminations. If the magistrate rules against MAiD, the decision could be reviewed when the clinical situation progresses. Data can be systematically gathered and centralized so we can study the MAiD process effectively. Why shouldn't each health authority have an Office of MAiD Access? Canada is full of energetic elderly who want to call their own shots.

Most physicians would willingly share complex elective death decisions with legal and ethical specialists. It is good to spread the responsibility across several professional constellations and acknowledge all aspects of society that will be affected by MAiD. What says Hippocrates to that? I bet as a brilliant young physician, Hippocrates once upon a time did give poisons to a few patients. Some sort of disaster ensued, the kind that changes your practice forever – like a perpetual coma in his mother-in-law, or maybe a hostile hoplite half-brother showing up from Sparta with weapons drawn. That's when Hippocrates declared, (in heroic verse no doubt) "By the beard of noble Asclepius – I'll never do that again!" That being said, his contemporary, the great Socrates, willingly chose a lethal cup of Hemlock over banishment from Athens and look how fondly he is remembered.

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