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The ‘Means Available to Relieve Suffering’: Translating Medical Assistance in Dying Safeguards in Canadian Policy and Practice

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In Canada in 2021, people with non-life-limiting health conditions and disabilities became eligible for medical assistance in dying (MAiD). New legislative safeguards include a ninety-day assessment period and a requirement that health professionals engage with the person requesting MAiD about ‘means available to relieve their suffering’ (MARS). Government communications about the MARS safeguards emphasise distinct policy objectives, that we illustrate by analysing two texts. We then report on an ongoing study with health professionals involved in MAiD. In interviews, participants described supporting patients to imagine possibilities for feeling differently, creatively devising interventions, and actively connecting patients with (and in some cases bringing about) services and resources. Drawing on literature on front-line policy making we show how discourses of expert communication, care, and advocacy animate a specific translation of the MARS safeguards, one that recognises social and relational as well as deliberative autonomy, and reflects a range of MAiD policy goals.

Keywords: Medical assistance in dying (MAiD); Canada; policy translation; street-level bureaucrats

Introduction

In Canada, medical assistance in dying (MAiD) was brought about by a series of court challenges.¹ While multiple efforts to decriminalise assisted death had been undertaken through Parliament in the 1990s and 2000s, the bill that created MAiD’s regulatory framework was prompted by a Supreme Court ruling that the Criminal Code prohibitions against assisted suicide infringed on the right to life, liberty, and security of the person (*Carter v. Canada*, 2015). MAiD was introduced in 2016. At the time, the federal Department of Justice indicated that MAiD’s ‘core policy was to give Canadians who were suffering intolerably during the dying process, the choice to have a medically assisted death’ (Government of Canada, 2020).

In March 2021, following on further successful court challenges (*Truchon v. Attorney General of Canada*, 2019), the requirement that death be ‘reasonably foreseeable’ was removed from MAiD legislation. With this change, people with non-life-limiting health conditions and disabilities who meet all other criteria² became eligible for MAiD (called ‘Track 2’ MAiD). Currently people whose only medical condition is a mental illness are excluded from eligibility (Government of Canada, 2023).

From the outset of MAiD advocacy, and especially in relation to Track 2 MAiD, concerns have come forward about the potential for material disadvantage, ableism, and ageism to create pressure on marginalised people to pursue MAiD (Beaudry, 2019; Lazin and Chandler, 2022;

Brassolotto *et al.*, 2023; Frazee, 2024). In the legislation, concerns about social and individual vulnerability informed new safeguards for medical practitioners to follow in situations where the person's natural death is not foreseeable. Central to the current article, the law related to Track 2 MAiD requires ninety days between the day the first assessment begins and the day MAiD is provided (unless the person is about to lose capacity, where this can be shortened), and requires that health professionals engage with the person requesting MAiD about 'means available to relieve their suffering' (*Criminal Code of Canada*).

Purpose of the article

In its public account of Canada's current MAiD law, the federal Department of Justice lays out a range of value frameworks and policy goals:

The Government of Canada is committed to ensuring our laws reflect Canadians' needs, protect those who may be vulnerable, and support autonomy and freedom of choice (Government of Canada, 2023).

Government publications about MAiD safeguards in situations where death is not reasonably foreseeable emphasise different aspects of these values and policy objectives. To illustrate this, we explore how the Track 2 safeguards related to the 'means available to relieve suffering' (MARS) are represented in the Charter Statement about Bill C-7³ (Bill C-7, 2020) and on the Department of Justice MAiD website (Government of Canada, 2023). See Table A1 for the text of the Criminal Code section on MARS, alongside the accounts of the MARS safeguards in the Charter Statement and on the Department of Justice website.

In the next section of the article we review scholarship about the relationship between policy texts developed at one site, and their enactment in other sites or settings. As Clarke *et al.* (2015a) argue, policies are never merely implemented, they are always 'translated'. We outline research about the significance in the policy process of front-line workers' discretion and the mediators of their decisions and actions.

We then turn to early results of an ongoing study about MAiD practice with people whose natural deaths are not reasonably foreseeable (Track 2 MAiD). We make visible one approach to the Track 2 MAiD safeguards – one front line 'translation' of the safeguards – and highlight the professional discourses and self-concepts that shape this approach.

The paper is not an evaluation of the adequacy of the Track 2 safeguards, nor a prescription for practice. We are not making the claim that every decision and action in every patient encounter reflected this approach. Yet the 'translation' of the safeguards that we illuminate in this paper was consistently present in the accounts of the health professionals (HPs) we interviewed. In the Discussion we consider its significance in policy terms.

Representation of 'Means Available to Relieve Suffering' (MARS) in the Charter Statement about Bill C-7

For every government bill in Canada, a Charter Statement is prepared that considers the bill's consistency with the *Canadian Charter of Rights and Freedoms*. The Charter Statement about Bill C-7 (Government of Canada, 2021) first outlines the assessment period for Track 2 requests. The requirement of minimum ninety days for the assessment is followed by this sentence: 'In order to conclude that a person is eligible for MAiD, the practitioner must determine that all of the eligibility requirements set out in subsections 241.2(1) and 241.2(2) are satisfied' (Government of Canada, 2021). Here, the ninety-day period is the time required for the MAiD assessor to consider each of the legal eligibility requirements and to determine that the person is eligible (or not) for MAiD.

The section of the Charter Statement that relates to the ‘means available to relieve suffering’ appears as follows:

Finally, the Bill would introduce two changes clarifying the requirements of informed consent in this context. The first change would be an express requirement that the person be informed of available counselling services, mental health and disability support services, community services and palliative care, as appropriate to the individual’s situation, and be offered consultation with professionals who provide those services. Second, the person and practitioners would have to agree that reasonable and available means of alleviating the person’s suffering had been discussed and seriously considered before MAiD could be provided (Government of Canada, 2021).

In the Charter Statement, then, the ninety-day assessment period allows the practitioner adequate time to examine the person’s eligibility for MAiD in relation to the criteria set out in law, and the MARS safeguards are explicitly tied to consent for MAiD: providing information about services and offering consultations with providers, and confirming that the patients has seriously considered these services, are steps the practitioner must take to ensure that the patient’s consent to receive medical assistance in dying is ‘informed’. They are among the essential conditions and constraints on the HP’s action of administering a lethal injection.

Representation of MARS on the Department of Justice website

The Department of Justice website, in contrast, lays out more expansive purposes for the ninety-day assessment period and the MARS safeguards:

This approach to safeguards ensures that sufficient time and expertise are spent assessing MAiD requests from persons whose natural death is not reasonably foreseeable . . . These safeguards seek to address the diverse source of suffering and vulnerability that could potentially lead a person who is not nearing death to ask for MAiD (Government of Canada, 2023).

On the Department of Justice website, the MARS safeguards are not (or not only) the steps the practitioner must take to assess a patient’s legal eligibility for MAiD prior to providing their assisted death. The purpose of the safeguards is framed differently: ‘sufficient time’ should be given, and ‘sufficient . . . expertise’ should be brought to bear *on the request itself*.

In the Charter statement, the MARS safeguards are requirements of informed consent to a medically assisted death. On the Department of Justice website, the MARS safeguards ‘seek to address’ sources of suffering and vulnerability that may motivate someone not nearing death, to ask for help to die. In contrast with the Charter statement, the Department of Justice frames an approach in which HPs’ attention to suffering and the means available to relieve it are much more ‘upstream’ and comprehensive.

Contradictions or ambiguities in how policies are communicated, or between or within formal policy texts, are not uncommon (Hasenfeld, 2000). Diverse policy goals and tensions among them are among the reasons that policy interpretation and translation at the front lines are so consequential.

Policy translation at the front lines

Conventional framings of policy processes imply that state-level policies are produced by national governments and subsequently implemented in regional or local settings. This framing implies

that the policy itself is fixed and unequivocal, a kind of object that can be readily transported and rolled out at the front lines of service or care (Clarke *et al.*, 2015b). Yet policies themselves are assembled from heterogenous and sometimes-contradictory elements (Clarke *et al.*, 2015b). And central to the point of this article, critical and interpretive policy scholarship confirms that much more happens at the front lines of a care or service than any straightforward version of ‘implementation’.

A considerable literature examines the knowledge, perceptions, decisions, and actions of front-line actors and their consequences in policy outcomes (Meyers and Vorsanger, 2013). Much of this literature draws themes and inspiration from Michael Lipsky’s studies of public sector organisations and workers (Lipsky, 1980, 2010). In theorising the common features and dilemmas of the work of teachers, judges, social workers, counsellors, etc., Lipsky draws attention to an ‘essential paradox’ that links otherwise diverse occupations:

On the one hand, the work is often highly scripted to achieve policy objectives that have their origins in the political process. On the other hand, the work requires improvisation and responsiveness to the individual case. Not only that, but generally the public wants administrators of public services to be at least open to the possibility that a special case is presenting itself, or that extraordinary efforts of one sort or another are called for (Lipsky, 2010: xii).

In living out this ‘essential paradox’, workers at the front lines of care or service provision must have detailed knowledge of regulatory frameworks and eligibility criteria and, in one-on-one interactions, must talk with and respond to particular people in particular circumstances, and make decisions about the resources and services they will receive (Meyers and Vorsanger, 2013). Many policy scholars argue that in this process, front-line actors are not merely applying a pre-given policy in a specific situation: rather, they are making policy in the doing of it. Front line workers:

not only deliver but also actively shape policy outcomes... through their day-to-day routines and decisions, they *produce* public policy as citizens experience it (Meyers and Vorsanger, 2013: 4, emphasis in original).

In Lipsky’s terms, ‘their actions *are* the policies provided by government in important respects’ (Lipsky, 2010: xix, emphasis in original).

While a body of empirical work highlights issues of political authority over front line workers’ discretion – questions of whether and how the originators of policy can control its implementation, including through technology – researchers have increasingly focused on the multiple sources of accountability, operating vertically and horizontally within networked systems, that shape front line workers’ decisions and actions (Hupe and Hill, 2007; Meyers and Vorsanger, 2013; Gilson, 2015).

Among these sources of accountability, Meyers and Vorsanger (2013) identify organisational factors (resource constraints and organisational norms), workers’ belief systems, and professional norms. With respect to professional norms, healthcare workers typically have higher levels of discretion than most public sector workers (Hupe and Hill, 2007) and Evans (2010) argues that professional status significantly shapes discretion in that it entails commitments to service user wellbeing. More generally, Watkins-Hays notes that ‘*how* street-level bureaucrats think of themselves... shapes *what* they value, what they emphasise’ and how they navigate their responsibility to make decisions as agents of the state (Watkins-Hays, 2009, in Meyers and Vorsanger, 2013: 9).

Addressing similar social processes, Clarke *et al.* (2015a) argue that at the site of enactment, policies are not so much implemented as they are translated: front-line professionals interpret the

meanings of a policy in its original context and recast these meanings for and in relation to their own contexts. Salient to the metaphor and process of translation, distinct discourses operate in each setting: standards by which actions are justified in healthcare, for example, are often distinct from those operating in the law. Clarke argues that

... contexts are neither the 'background' from which policies emerge nor the receptacles into which policies arrive. Rather, contexts *animate* translation in different ways (Clarke, 2013, in Clarke *et al.*, 2015c: 49, emphasis in original).

These themes – professional self-concepts and the accountabilities they imply, and the discursive and organisational contexts of front-line professional practice – are especially relevant to the current analysis.

The MARS safeguards in practice: study results

In this section of the article we present results from an ongoing qualitative study of Track 2 MAiD in the greater Hamilton region, in Ontario, Canada, cleared by the McMaster Research Ethics Board. The purpose of the study is to learn about social factors salient to Track 2 MAiD in the region, and how HPs are responding to them. This study is intended to inform a regional model of care for Track 2 MAiD.

Methods

Health professionals (HPs) involved in MAiD coordination, assessment, and provision in the greater Hamilton region were recruited through the Greater Hamilton Health Network MAiD Steering Committee. In semi-structured interviews, participants were asked to discuss two or three Track 2 MAiD cases in detail: what they observed and heard in meetings with patients, and how they responded, with particular attention to social factors operating in the situation.

At this point five HPs involved in coordination, assessment, and provision of MAiD have taken part in the study, three physicians (all with family medicine as their specialty), one nurse practitioner, and one allied professional (in a care coordination role). Interviews lasted between one and two hours; three HPs participated in follow up interviews of between thirty minutes and one hour to review and confirm the use and analysis of their quotes, or to clarify aspects of the patient situations and their responses. All had the opportunity to review and revise transcripts of their interviews.

Together HPs discussed their involvement and interactions with thirteen people undergoing assessment for MAiD, describing social factors that included very difficult family relationships and/or estrangement from family and social isolation linked with physical and mental health struggles. In three cases, patients also lived in poverty and/ or very poor housing conditions (additional details of patient situations appear in the results section).

Using NVivo, each patient was organised as a case, so that all references a HP made over the course of the interview to that patient could be examined together. All interviews were coded for references to social and health services, resources, supports, and interventions (generally, as well as those considered for or discussed with a particular patient); references to the formal MARS safeguards; and HPs' accounts of their thinking, goals, and actions with respect to relieving the patient's suffering; aspects of their professional role and practice setting relevant to their approach to MARS, and perceived to be needed in a regional Model of Care; and patient responses to the HP's communication and action with respect to MARS.

Early in the process of analysis we noted that HPs sometimes framed their decisions and actions in terms of the legislation (for example, saying: 'you have to show due diligence of people giving serious consideration to things' – a direct reference to the criminal code requirements).

More commonly, however, HPs situated their approach in terms of their accountabilities as health professionals and in the contexts of their usual practice with patients. In doing so they articulated a particular ‘translation’ of the MARS safeguards, which we explore in the following section.

Results

In this study, and echoing research on professional discretion (Meyers and Vorsanger, 2013), participants’ approaches to MARS were commonly oriented around their identities as health professionals and norms of professional practice: discussing and actively bringing about health and social supports was ‘what we do’. In addition to informing about and referring to services, HPs commonly proposed or asked patients to ‘try out’ interventions, and sometimes actively advocated for, or enabled, care options. The means of relieving suffering HPs suggested or facilitated were sometimes deeply individualised and informal, and oriented not only around the relief of suffering but also around living with illness and loss. HPs also reflected on features of their own practice contexts, and wider health system constraints, that facilitated or impeded their efforts to meaningfully link patients with MARS.

Pursuing MARS is ‘what we do’

Describing the months leading up to Track 2, and reflecting specifically on the uncertainties associated with this new group of patients seeking MAiD, HP3 highlighted his and his colleagues’ dual accountabilities: ‘I think we’re all wanting to do right by our patients and do right by the legislation’ (HP3).

Exploring a wide range of means of easing the patient’s suffering was in many instances framed as a normal and expected component of ‘doing right by our patients’, in both Track 1 and Track 2 MAiD. As HP1 explained:

Unmet needs is hugely part of the conversation. And whether it’s you know, we need to . . . look at symptom relief or symptom control or we need, we need to connect with your family doctor, whatever the issue is, we’re always looking for things that are actually sort of unmet needs, whether or not they would change the trajectory of somebody’s request . . . Typically there’s two of us going out on an assessment and between the two of us, we almost always will stop and say, ‘is there anything else we could be suggesting, anything else we should be raising, anything else?’ You know, any sort of stone unturned, intervention that we should be mentioning, regardless of the person’s eligibility for assisted dying.

In these quotes, HP1 establishes herself and her colleagues as health professionals ‘always looking for’ unmet care needs, and, in this region (where two professionals are typically involved in each assessment), routinely pooling their observations and knowledge to identify interventions that might address suffering and speaking with other HPs, like the person’s family physician, to better understand the person’s health situation and needs. HP1 is explicit that their primary motivation is not the legislative safeguard: the team’s efforts to ensure that ‘no stone is left unturned’ is distinct from their assessment of the person’s eligibility for a medically assisted death. She is also clear that efforts to address the person’s unmet care needs are not undertaken in the hopes of diverting the patient from MAiD: she and her colleagues are committed to pursuing ways of relieving the person’s suffering regardless of their effects on the person’s desire to die or intent to ask for an assisted death. In this passage, drawing on Clarke *et al.* (2015c), the context of routine professional practice animates a translation of MARS that is distinct from the Charter Statement on Bill C-7, though not necessarily in tension with it.

In discussing the case of a patient with a brain injury who had inquired about MAiD when it was restricted to people with foreseeable deaths, HP2 made explicit reference to the legislation that allowed for Track 2:

We knew there was going to be stipulations in Bill C-7 about, you know, ensuring maximisation of opportunities to improve symptoms and things like that

‘Ensuring maximisation of opportunities to improve symptoms’ is, in its language and implications, beyond the accountabilities defined in the Charter Statement on Bill C-7. HP2 actively established or re-established connections with specialist providers and programmes for this patient. In describing what she did, HP2 initially referenced the eligibility assessment. But when the interviewer reiterated the salience of the legislation, the HP cited an additional source of accountability (Meyers and Vorsanger, 2013):

HP2: So I did a bunch of advocacy things for him, well beyond kind of what my role as the assessor was, because I was/ it wasn’t part of the assessment at that point, but I was preparing.

C: Yeah. Anticipating [the change in legislation], yeah.

HP2: And also wanting to help him right, I mean, that’s what we do, right?

This HP confirmed the relevance of the legislation to her actions, yet at the same time made a point of affirming her identity and role as a helping professional, and went on to describe her advocacy and active support to this patient as points of professional and personal pride. In this instance, professional status and identity shape discretion (Evans, 2010).

MARS took informal, individualised, experiential forms; HPs proposed, tracked down, devised and arranged MARS

In formal descriptions, the ‘means available to relieve suffering’ include ‘counselling services, mental health and disability support services, community services, and palliative care’. The actions that HPs are required to take in relation to MARS include ‘ensuring that the person has been informed . . . and has been offered consultations’; ensuring they have discussed with the person ‘reasonable and available’ MARS; and ensuring they ‘agree with the person that the person has given serious consideration to those means’ (*Criminal Code of Canada*).

In the narratives of HPs involved in this study, MARS included these services as well as many less formal or recognised forms of support and intervention. HPs’ actions, in addition to the actions listed in the legislation and described in the section above, commonly involved careful dialogue about what changes might be possible in individuals’ lives, and what might make a difference to their desire to die; it also involved devising and proposing, and sometimes actively arranging, interventions and supports. In this section we describe these less formal or recognised forms of engagement and how HPs account for them.

HP4 described careful, detailed conversations with people seeking MAiD related to MARS. In addition to inviting the person’s own knowledge and reflections on possible means of relieving suffering, HP4 described raising potential changes in physical and social circumstances and seeking to understand the effects the person believed these could have:

‘if we knew that we could get you from a pain of nine out of ten all day long, every day to, you know, five . . . what do you think that would [do]?’ –

‘if you were living in a different situation . . . would that make you more feel more able to cope with what’s going on, or that you would want to continue to live?’

I often say, ‘if we imagine a different situation for you, you know, is it possible you think, that it could be better?’

HP4 said these conversations helped her ‘build a picture of understanding’ of the person’s suffering, the kinds of supports or changes that might make a meaningful difference in their lives, and their capacity and willingness to (continue to) engage. In this description of her work, discussing the ‘means available to relieve suffering’ is not (or not only) a step in ensuring the person’s informed consent to a medically assisted death; rather, it is an exploration of the changes in experience and circumstance that could tip the person into wanting to live.

Actively supporting people to be able to imagine different situations for themselves also came forward in a case described by HP5, in which a patient met eligibility criteria for MAiD but a combination of social factors (a very difficult spousal relationship, estrangement from children, a daughter’s substance use, constrained finances) were ‘speaking into his suffering.’ She described a conversation with colleagues:

He’s absolutely eligible, but we think if he had better social supports, he wouldn’t want MAiD. And so we asked him to go to [a respite care setting] just for a short amount of time, to experience what life would be with different social supports.

In reflecting on this situation, HP5 drew attention to how this individualised, short-term intervention addressed a dilemma for the HP undertaking the independent assessment: they were confident that the patient met the eligibility criteria but conflicted about ‘signing off’ on the assessment. In this situation, and in keeping with similar cases described by Close *et al.* (2023), standards of justification in the legislation appeared inadequate to the HP’s own standards of justification.

In another case discussed by HP5, the MARS ‘intervention’ did not involve any formal services. HP5 spoke of a patient who had been in a serious accident and who felt deeply the loss of a previous and much-valued identity as ‘the life of the party’. Learning about the social situations the patient was most afraid of, the HP asked the patient to try that activity at least once. As HP5 explained, in this situation,

it wasn’t necessarily a lack of social supports, but it was . . . not knowing on his part, with the proper supports what his life could look like. So highlighting those things I think is important.

In the cases described by HP5, professionals involved with these patients discerned that they had asked for MAiD in large part because they could not see a way out of their situations of suffering. HPs encouraged and enabled patients to ‘try something out’ for a limited time, to ‘experience what life would be’ or what ‘life could look like’ (HP5).

In reflecting on the cases she described, HP5 said she perceived the requests HPs made of patients (to try out the respite bed, to do the feared social event) as emerging from a ‘relational conversation’ and as generating information vital for the patient:

I feel like we’re the experts of healthcare and they’re the experts of themselves and they need us to use our expertise to help them make an informed decision rather than just be ‘yes men’ for their decision.

This conceptualisation of the HP's roles in the patient's informed decision making and in enacting the Track 2 safeguards is distinct from that conveyed in the Charter Statement on Bill 7. In the Charter Statement, HPs' 'time and expertise' are tied to assessing eligibility for MAiD. In contrast, and in keeping with the Department of Justice account of the Track 2 safeguards (Government of Canada, 2023), HP5 links professional expertise with accurately discerning the sources of the patients' motivation to ask for MAiD and envisioning supportive interventions closely tailored to the patient's situation. In both cases, it was clear that if the patient had emerged from the 'intervention' saying "no, I'm still intolerably suffering, this is still awful" . . . we could have moved forward' (HP5) with MAiD or with the next stages of assessment.

HP4 also described a case in which she and her colleagues took a very active role in pursuing, advocating for and arranging supports for a patient. The patient had leg ulcers among the worst she had ever seen, and he was in a 'horrible living situation.' His living conditions hampered healing – he was unable to do laundry or clean his apartment, and his diet was poor. HP4 believed his leg ulcers would get better if properly cared for, and she describes how he 'brightened up' when she talked with him about the possibility of getting better nursing care. Yet despite multiple conversations with programmes and specialists – the regional home care programme, a skin specialist, and a wound specialist – she was unable to secure more than three home visits a week. HP4 also perceived that his social class meant that professionals' expectations of what was possible in terms of healing were low.

In this situation HP4 described acting as a MAiD assessor as well as 'a family doctor . . . a social worker . . . an advocate'. This framing highlights accountabilities and standards of justification for action that include, but also extend beyond, those defined in the legislation. The fact that another resident charged the man for small tasks, like carrying the groceries upstairs, further propelled her:

He was paying thirty bucks for the kid in the first floor of his apartment building to carry his groceries upstairs. You know, he ordered them, they were delivered, and he had to pay thirty bucks for that kid to walk them up the stairs. Like it just, I was so mad about the whole thing as well . . . So I just like, I needed him to be out of there [laughs].

Asking about packed boxes in his apartment, HP4 learned the man had been accepted into a long-term care facility the year prior but, because of a misunderstanding about its cost, had withdrawn his request. The team's MAiD coordinator contacted the facility, explained the situation, and the man was offered a bed within the month. HP4 emphasised how unusual this was: wait lists for long-term care are typically many months long, and 'nothing about the system would have supported that happening'.

In these accounts, HPs described their engagement with patients about the 'means available to relieve suffering' in terms that go well beyond informed consent as it is highlighted in the Charter Statement on Bill C-7. In their conversations they supported patients to *imagine* how things might be different; they *asked* patients to try certain interventions; they also *brought about* and encouraged *experiences* of a different life. Their accounts highlight more expansive roles for HPs and more relational and social visions of autonomy than are typically evident in prevailing discourse around MAiD. We return to this theme in the Discussion.

MARS were oriented in part around living with bodily realities and losses

The recognition that physical conditions or limitations could not be changed, but that one's relationship to these realities might shift, was highlighted in HP5's account of the patient who had experienced the accident. In that situation, the intervention HP5 described was focused on a psychosocial process of coming to perceive the possibility of living well, or well enough, with a changed body. Similarly, HP4 described this interaction with a patient:

I said . . . ‘you know I think we’ve exhausted what’s available right now for pain. And so the question I have is, if something was different, if there was something different in your life that you could cope differently with the pain, would that be helpful?’ . . . It comes down to, could she learn to live with this differently? Would that make her want to live longer?

This theme of adaptation to bodily realities was also present in HP1’s reflections about a patient in her thirties with fibromyalgia. HP1 said:

I would want to do everything in my power to see if we could improve that person’s desire to die right now. And I don’t think that means that I’m not supporting their request to be assessed for assisted dying. I just think that the assessment for assisted dying is very different depending on who’s asking.

This experience of knowing patients who over very long stretches of time live well enough with a difficult illness (or this specific difficult illness) informed HP1’s orientation to MARS in this situation, her commitment to do ‘everything in my power’ to address the patient’s suffering and desire to die. In all three cases, developing new relationships to bodily realities and losses was understood as a ‘means to relieve suffering’ and these HPs perceived themselves to have a role in supporting patients in this process. For HP1, this support sometimes took the form of extended discussions with patients in her family practice who had raised MAiD. As she said, ‘there’s a lot of ongoing conversation and people who express interest [in MAiD] and come close to getting fully assessed, and then sort of back away and then come back.’ As noted previously, ‘contexts *animate* translation in different ways’ (Clarke *et al.*, 2015c: 49). The ongoing conversation about bodily experience and suffering, and the reaching for and retreating from MAiD that HP1 described, is a translation of the Track 2 safeguards animated at least in part by the infrastructure of long-term relationships between HPs and patients. We return to this point in the Discussion.

Discussion

In this article we draw attention to differences in the articulation of the ‘means available to relieve suffering’ safeguards in government documents about Track 2 MAiD: one oriented to ensuring the patient’s consent to MAiD is informed; the other oriented to addressing sources of suffering that may motivate someone who is not nearing death to request an assisted death. Our qualitative study begins from the recognition that contradictions or tensions at the level of policy are necessarily managed at the front lines of practice: that front-line workers do not so much implement as they *translate* government policy (Lipsky, 2010; Meyers and Vorsanger, 2013).

In the accounts highlighted in this article, HPs meeting with people who had asked for MAiD under Track 2 described carefully supporting patients to imagine possibilities for feeling and living differently (including through adapting to losses), creatively devising interventions, and actively connecting patients with (in some cases bringing about) care services and resources. The discretion they exercised was mediated by professional self-concepts and norms and related discourses of expert communication, care, and advocacy. Their approaches resonate with those described in a study with fifty nurses and nurse practitioners across Canada with significant experience with MAiD (Pesut *et al.*, 2021). Pesut *et al.* (2021: 13) note that healthcare providers involved with MAiD ‘consider many aspects beyond the legality of eligibility and safeguards’ and assert that in the context of MAiD, ‘the most important healthcare intervention is relational and dialogical in nature.’ Echoing literature about the factors that shape HPs’ decisions and actions at the front lines (Meyers and Vorsanger, 2013; Gilson, 2015), they underline the significance of normative expectations, particularly of clinical colleagues, in shaping practice.

Beaudry (2018) argues that the conceptualisation of autonomy underpinning Canada's MAiD policy is a deliberative one, concerned centrally with protecting people's decisional capacities (that is, focused on capacity, informed consent, freedom from coercion etc.). He advocates, in contrast, social autonomy, which entails 'an obligation [on the part of the state] to ensure that the patient's range of options rise above a threshold that would take into account a number of social determinants of people's motivations to end their lives' (Beaudry, 2018: 359).

As we have noted, this paper was not intended as an evaluation of the adequacy of the Track 2 safeguards. Yet health professionals' accounts offer insight into the possibilities and limits of translating Track 2 MAiD policy at the front lines in ways that align with the broad range of policy goals articulated by the Government of Canada (2023) – or, in Beaudry's (2018) terms, that recognise social and relational, as well as deliberative, autonomy.

In relation to the goal of bringing time and expertise to bear on the MAiD request itself (Government of Canada, 2023), HPs in this study highlighted the value of practice contexts in which HPs and patients have long-term relationships (such as primary care). In the model of physician assisted dying in the Netherlands, sustained relationships between patients and family physicians provide a structure for discussions about living with illness, impairments and suffering in which 'the euthanasia process most often occurs as ongoing talk and not simply as a life-ending act' (Norwood *et al.*, 2009). A recent multi-sector meeting of stakeholders focused on developing Track 2 MAiD care noted the important role of primary care providers in 'exploring the reasons for a patient's request' and ensuring appropriate consultations 'even before a MAiD assessment goes forward' (Thorne *et al.*, 2023). A recent study of the challenges that MAiD assessors face when natural death is not reasonably foreseeable found that just over one third of patients had not been offered all appropriate and available treatments for their conditions prior to submitting MAiD requests (Wiebe and Kelly, 2023).

The current study also makes apparent the time, skill, tenacity, and creativity required to discern and attempt to bring about 'means to relieve suffering'. In keeping with emerging research (Pesut *et al.*, 2021; Close *et al.*, 2023; Thorne *et al.*, 2023), HPs in this study expressed a clear need for adequate time and remuneration for the complex work; they also highlighted the value of collaboration across care sectors, and strongly endorsed dedicated systems navigators for community MAiD programmes.

Yet study participants also emphasised that systems navigation cannot make up for inadequate or inaccessible public services and resources. HP3 echoed others in the study when he affirmed the skill of the systems navigator he works with and the strengths of the social services in the region. At the same time, as he went on to say,

... increasingly, those organisations are not able to meet the needs of our patients. Financial issues are just so much worse than they've ever been in these last three years for a lot of people. I mean, housing is the biggest piece right now. We make referrals to our system navigator all the time for housing support, and [the navigator says], 'there's nothing I can do anymore.' I mean the wait lists are ten years long for subsidised housing.

Along the same lines, in the case described by HP4, securing adequate care for the patient with leg ulcers was very nearly impossible. Multiple efforts and strategies by skilled HPs to arrange more frequent wound care in the man's home were unsuccessful (in HP4's observation, home care services have not returned to pre-pandemic levels). The LTC bed came about through an exceedingly rare alignment of circumstances and people. HP4 affirmed that the more likely scenario would have been that the man's only option was to continue to live in unbearable suffering, or to ask the HP to assist him to die. As has been noted in other Canadian studies, the lack of (timely) availability of social supports and resources known to ease suffering raises ethical dilemmas and generates moral distress for health professionals involved in MAiD (Pesut *et al.*, 2021; Christie and Li, 2023; Wiebe and Kelly, 2023).

Limitations

The analysis presented in this article drew from interviews with a small number of professionals in a defined geographic area and is thus reflective of a local culture of practice. It is also no doubt shaped by the specialties of the professionals who came forward to be interviewed.

Importantly, our analysis in this article did not devote focused or systematic attention to how patients responded to HPs communications and actions. This matters in policy terms because, as Meyers and Vorsanger (2013: 3) put it, front-line workers always ‘engage in a joint production process’ with individuals who seek public services. Future manuscripts will take up this theme and consider the implications of the patients’ responses (including their reluctance about or rejection of services and interventions) for HP’s actions and decisions.

Conclusion

Among contrasting or competing policy visions, this paper highlights front-line enactments of Track 2 MAiD safeguards animated by professional self-concepts and discourses of expert communication, care, and advocacy. The paper also contributes to an analysis of the possibilities and limits of translating Track 2 MAiD policy at the front lines in ways that align with social and relational as well as deliberative autonomy, and thus reflect the full range of policy goals articulated by the Government of Canada (to ‘reflect Canadians’ needs, protect those who may be vulnerable, and support autonomy and freedom of choice’) (Government of Canada, 2023).

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Notes

1 The province of Quebec is the exception: for discussion, see Downie (2022).

2 Eligibility for medical assistance in dying, from the *Criminal Code*:

- (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
 - (a) they are eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada;
 - (b) they are at least eighteen years of age and capable of making decisions with respect to their health;
 - (c) they have a grievous and irremediable medical condition;
 - (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
 - (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Grievous and irremediable medical condition

- (2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:
 - (a) they have a serious and incurable illness, disease or disability;
 - (b) they are in an advanced state of irreversible decline in capability; and
 - (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

3 Bill C-7 removed from MAiD law the requirement that death must be ‘reasonably foreseeable’ and created Track 2 MAiD.

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Appendix

Table A1. Articulations of the ‘means available to relieve suffering’ safeguards

Criminal Code of Canada
<u>Safeguards – natural death not foreseeable</u>
(3.1) Before a medical practitioner or nurse practitioner provides medical assistance in dying to a person whose natural death is not reasonably foreseeable, taking into account all of their medical circumstances, the medical practitioner or nurse practitioner must . . .
(g) ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care;
(h) ensure that they and the medical practitioner or nurse practitioner referred to in paragraph (e) have discussed with the person the reasonable and available means to relieve the person’s suffering and they and the medical practitioner or nurse practitioner . . . agree with the person that the person has given serious consideration to those means.
(i) ensure that there are at least 90 clear days between the day on which the first assessment under this subsection of whether the person meets the criteria set out in subsection (1) begins and the day on which medical assistance in dying is provided to them . . . (<i>Criminal Code of Canada</i>).
Charter Statement about Bill 7
First, the Bill would require a minimum of 90 days for the assessment of a person’s eligibility for MAID. In order to conclude that a person is eligible for MAID, the practitioner must determine that all of the eligibility requirements set out in subsections 241.2(1) and 241.2(2) are satisfied . . .
Finally, the Bill would introduce two changes clarifying the requirements of informed consent in this context. The first change would be an express requirement that the person be informed of available counselling services, mental health and disability support services, community services and palliative care, as appropriate to the individual’s situation, and be offered consultation with professionals who provide those services. Second, the person and practitioners would have to agree that reasonable and available means of alleviating the person’s suffering had been discussed and seriously considered before MAID could be provided (Government of Canada, 2021b)
Department of Justice website
<u>Procedural safeguards</u>
The 2021 revisions to Canada’s MAID law created a two-track approach to procedural safeguards for medical practitioners to follow . . .
This approach to safeguards ensures that sufficient time and expertise are spent assessing MAID requests from persons whose natural death is not reasonably foreseeable . . .
New safeguards now apply to persons whose natural death is not reasonably foreseeable. These safeguards seek to address the diverse source of suffering and vulnerability that could potentially lead a person who is not nearing death to ask for MAID. (Government of Canada, 2023).

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