

## About the Author



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# Palliative Care and Medical Assistance in Dying: The State of the Relationship in Canada

Jeff Myers, MD

## Introduction

Nearly a decade has passed since the Canadian government passed federal legislation that permitted eligible Canadians to request medical assistance in dying (MAiD), and it has been almost five years since the implementation of expanded eligibility criteria. Over this period, there has been a substantial increase in the number of jurisdictions around the world that have legalized assisted dying (**Figure 1**). At a time when the global landscape of care at the end-of-life is dramatically shifting, here we examine the state of the relationship between palliative care and MAiD in Canada.

## The Intersection and Access

Since the legalization of MAiD in 2016, the number of provisions has steadily increased, accounting for nearly 5% of all deaths in Canada by 2024.<sup>2</sup> Access to MAiD expanded significantly in 2021, with the removal of the criterion of a

reasonably foreseeable natural death. Although MAiD continues to be accessed predominantly by men, individuals with cancer, and people who identify as white, these trends do not necessarily reflect issues with access among their peers.<sup>2</sup>

Over the same period, access to palliative care in Canada has evolved less consistently. Despite having a national palliative care framework, access remains heavily influenced by factors such as geography, care setting, and age.<sup>3</sup> Racialized and immigrant communities continue to face layers of barriers, and non-cancer populations (e.g., people with dementia, organ failure, neurodegenerative diseases or frailty) often experience delayed or absent involvement in palliative care.<sup>3</sup> A potential source of tension for the relationship between the two services is that access to MAiD has expanded and access to palliative care remains inconsistent.

In 2023, over three-quarters of Canadians who received MAiD also received palliative care, with just over half receiving it for one month or longer.<sup>2</sup> However, delivery of healthcare occurs at

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the provincial level, and closer examination reveals substantial variation in access across the country, from a low of 55.1% of MAiD recipients receiving palliative care in Nova Scotia to a high of 84.1% in Prince Edward Island.<sup>2</sup> Data addressing the frequency of MAiD requests and provisions among all patients cared for in palliative care settings is not readily available. This makes quantifying the overall impact of MAiD on palliative care difficult and reflects an important evidence gap.

Despite variations across provinces and gaps in the evidence, at the practice level an intersection between palliative care and MAiD exists. For patients under the care of palliative care teams who are considering MAiD, how this intersection is formed and how it functions may have substantial implications for patients, families, providers and systems of care. National or provincial standards addressing this intersection have yet to be developed, which has left the responsibility of navigating this complex task to institutions, teams, and individuals.

## What is the Evidence?

Although empiric data that directly addresses the interface between palliative care and MAiD has only recently entered the literature, our understanding of their relationship has deepened. For example, Canadian health leaders report improvements in the relationship, crediting progress to better communication between services.<sup>4</sup> They also note the absence of a consistent framework for how palliative care and MAiD should interact, and express diverse opinions on what the optimal relationship should look like. These include models ranging from full integration, complete separation, and a model that functions in a parallel but coordinated fashion.<sup>4</sup> A point of agreement among leaders is the need for cooperation between palliative care and MAiD, which is viewed as essential for ensuring appropriate referrals and coordinated care.<sup>4</sup>

The broader body of empirical literature on the topic consistently reinforces that there is no single model for how palliative care and assisted dying relate. Within jurisdictions that have legalized assisted dying, descriptions of the relationship include integrated, synergistic, cooperative, collaborative, supportive, not mutually exclusive, neutral, coexisting, ambivalent, opposed, conflicted, and antagonistic.<sup>5</sup>

Among palliative care clinicians in other jurisdictions, ambiguity about their role in assisted

dying is widely reported.<sup>5</sup> This ambiguity seems to be primarily driven by a discordance between policy and practice, largely due to a lack of clarity in what actions professional bodies consider permissible.<sup>5</sup> For example, in many settings nurses and social workers are unsure about what information they are permitted to share about assisted dying.<sup>5</sup>

Belgium is often identified as a comparator in discussions about the relationship between palliative care and assisted dying, as it has maintained a model of full integration and synergy since 2002, when assisted dying was legalized.<sup>6</sup> A critical element of Belgium's narrative is that, also in 2002, a statutory right of access to palliative care was legislated.<sup>7</sup> In contrast, Canada has not implemented a similar legal guarantee, which is an additional source of tension.

## On the Frontline

The overarching view among many palliative care clinicians is that MAiD has reshaped their daily practice. They describe it as introducing a new dying experience for patients, one that is parallel to, but does not replace, a palliative approach to care.<sup>8</sup> Aligning with the perspective of health leaders, many frontline clinicians also characterize the relationship as having improved.<sup>9</sup> A notable perspective shift has occurred in several hospice settings that initially required patients who requested MAiD to be transferred elsewhere. The experiential impact of transfers has led some organizations to revisit these policies, now allowing and facilitating on-site MAiD provisions.<sup>10</sup> In addition, as palliative care colleagues witness well-articulated rationales for requesting MAiD from patients under their care, many MAiD providers have also experienced improvements in the relationship between the two services.<sup>11</sup>

For other clinicians, the relationship between palliative care and MAiD remains a challenge. A distinction is often made between moral uncertainty and moral distress, and both are pervasively present in the interprofessional discourse.<sup>12</sup> Dorman and colleagues characterize moral uncertainty as arising when a right action is not known, and moral distress as occurring when one is constrained from acting on what they believe to be right.<sup>12</sup> Palliative care clinicians report experiencing moral uncertainty around how and when to broach the topic of MAiD with patients, which is typically rooted in the fear of

being misinterpreted.<sup>12</sup> Moral distress around professional identity is frequently described among clinicians who are either conscientious participants or conscientious objectors, as both frequently feel unsafe to identify as such.<sup>13</sup> Finally, moral uncertainty surfaces among clinicians who consider how the relationship between palliative care and MAiD could be reconciled.<sup>12</sup> Across these challenges, frontline clinicians frequently report the need for mitigation strategies that include organizational clarity, supportive policy, and explicit role delineation.<sup>12,14</sup>

## Palliative Sedation

One source of tension in the relationship between palliative care and MAiD is how palliative sedation has become part of the broader discussion. Continuous palliative sedation therapy (CPST) involves the use of pharmacologic agents to reduce consciousness as a strategy for managing intolerable and refractory symptoms in patients with advanced progressive illness.<sup>15</sup> In practice, the symptoms for which CPST is most often used include pain, delirium, and breathlessness, and it is typically recommended that consultation with a palliative care clinician occur prior to CPST initiation.<sup>16</sup> The intent of CPST is to relieve intolerable suffering, and when used according to clinical guidelines, i.e., titrating sedation to symptom relief, data suggests that CPST neither shortens nor lengthens survival.<sup>17</sup>

Despite the existence of numerous national and international policies, protocols, and guidance documents, significant variability remains in how palliative care clinicians define and practice CPST, which extends to the perceived relationship between CPST and MAiD.<sup>18,19</sup> Some palliative care clinicians view this relationship as fluid and the two as interchangeable, i.e., if a person is unable to consent to MAiD or does not have access to a provider, CPST is considered an alternative.<sup>20</sup> Regardless of how this relationship is viewed, palliative care clinicians in general report that discussions about CPST have become more frequent since the legislation of MAiD, with several describing the new experience of navigating direct requests for CPST from patients and families.<sup>21</sup> The impetus for such requests is typically the upstream education occurring with patients about the availability of CPST and MAiD as end-of-life options.

The view of CPST and MAiD as interchangeable and positioning the two as

equivalent alternative end-of-life options introduces two potentially important risks. First, when both options are presented to a person who worries that suffering will become intolerable, the typical intention is to reassure. The consequence with this however is that it can reinforce the underlying assumption that intolerable suffering is inevitable.

The second risk in blurring the distinction between CPST and MAiD lies in oversimplifying the complexity of clinical decision-making related to CPST, which can create confusion about how the two differ. This may lead to misunderstood and unmet care expectations among patients and families and ultimately impact an ability to establish trust with the clinicians who provide the care downstream.

## Moving Forward

Palliative care and MAiD share important common ground: both require sensitive communication, trust, and the expertise of skilled clinicians. From here, policymakers, researchers, clinicians, and communities must engage in ongoing dialogue to ensure that the relationship between palliative care and MAiD evolves in ways that best serve Canadians. Specific actions might include:

- *Clarifying public messaging* ensuring that patients and families understand palliative care and MAiD, an essential step in maintaining trust.
- *Educating teams* about the downstream impact of imprecise or incomplete information shared with patients and families about the end-of-life, along with the risks of fragmented care.
- *Tending to clinicians* to ensure their well-being and retention in both palliative care and MAiD-related care settings.
- *Protecting equity* by monitoring for disparities across socioeconomic and geographic lines.
- *Transparent and public reporting* of national and provincial data, not only on MAiD-related care but also on palliative care access, timing, quality, socio-demographic disparities, as well as patient and family experiences.

Finally, while efforts to work toward national or provincial standards for the form and function of the relationship between palliative care and MAiD are encouraged, these efforts require stronger empirical accounts of practice models and outcomes.



## Summary

The relationship between palliative care and MAiD in Canada is neither settled nor uniform. Across systems, the interface is complex and contextual and can exist in forms that range from integrated and collaborative to neutral, ambivalent, or explicitly opposed—with the potential for all views within the same jurisdictional ecosystem. This is not an impressionistic claim; it is reflected in the spectrum of relationships documented in empirical studies.<sup>5</sup> Given this heterogeneity and considering that the law governing assisted dying may continue to evolve toward a relationship that is cooperative and coordinated may be the most feasible path forward.

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## Financial Disclosures

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