MISSION: Assistance in Living

Re-affirming our Commitment to Patient-Centred, Whole Person Care

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CATHOLIC HEALTH ASSOCIATION OF MANITOBA
ASSOCIATION CATHOLIQUE MANITOBAINE DE LA SANTÉ
МАНІТОБСЬКА КАТОЛИЦЬКА АСОЦІЯЦІЯ ЗДОРОВ'Я

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Executive Summary

The Catholic Health Association of Manitoba (CHAM) is a voluntary, provincial association dedicated to the healing Ministry of Jesus Christ and its mission of compassionate concern and respect for all persons through its ministries of education, health care ethics, spiritual care, social justice, and Catholic sponsorship.

In specifically contemplating the Canadian MAiD experience to date, CHAM believes there is a critical need for individuals and organizations to re-ignite a life-affirming approach to the care and wellbeing of all Canadians based in shared values of the dignity of the human person. There is a need to rally around a collective, intentional vision and action aimed at supporting the person in all dimensions—physical, social, psychological, emotional, spiritual—as a form of social justice. We could call this approach "Mission: Assistance in Living" (MAiL).

MAiL is aimed at identifying, providing, improving and/or facilitating access to care and supports that advance the inherent dignity, security and fundamental equality of all persons— including persons with physical or mental illness, disability or older age, as well as persons experiencing poverty, homelessness, isolation or a lack of care and support—in order to live with dignity, to flourish, and fully participate in society on an equal basis with others.

This document sets out background information to support the need for a MAiL model and is followed by general guidelines, corollary commitments, and preliminary action items.

Background

The 2016 Supreme Court Challenge and the subsequent change to the Criminal Code paved the way to permit medical assistance in dying in Canada under defined conditions. The eligibility requirements for MAiD were amended to include those whose death is *not* forseeable in 2021. Access to MAiD is anticipated to expand once again in March 2024, when restrictions on accessing MAiD for reasons of mental illness is set to expire.

More and more Canadians are accessing MAiD each year, at a time when many Canadians continue to struggle with systemic ageism and ableism and cannot access basic social supports and medical care, including mental health services and palliative care. In the face of these realities, it is vital to ensure that MAiD does not become a default for Canada's failure to fulfill its human rights obligations and its commitment to ensure that everyone can live with dignity.

As MAiD becomes more intertwined with other areas of medicine and health care and as eligibility broadens, the legal construction and moral understanding of MAiD and its societal implications will become increasingly complex and will give rise to new ethical dilemmas.

As MAiD practice continues its rapid pace in Canada, we must recognize and deal with the tremendous implications for our country. As a Canadian society, we must have important conversations about the social costs of trauma and complicated grief for families and caregivers and health care provider stress. As people committed to justice, we must challenge the view of MAiD as a "harm reduction" strategy in the face of unjust circumstances and be transparent about the economic dimensions of MAiD with rising health care costs and an aging population.

Guiding Principles

Mission: Assistance in Living (MAiL) is rooted in deeply held principles based in Catholic social teaching.

1. **Inviolability of Human Life**—For all who believe deeply in life as a sacred gift, the intentional ending of a human life at the heart of MAiD is directly opposed to this fundamental belief.
2. **Justice and the Common Good**—Justice is rooted in fundamental care, responsibility, and respect for another. Inherent in the call to justice is a commitment to safeguarding the life of another, upholding individual and collective rights and desiring and working towards the *good of all* with love and acceptance.
3. **Accompaniment and Solidarity**—The core commitment to accompany others is key—walking with, respecting, and sustaining the person in all dimensions of being human. Solidarity does not measure the value of human life based on its quality, efficiency, or utility—but strives for fundamental equality by upholding the intrinsic value and dignity of human life and supporting individual flourishing and communal growth.

CHAM Commitments

Reaffirming a commitment to patient-centred, whole person care, CHAM looks to identify and respond to unmet needs and suffering in all its forms and supporting those most vulnerable, marginalized and disadvantage in our society. This call includes:

- maintaining a distinction between MAiD and palliative care
- establishing an ethos and culture that sustains and promotes people's intrinsic dignity, sense of worth, moral agency, security, and equitable access to supports.
- providing the best and highest quality of care and support at all life's stages
- advocating that Governments recognize social, economic, and cultural rights with universal palliative care and access to mental health and social supports so that MAiD is never the default option.
- focusing on outreach to address loneliness and isolation
- continuing a journey of Truth and Reconciliation with Indigenous Peoples
- helping to develop a policy framework that affirms and supports MAiL

Call to Action

In keeping with these commitments, CHAM has proposed several priorities (see pages 16-18) in the following key action areas to advance MAiL and seeks partnerships with those who share a commitment to this journey:

- Social Justice
- Education and Training
- Spiritual Care and Outreach
- Heath Care Ethics

Catholic Health Association of Manitoba

The Catholic Health Association of Manitoba (CHAM) is a voluntary, provincial association dedicated to the healing Ministry of Jesus Christ as exemplified (or taught) by the Catholic Church. Through its Ministries of education, health care ethics, spiritual care, social justice, and Catholic sponsorship,[1] CHAM fulfills its mission of *compassionate concern* and *respect for all persons*.

Purpose of Document

Given ongoing expansion of the practice of Medical Assistance in Dying ("MAiD") in Canada, which includes anticipated future expansion to MAiD for mental illness in March 2024, the timing is appropriate for CHAM to reflect upon and re-affirm its commitment to patient-centred, whole person care.

In specifically contemplating the Canadian MAiD experience to date through the lens of CHAM's mission of *compassionate concern* and *respect for all* persons, CHAM has come to identify that there is a critical need to reaffirm a life-affirming approach to care based on the inherent dignity of each person as taught by Christ and aimed at supporting the person in all dimensions (physical, psychological, social, familial, spiritual) known as "medical assistance in living".

The urgency for **medical assistance in living** (MAiL) as a form of social justice has been brought into sharper focus through the emergence of stories of persons who have shared their lived experiences of suffering and anguish as they attempt to access services and supports but are met with barriers. These stories include persons whose medical conditions or disabilities make them eligible for MAiD and who have inquired, sought, or requested death by MAiD not because of an immediate desire to die but to escape the lack of care, services and support needed to experience a life with dignity, security, and hope. In other words, these stories reflect exactly what CHAM is focused on, responding to those who are asking for assistance in living. Indeed, "[e]veryone should be concerned to create and support institutions that improve the conditions of human life."[2]

Accordingly, MAiL is aimed at identifying, providing, improving and/or facilitating access to care and supports that advance the inherent dignity, security and fundamental equality of all persons — including persons with physical or mental illness, disability or older age, as well as persons experiencing poverty, homelessness, isolation or a lack of care and support — in order to support persons to live with dignity, to flourish, and fully participate in society on an equal basis with others. Thus, MAiL includes within its approach, consideration of health equity and the social determinants of health.

As succinctly put by the Catholic Health Association of the United States:

> Addressing the root causes of poor health is not unique to Catholic health care. What is unique to Catholic health care is that our faith compels us to give special attention to our neighbors who are economically poor and to work for the common good. It is these values that drive us to lead the way in this work, even when the path forward is not clear.[3]

In short, the purpose of this document is to re-affirm and revitalize CHAM's commitment to patient-centred, whole person care by re-focussing on a "**medical assistance in living"** care approach. Although this is a first step and the contours and substance of this approach will likely continue to evolve, this particular document sets out key background information that encourages proceeding with a "**medical assistance in living**" approach and is followed by general guidelines, corollary commitments and preliminary action items.

Definitions

For the purposes of this document, the following terms are defined as follows:

Palliative Care	"Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual."[4] Dying is a normal part of life and palliative care helps people to live and die well. Unlike MAiD, which intentionally ends a person's life at their request, palliative care intends neither to hasten nor postpone death, and should be available over the continuum of care of a life-limiting illness.[5]
Medical Assistance in Living or "MAiL"	**Medical assistance in living** (MAiL) is a life-affirming approach to care aimed at supporting the person in all dimensions (physical, psychological, social, familial, spiritual). **Medical assistance in living** therefore includes but is not limited to "palliative care". **Medical assistance in living** is aimed at identifying, providing, improving and/or facilitating access to care and supports to advance the inherent dignity, security and equality of all persons and thus includes within its parameters promoting health equity and the rights of all persons informed the social determinants of health.
Social Determinants of Health	The social determinants of health are the social and economic factors that influence health outcomes. They are the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems." Examples of relevant factors include:[6] income and social protection; education; unemployment and job security; working life conditions; food security; housing, basic amenities, and the environment; early childhood development; social inclusion and non-discrimination; structural conflict; access to affordable and quality health services; access to culturally sensitive supports and services; and spiritual care.

Health Equity	Health equity is when all people have or are given "the opportunity to 'attain their full health potential' whereby no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance". [7]
Medical Assistance in Dying or "MAiD"	Medical Assistance in Dying (MAiD) is a statutory term and defined in Section 241.1 of the Canadian Criminal Code as:[8] "(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (*aide médicale à mourir*)." MAiD therefore involves the intentional and deliberate ending of a person's life through the administration or provision of a lethal substance to a person at that person's request. MAiD therefore encompasses both "euthanasia" and "physician-assisted suicide" as further defined below.
Euthanasia	Euthanasia is the act of intentionally and deliberately ending the life of a patient. The MAiD procedure whereby a practitioner administers a substance to a person, at their request, to intentionally and deliberately cause the person's death is therefore a form of euthanasia.
Physician-assisted suicide	Physician-assisted suicide is the intentional and deliberate act of enabling a patient to end his or her own life. The MAiD procedure whereby a practitioner prescribes or provides a lethal substance to a person for self-administration, at their request, to intentionally and deliberately cause the person's death is therefore a form of physician-assisted suicide.

Background

In response to a decision of the Supreme Court of Canada,[9] the Canadian Parliament amended the Criminal Code in June 2016 to allow physicians and nurse practitioners to legally administer (or prescribe) a substance to an adult patient to intentionally cause that patient's death.[10] This procedure which is subject to specific eligibility and procedural requirements, is called "medical assistance in dying" or "MAiD".

The eligibility criteria for MAiD include that the person:

- be at least 18 years of age and capable of making health decisions;
- make a voluntary request and give informed consent to the procedure; and
- have a "grievous and irremediable" medical condition.

The term "grievous and irremediable" medical condition, in turn, required the following additional criteria be met:

- serious and incurable illness, disease or disability;
- advanced state of irreversible decline in capability;
- enduring and intolerable physical or psychological suffering caused by the illness, disease or disability; and
- natural death be "reasonably foreseeable".*

In March 2021, pursuant to Bill C-7, Parliament amended the Criminal Code MAiD provisions and removed the "reasonable foreseeable natural death" as a MAID eligibility requirement.[11] This amendment established what is now described as the "two tracks" to MAiD:

- "track one" for persons whose natural death is foreseeable; and
- "track two" for persons whose natural death is <u>not</u> foreseeable.

The relevance of these two different tracks as far as the Federal MAiD law is concerned, is that the law imposes different procedural safeguards based on whether the patient's natural death is foreseeable or not.[12]

With the March 2021 expansion of the MAiD law to allow physicians and nurse practitioners to intentionally end the lives of patients who are experiencing suffering but who are not at end of life or otherwise foreseeably dying, arose the issue of whether the MAiD procedure should also be legally permitted for persons whose suffering stems solely from a mental, rather than a physical illness, disease, or disability.

At that time, Parliament chose to expressly exclude "mental illness" as a sole underlying medical condition ("MAiD for mental illness" or "MAiD MD-SUMC")[13] from MAiD eligibility but only for two (2) years. That is, Parliament's express exclusion of MAiD for mental illness under Bill C-7 was for a limited duration and originally due to expire on March 17, 2023.

In March 2023, however, Parliament determined that it would continue to delay implementation of MAiD for mental illness for an additional year.[14] Accordingly, the revised date for when Canada is anticipated to allow the practice of MAiD for mental illness is March 17, 2024.[15] Recent public polls, however, show that the majority of Canadians either do not support or are unsure of MAiD MD-SUMC.[16] Similarly, although the Canadian Psychiatric Association has stated that it "did not and does not take a position on the legality or morality of MAiD",[17] many psychiatric professionals do not support MAiD MD-SUMC,[18] and the province of Quebec has recently passed legislation to expressly exclude it (with the exception of neurocognitive disorders) from its provincial medical aid in dying legislation.[19] That said, within this same legislation, Quebec has expanded "aid in dying" within the province to allow euthanasia for persons who are incapable of consent but pursuant to an "advance request" made by the patient when they were capable but in anticipation of their future incapacity. Furthermore, Quebec has prohibited all palliative care hospices from excluding aid in dying.[20]

While it is beyond the scope of this document to examine the details of why Parliament is continuing to move forward with decriminalizing MAiD MD-SUMC, it can be noted that this expansion appears in part to be connected with certain human rights-based perspectives and arguments in relation to particular applications of the concepts of autonomy, self-determination, equality and suffering.[21] Additionally, certain legislators also assert a view that Canadian courts have said that MAiD MD-SUMC is a Charter "right" of Canadians.[22]

Although the above legal interpretation of the caselaw has yet to be definitively settled, it should be noted here that MAiD was established and made legally permissible through the creation of exemptions in the Criminal Code, namely, exemptions from the offences of culpable homicide,[23] aiding suicide[24] and/or administering a noxious thing.[25] Exemption under the criminal law does not create or confer a positive right to that exempted activity – in this case, MAiD – a principle that has been unanimously confirmed by the Supreme Court of Canada in the recent case *Murray-Hall*:

> The principle to be drawn from these excerpts is that the making of exceptions or exemptions under a criminal law scheme cannot serve to confer positive rights to engage in the activities covered by those exceptions or exemptions. …
>
> ... I cannot accept that exceptions or exemptions made under a scheme of criminal offences may give rise to positive rights, even where the exceptions or exemptions are closely related to the achievement of criminal law purposes. …The recognition of positive rights created out of exceptions or exemptions closely related to a valid criminal law purpose would improperly extend the scope of the federal criminal law power.[26]

Nonetheless, while there can be no positive right to MAiD conferred by the Criminal law, it remains that the MAiD procedure:

- is available throughout Canada and delivered through provincial health care;
- has expanded eligibility from persons whose deaths were naturally foreseeable to include persons whose deaths are not naturally foreseeable; and
- is currently scheduled to expand to persons whose sole underlying condition is a mental illness on March 17, 2024.

The number of MAiD deaths is steadily increasing every year. In 2021, for example, 3.3% of all deaths (or 10,064 people) were MAiD deaths which represents a 32.4 per cent growth rate from 2020.[27] Furthermore, the percentage of MAiD deaths in parts of Canada is already surpassing the rates in other jurisdictions where euthanasia practice has been in place for many years. And, over the past few years there has been increased reporting of "regrettable" incidents and/or concerns in respect of MAiD implementation in Canada.

For example, there have been reports of the unsolicited introduction of MAiD to non-seeking persons, including Canadian veterans, as a solution for their medical issues.[28] Additionally, there have been several narrative accounts of persons with medical conditions or disabilities who meet the MAiD eligibility criteria, but who have been motivated to request MAiD in order to relieve suffering related to lack of health care or social supports, poverty and fear of homelessness etc.[29] The United Nations Special Rapporteur has warned of this type of "architecture of choice" whereby the interplay between MAiD for non-terminal disabling conditions and the lack of availability or access to services or support options causes pressure and interferes with the autonomy and decision-making of persons with disabilities.[30]

In addition to the related and unresolved question of the impacts of MAiD in terms of advancing and provoking ableist, ageist and racist assumptions about the quality and worth of the lives of disabled, older or racialized persons, including Indigenous persons, these concerns in turn raise the issue of human rights' obligations and whether Canada is meeting these obligations.[31] Notwithstanding that there may indeed be persons who request MAiD for reasons unrelated to unmet need, lack of support, or the social-economic determinants of health, the fact remains that Canadians still do not have universal access to quality palliative care, nor to universal mental health care nor the many other programs and supports to which they are entitled under various human rights laws.[32] Thus as recently described by Marie-Claude Landry, the Chief Commissioner of the Canadian Human Rights Commission:

> Social and economic rights – the right to an adequate standard of living, the right to adequate housing, the right to healthcare and the right to accessible services – are fundamental human rights. They are essential to living a life of dignity. Without access to social and economic rights, our other rights have little meaning.

> Canada has an obligation to ensure that everyone can live with full enjoyment of these rights. Social and economic rights – fundamental human rights – should be enshrined in law. This would give people recourse when they are being denied an adequate place to live, or are unable to find healthcare or are excluded from receiving a service. It would provide access to justice. It would provide options beyond ending one's life.
>
> Medical Assistance in Dying cannot be a default for Canada's failure to fulfill its human rights obligations.[33]

One of the key arguments to support MAiD decriminalization – as well as its ongoing expansion – is that even though there are societal shortcomings and unjust social circumstances that ought to be addressed, such shortcomings or circumstances do not justify denying MAiD access or eligibility to people who are decisionally capable. In other words, while society should, for example, continuously work to improve access to palliative care or address the social-economic determinants of health, addressing these shortcomings or unjust circumstances should not be a pre-condition for proceeding with MAiD access or eligibility because – according to the argument – this would be an unacceptable leveraging of the suffering of persons seeking MAiD and a form of scapegoating. Furthermore – as the argument continues – to deny MAiD MD-SUMC, perpetuates harmful bias and stigmatization of persons with mental illness, removes patient agency, infringes patients' rights and is an egregious form of paternalism.[34] This line of argumentation has been expanded to describe MAiD as a form of "harm reduction" in unjust social circumstances where people would have chosen otherwise "were conditions more just", "even though such decisions are tragic".[35]

While such arguments may support the secular case for access (and expanding access) to MAiD to a variety of circumstances where suffering is present, the concerns regarding societal shortcomings and unjust social circumstances do not simply disappear "merely because" MAiD has been decriminalized.[36] Indeed, justice demands that these circumstances be addressed.

Another critical MAiD-related consideration is the short and long-term impacts on family members, family caregivers or close others of persons who choose to die by MAiD. Legally-speaking, persons who seek MAiD in Canada do not have to involve or alert a family member of their decision to proceed with MAiD.[37] For some families and close others, albeit not all, this kind of situation has caused significant trauma and what has been described by some as a "complicated grief".[38] Even when the circumstances are such that the death is anticipated (whether through natural causes or MAiD), many family members and close others must still cope with grief and distress, notwithstanding that personal experiences will vary.

Furthermore, as MAiD "intertwines" with other areas of medicine and health care (such as organ donation after MAiD for example) and as eligibility for MAiD continues to broaden (for example, MAiD MD-SUMC), the legal construction and moral understanding of what MAiD actually is, is becoming increasingly complex and likely to provoke new ethical dilemmas.[39]

Accordingly, notwithstanding that MAiD is being delivered across Canada through the health care system, it is not difficult to anticipate healthcare provider stress and trauma in relation to MAiD (whether as a conscientious participant or a conscientious objector), particularly as elements of the MAiD framework may not always reconcile with evidence-based medical practice and as MAiD-request stories related to lived experience and unmet need or support are likely to continue to emerge.[40]

Finally, as is the case in many other parts of the world, the Canadian population is aging. The experience with respect to long term care facilities during the first wave of the COVID-19 pandemic revealed the existence of systemic ageism and ableism within Canada as well as systemic fragility in being able to protect and defend the basic human rights of older Canadians.[41] We also know that health care is resource intensive while MAiD on the other hand results in a net reduction of health care costs.[42] Given such considerations, the cost-savings aspects of MAiD must be kept as contextually transparent as possible.

General Guidelines

1. Inviolability of Human Life

There is no question that MAiD is a challenging and confronting matter for any Catholic individual or institution.

The Church's teaching is clear that while treatment decisions are never to include actions or omissions that *intentionally* cause death, the following treatment decisions are appropriate, *even if* death is foreseeable or may result:[43]

- refraining from or suspending the use of therapeutic measures that have no benefit or are over-burdensome *in the opinion of the patient* (i.e. respect for the wishes, values and needs of the person receiving care);
- withholding or withdrawing life-sustaining treatment if the *burdens outweigh the benefits* (i.e. proportionality of treatment); or
- palliation and relief of pain with medication that may carry a level of *risk that death, could be hastened* (i.e. the principle of "double effect").

The *intentional* ending of human life, however, is *never* permissible.

It is relevant to note that Canadian judicial analysis leading to the decriminalization of MAiD in the Criminal Code described that "the "preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death" and furthermore found that there were "qualified Canadian physicians who would find it ethical to assist a patient in dying if that act were not prohibited by law".[44]

From the Catholic perspective, however, the moral and ethical distinctions remain because the act of MAiD is **intentional and opposes life itself**.[45] As described by Pope Benedict XVI, "[L]ife is the first good received from God and is fundamental to all others; to guarantee the right to life for all and in an equal manner for all is the duty upon which the future of humanity depends."[46]

2. Justice and the Common Good

Similarly, as the MAiD act is accepted or perceived by many as the ultimate act of compassion and liberation, those committed to Christian values (whether individual or institutional), are called, indeed challenged and obliged, to show "a concrete capacity to love".[47] This does not mean imposing one's will upon another but rather to guard against succumbing to an "efficiency mentality" towards others — along with its tendency to marginalize or disengage[48] — by committing to listening, understanding, comforting, providing constant encouragement, accompaniment and support.[49]

This relationship of care, of responsibility, of closeness and respect, further discloses "the twofold dimension of the principle of **justice** to promote human life (*suum cuique tribuere*) and to avoid harming another (*alterum non laedere*)."[50]

The life-time challenge of the Christian to commit to *love* (*caritas*) within the dimension of *justice,* is grounded in and directed by the principle of *charity*, the "driving force behind the authentic development of every person and of all humanity" and "the principle around which the Church's social doctrine turns".[51]

As described by Pope Benedict XVI,

> First of all, justice. *Ubi societas, ibi ius*: every society draws up its own system of justice. *Charity goes beyond justice*, because to love is to give, to offer what is "mine" to the other; but it never lacks justice, which prompts us to give the other what is "his", what is due to him by reason of his being or his acting. I cannot "give" what is mine to the other, without first giving him what pertains to him in justice.
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> If we love others with charity, then first of all we are just towards them. Not only is justice not extraneous to charity, … justice is inseparable from charity, and intrinsic to it. … charity demands justice: [the] recognition and respect for the legitimate rights of individuals and peoples.[52]

*The **common good*** is a second criterion governing moral action that is rooted in the principle of *charity* and like *justice*, has been described by Pope Benedict XVI as being of "special relevance" to societal development:

> …To love someone is to desire that person's good and to take effective steps to secure it. Besides the good of the individual, there is a good that is linked to living in society: the common good. It is the good of "all of us", made up of individuals, families and intermediate groups who together constitute society. It is a good that is sought not for its own sake, but for the people who belong to the social community and who can only really and effectively pursue their good within it. To desire the *common good* and strive towards it *is a requirement of justice and charity*.

> To take a stand for the common good is on the one hand to be solicitous for, and on the other hand to avail oneself of, that complex of institutions that give structure to the life of society, juridically, civilly, politically and culturally, making it the *pólis*, or "city". The more we strive to secure a common good corresponding to the real needs of our neighbours, the more effectively we love them.[53]

The purpose of **medical assistance in living** is to advance *justice* and *the common good* by:

- identifying, providing, improving and/or facilitating access to care and supports that advance the inherent dignity, security, and fundamental equality of all persons – including persons with physical or mental illness, disability or older age, as well as persons experiencing poverty, homelessness, isolation or a lack of care and support – to live with dignity, to flourish, and fully participate in society on an equitable basis with others; and

- including within its parameters the rights of all persons, including the right to life in an equal manner for all, informed by the social-economic determinants of health.

3. Accompaniment and Solidarity

The goal of **medical assistance in living** is thus also a commitment to *accompaniment* aimed at supporting the intrinsic dignity and integrity of the individual human person by respecting and sustaining the person in all dimensions (physical, psychological, social, familial, spiritual). This becomes particularly relevant at the times when a person is faced with difficulties, including those connected to medical conditions, illness or disability, and especially when cure is unlikely or impossible.[54]

Assistance in living as a commitment to seeing and being in the presence of those who may be experiencing suffering in its various forms and helping to shoulder and address that suffering with care, support and compassion is also a critical form of *solidarity* in action. As described by Pope Francis:

> … the supreme commandment of *responsible closeness*, must be kept uppermost in mind, as we see clearly from the Gospel story of the Good Samaritan (cf. *Lk* 10:25-37). It could be said that the categorical imperative is to never abandon the sick. The anguish associated with conditions that bring us to the threshold of human mortality, and the difficulty of the decision we must make, may tempt us to step back from the patient. Yet this is where, more than anything else, we are called to show love and closeness, recognizing the limit that we all share and showing our *solidarity*. Let each of us give love in his or her own way—as a father, a mother, a son, a daughter, a brother or sister, a doctor or a nurse. But give it! And even if we know that we cannot always guarantee healing or a cure, we can and must always care for the living, without ourselves shortening their life, but also without futilely resisting their death. This approach is reflected in palliative care, which is proving most important in our culture, as it opposes what makes death most terrifying and unwelcome—pain and loneliness.
>
> Within democratic societies, these sensitive issues must be addressed calmly, seriously, and thoughtfully, in a way open to finding, to the extent possible, agreed solutions, also on the legal level. On the one hand, there is a need to take into account differing world views, ethical convictions and religious affiliations, in a climate of openness and dialogue.

> On the other hand, the state cannot renounce its duty to protect all those involved, defending the fundamental equality whereby everyone is recognized under law as a human being living with others in society.
>
> Particular attention must be paid to the most vulnerable, who need help in defending their own interests. If this core of values essential to coexistence is weakened, the possibility of agreeing on that recognition of the other which is the condition for all dialogue and the very life of society will also be lost. Legislation on health care also needs this broad vision and a comprehensive view of what most effectively promotes the common good in each concrete situation.[55]

The principle of *solidarity* thus takes the sanctity of life and the intrinsic dignity of the human person at face value in that *solidarity* does not measure the value of a human life on the basis of its quality, efficiency or utility (or conversely on the basis of any particular human condition, such as illness, disability, age or nearness to death).[56] When this formulation of *solidarity* is positioned as a foundation of our relationships, and in turn implemented through *accompaniment* directed by *justice* and *the common good*, fundamental equality is realized and the intrinsic value and dignity of human life is upheld,[57] supporting individual flourishing and communal growth.[58]

Commitment

With the foregoing in mind, the Catholic Health Association of Manitoba (CHAM) re-affirms the centrality of and its commitment to *patient-centred, whole person care* to be able to identify and respond to unmet needs and suffering in all its forms and *supporting the interests of those who are most vulnerable, marginalized and disadvantaged in our society*.

In order for this commitment to be respected fully, CHAM further recognizes the importance of the following:

1. maintaining a bright-line distinction between MAiD where causing death is intended and palliative care, the appropriate withholding/withdrawing of life-sustaining treatment and other end of life practices or treatment decisions where death may be foreseeable or results but is unintended;

2. establishing an ethos and culture that sustains and promotes a person's intrinsic dignity, sense of worth and moral agency, security, and equitable access to supports – regardless of cultural, political or faith background;[59]

3. providing the best and highest quality of care and support possible whether it is at end of life or during life;

4. the need for federal and provincial governments to create legislation and policies in light of social, economic and cultural rights (including the right to the highest attainable standard of health) to help promote justice and the common good and to provide funding and resources necessary to:

    a. establish universal palliative care and provide related supports to ensure better pain management in all environments including those where our aging community is found;

    b. support all individuals experiencing mental health challenges, homelessness, poverty, and substance use, and to build on individual recovery in the community (physical, emotional, spiritual, psychological, and financial) so that MAiD is never the "default" option; and

    c. to enable people to age in place (e.g. improved proper home care, palliative support);

5. outreach, investing in and developing responses to identify and address loneliness and isolation;

6. Catholic health becoming and being "a healing presence on the journey of Truth and Reconciliation and moving forward with honesty about our history and the impact of our actions on the health status of Indigenous Peoples". "In doing so, we acknowledge difficult truths and seek to build trust and relationships through the ongoing self-examination, learning, dialogue and concrete action necessary to address the harms of the past and create a more equitable future";[60] and

7. helping to develop, support and/or advocate for a public policy framework that affirms and supports MAiL.

Proposed Action Items

CHAM will share with partners the following list of proposed action items and shall discuss and prioritize the actions to be undertaken based on their comments and engagement.

1. Social Justice

- *increase awareness* amongst CHAM members and the community, and engage in conversations on medical assistance in living in light of the Guiding Principles of the inviolability of life, justice and the common good, and accompaniment and solidarity;
- *explore* the creation of a coalition to support conversations on medical assistance in living in community with other partners;

- *promote and/or support* the review of available mental health supports and services within the province with a view to identifying gaps, needs, delivery, outreach and advocacy opportunities;
- *monitor* the experience of those seeking MAID as publicly reported to identify shortcomings and gaps of services required to support end of life care, which can be used to inform public policy development and needed advocacy efforts;
- *support* the evaluation of current palliative care strategy with a view to determining need and resources necessary to increase delivery of person-centred palliative care in both home and personal care home settings; and
- *review* opportunities to increase financial resources to support MAiL development.

2. Education and training

- *develop and/or promote* workshops and seminars on:
    - the current state of the law and developments with respect to MAiD;
    - research and initiatives with respect to MAiL; and
    - end of life, palliative care and advance care planning which also explores the spiritual, philosophical, theological, and ethical dimensions of death and dying.[61]
- *explore* whether there is a need to develop MAiL-specific CHAM materials.

3. Spiritual Care and Outreach

- *support the development of* a pilot project to explore loneliness and isolation within the community and the support role of parishes, neighbours, friends etc.;
- *develop* and/or *support the development of* a pilot project to explore and evaluate trauma and trauma informed care within our facilities including palliative care units and personal care homes;
- *support the development of* an accessible one-stop resource or central repository which identifies community resources and supports for **medical assistance in living** within the community; and
- *review and evaluate* the role of volunteers in supporting new spiritual care and outreach initiatives.

4. Health Care Ethics

CHAM shall remind the sponsored works of the need to update policies from the MAiL perspective and revise/update if necessary.

In particular:

- *examine policies and protocols* to ensure patients are protected from conflicts at the administrative level; and
- *examine policies and protocols* including with respect to: withholding/withdrawing of LST, Do Not Resuscitate, Organ Donation After Cardiac Death, Palliative Sedation, Goals of Care, Advance Care Directives.

Endnotes

[1] Sponsorship of Catholic health care involves promoting and assuring Jesus' healing mission. Those who sponsor are responsible for the continued viability of the health care ministry, promoting its ongoing mission, and animating its life. Sponsors act publicly on behalf of the Roman Catholic Church and have been entrusted to serve the Church by guiding and overseeing a specific institutional ministry in a formal and public way.

[2] Catechism of the Catholic Church, nn. 1925-27

[3] Catholic Health Association of the United States, "Social Determinants of Health". ["CHAUSA"]. Online: https://www.chausa.org/communitybenefit/social-determinants-of-health (accessed June 2023).

[4] World Health Organization, "Palliative Care" (August 5, 2020). Online: https://www.who.int/news-room/fact-sheets/detail/palliative-care (accessed June 2023).

[5] Canada, Health Canada, *Framework on Palliative Care in Canada* (Ottawa: Government of Canada, December 4, 2018) at Appendix A. Online: https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html#appa; See also Canadian Hospice and Palliative Care Association, "CHPCA and CSPCP – Joint Call to Action" (November 27, 2019) ["CHPCA and CSPCP"]. Online: https://www.chpca.ca/news/chpca-and-cspcp-joint-call-to-action/ (accessed June 2023).

[6] Canadian Public Health Association, "What are the Social Determinants of Health?". Online: https://www.cpha.ca/what-are-social-determinants-health (accessed June 2023); World Health Organization, "Social Determinants of Health". Online: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (accessed June 2023); See also CHAUSA, note 3; See also CDC, note 7.

[7] Centers for Disease Control and Prevention, Social Determinants of Health, Frequently Asked Questions. ["CDC"] Online: https://www.cdc.gov/nchhstp/socialdeterminants/faq.html (accessed June 2023).

[8] *Criminal Code of Canada*, R.S.C.1985, c. C-46 ["Criminal Code"]. Online: https://laws-lois.justice.gc.ca/eng/acts/C-46/page-33.html#h-119953 (accessed June 2023).

[9] *Carter v Canada (Attorney General),* 2015 SCC 5 (CanLII) ["Carter 2015"]. Online: http://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html (accessed June 2023).

[10] Bill C-14, *Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, S.C. 2016, c. 3. Bill C-14 received Royal Assent June 17, 2016. ["Bill C-14"]. Online: https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent (accessed June 2023); For eligibility criteria see Criminal Code, note 9 at Section 241.2.

[11] Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, S.C. 2021, c. 2. Bill C-7 received Royal Assent March 17, 2021. ["Bill C-7"]. Online: https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent (accessed June 2023); For government infographic of Bill C-7, see Government of Canada, "Canada's New Medical Assistance in Dying Law". Online: https://www.justice.gc.ca/eng/cj-jp/ad-am/docs/MAID_Infographic_EN.pdf (accessed June 2023).

[12] For the different procedural safeguards see Criminal Code, note 9 at Sections 241.2(3) and (3.1).

[13] "MD-SUMC" stands for "Medical Disorder as the sole underlying medical condition". Although the term "mental illness" is the term used in the Criminal Code MAiD provisions, the term "mental disorder" is frequently used in government documents and discussion regarding MAiD. For discussion regarding terminology see Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* (Ottawa: Health Canada, May 2022) at pages 6, 8-9. Online: https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.pdf (accessed June 2023).

[14] Bill C-39, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying)*. Assented to March 9, 2023. Online: https://www.parl.ca/DocumentViewer/en/44-1/bill/C-39/royal-assent (accessed June 2023).

[15] The one-year extension, according to the government, is to allow for "readiness" within the health care system. See for example discussion in Debates of the Senate (Hansard), (Thursday, March 9, 2023), 1st Session, 44th Parliament, Volume 153, Issue 105. Online: https://sencanada.ca/en/content/sen/chamber/441/debates/105db_2023-03-09-e?language=e (accessed June 2023). Note that whether Parliament will create new/additional statutory procedural safeguards for MAiD MD-SUMC remains to be seen.

[16] Angus Reid Institute, "Mental Health and MAID: Canadians question looming changes to Canada's assisted-death law" (February 13, 2023). Online: https://angusreid.org/assisted-dying-maid-mental-health/ (accessed June 2023).

[17] Canadian Psychiatric Association, Position Statement: "Medical Assistance in Dying: An Update". Online: https://www.cpa-apc.org/wp-content/uploads/2021-CPA-Position-Statement-MAID-Update-EN-web-Final.pdf (accessed June 2023).

[18] See for example discussion and resources from Dr. Sonu Gaind, Professor University of Toronto, Department of Psychiatry. Online: http://www.drsonugaind.com/maid (accessed June 2023).

[19] Bill 11, *An Act to amend the Act respecting end-of-life care and other legislative provisions* (June 7, 2023). Chapter in the annual volume of the Statutes of Québec: 2023, chapitre 15. Online: https://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-11-43-1.html (accessed June 2023); See also Canadian Mental Health Association, "Statement on upcoming changes to Canada's Medical Assistance in Dying (MAiD) law" (October 14, 2022). Online: https://cmha.ca/brochure/statement-on-upcoming-changes-to-canadas-medical-assistance-in-dying-maid-law/ (accessed June 2023).

[20] Pursuant to the Quebec EOL law. palliative care hospice "means a community organization that holds an accreditation granted by the Minister under the second paragraph of section 457 of the Act respecting health services and social services and has entered into an agreement with an institution under section 108.3 of that Act in order to secure all or some of the care required by its users".

[21] For an opening discussion of issues in the mental illness MAiD expansion see documentary, The Fifth Estate, "Is it too easy to die in Canada? Surprising approvals for medically assisted death" (January 19, 2023) ["The Fifth Estate"]. Online: https://youtu.be/plinQAHZRvk?t=2176 (accessed June 2023); For an example of rights-based advocacy for MAiD MD-SUMC see Mona Gupta, "Canadians shouldn't be excluded from requesting MAID just because they have a mental disorder", Macleans (May 4, 2023) ["Gupta"]. Online: https://macleans.ca/society/health/medical-assistance-in-dying/ (accessed June 2023).

[22] See for example, interview with Minister David Lametti in The Fifth Estate, note 22.

[23] Criminal Code, note 9 at Section 227(1)-(5).

[24] Criminal Code, note 9 at Section 241(2)-(7).

[25] Criminal Code, note 9 at Section 245(2)-(3).

[26] *Murray-Hall v Quebec (Attorney General)* 2023 SCC 10 at paras 97 and 99. Note however that Quebec also adopted its own provincial assisted death legislation prior to the Federal Criminal Code amendments permitting MAID. See *Act respecting end-of-life care*, CQLR, c. S-32.0001 which has been in effect in Quebec since December 10, 2015. ["Murray-Hall"]. Online: https://www.canlii.org/en/qc/laws/stat/cqlr-c-s-32.0001/latest/cqlr-c-s-32.0001.html.

[27] See Health Canada, *Third Federal Annual Report on Medical Assistance in Dying* (Ottawa: Health Canada, January 9, 2023). Online: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html (accessed June 2023).

[28] See CBC News, "Mother says doctor brought up assisted suicide option as sick daughter was within earshot" (July 24, 2017). Online: https://www.cbc.ca/news/canada/newfoundland-labrador/doctor-suggested-assisted-suicide-daughter-mother-elson-1.4218669 (accessed June 2023); See also CTV News, Chronically ill man releases audio of hospital staff offering assisted death (August 2, 2018). Online: https://www.ctvnews.ca/health/chronically-ill-man-releases-audio-of-hospital-staff-offering-assisted-death-1.4038841 (accessed June 2023); See also Veteran Affairs Canada, *Report into allegations of inappropriate conversations with Veterans about Medical Assistance in Dying (MAiD)* (March 2023). Online: https://duyxryp8txy49.cloudfront.net/pdf/about-vac/publications-reports/reports/maid-investigative-report.pdf (accessed June 2023).

[29] See for example, The Fifth Estate, note 22; See also for example: Hannah Alberga, "Toronto woman facing financial loss of long COVID begins process for medically assisted death", CTV News (11 July 2022). Online: https://www.cp24.com/news/toronto-woman-facing-financial-loss-of-long-covid-begins-process-for-medically-assisted-death-1.5982576?cache=juzexmjvhq (accessed June 2023); See also Avis Favaro, "Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing", CTV News (24 August 2022). Online: https://www.ctvnews.ca/health/woman-with-chemical-sensitivities-chose-medically-assisted-death-after-failed-bid-to-get-better-housing-1.5860579 (accessed June 2023); See also Brennan Leffler and Marianne Dimain, "How poverty, not pain, is driving Canadians with disabilities to consider medically-assisted death", GlobalNews (8 October 2022). Online: https://globalnews.ca/news/9176485/poverty-canadians-disabilities-medically-assisted-death/ (accessed June 2023); See also Janine LeGal, "Battle with ALS brought overwhelming struggle for supports" Winnipeg Free Press (12 November 2022). Online: https://www.winnipegfreepress.com/breakingnews/2022/11/12/battle-with-als-brought-overwhelming-struggle-for-supports (accessed June 2023); See also Hannah Alberga, "Toronto woman in final stages of MAiD application after nearly a decade-long search for housing", CTV News (15 November 2022). Online: https://toronto.ctvnews.ca/toronto-woman-in-final-stages-of-maid-application-after-nearly-a-decade-long-search-for-housing-1.6145487 (accessed June 2023); See also Cynthia Mulligan and Meredith Bond, "Ontario man not considering medically-assisted death anymore after outpouring of support", City News (16 November 2022). Online: https://toronto.citynews.ca/2022/11/16/ontario-medically-assisted-death-support/ (accessed June 2023); See also Andrew Phillips, "We're all implicated in Michael Fraser's decision to die", Toronto Star (18 November 2022). Online: https://www.thestar.com/opinion/star-columnists/2022/11/18/were-all-implicated-in-michael-frasers-decision-to-die.html (accessed June 2023); See also Brooke Kruger, "Regina resident applied for medically assisted death after consistent surgical delays", GlobalNews (30 November 2022). Online: https://globalnews.ca/news/9315789/regina-resident-medical-assistance-in-dying-surgical-delay/ (accessed June 2023); See also Ruth Farquhar, "Farquhar: Are the disabled choosing medically assisted death to escape poverty?", Sudbury Star (21 November 2022). Online: https://www.thesudburystar.com/opinion/columnists/farquhar-are-the-disabled-choosing-medically-assisted-death-to-escape-poverty (accessed June 2023).

[30] See for example, CBC, "As Bill C-7 reaches Senate, UN watchdog raises concerns about MAiD for persons with disabilities". Online: https://www.cbc.ca/radio/asithappens/as-it-happens-monday-edition-1.5896324/as-bill-c-7-reaches-senate-un-watchdog-raises-concerns-about-maid-for-persons-with-disabilities-1.5897749 (accessed June 2023); See also discussion in United Nations, "Disability is not a reason to sanction medically assisted dying" (January 25, 2021). Online: https://www.ohchr.org/en/press-releases/2021/01/disability-not-reason-sanction-medically-assisted-dying-un-experts?LangID=E&NewsID=26687 (accessed June 2023); See also discussion in Joan Bryden, "UN experts alarmed by trend toward assisted dying" CTV News (January 27, 2021). Online: https://www.ctvnews.ca/health/un-experts-alarmed-by-trend-toward-assisted-dying-for-non-terminal-conditions-1.5283804 (accessed June 2023).

[31] For preliminary discussion of concerns with MAiD implementation from a disability rights perspective see Catalina Devandas-Aguilar, *Visit to Canada, Report of the Special Rapporteur on the rights of persons with disabilities*, United Nations, Doc Reference: A/HRC/43/41/Add.2 (December 19, 2019). ["UN Special Rapporteur Report"]. Online:

https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/348/81/PDF/G1934881.pdf?OpenElement (accessed June 2023); See also joint letter issued by the United Nation's Special Rapporteur on the rights of persons with disabilities, the Independent Expert on the enjoyment of all human rights by older persons, and the Special Rapporteur on extreme poverty and human rights, United Nations, Doc Reference: OL CAN 2/2021(3 February 2021), ["UN Joint Letter"]. Online: https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=26002 (accessed June 2023).

[32] See UN Joint Letter, note 32; See also UN Special Rapporteur Report, note 32.

[33] Canadian Human Rights Commission, "MAiD cannot be an answer to systemic inequality" (May 10, 2022) Emphasis added. Online: https://www.chrc-ccdp.gc.ca/en/resources/maid-cannot-be-answer-systemic-inequality (accessed June 2023).

[34] See for example, Provincial-territorial Expert Advisory Group on Physician-Assisted Dying, Final Report (November 30, 2015) at page 20. Online: https://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf (accessed June 2023); See also *Carter v. Canada (Attorney General)*, 2012 BCSC 886 at para. 1274; See also for example: J. Downie and U. Schuklenk, "Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada" (2021) Vol. 47(10) Journal of Medical Ethics 662-669 and compare to: Tom Koch, "MAID's slippery slope: a commentary on Downie and Schuklenk" (2021) Vol. 47(10) Journal of Medical Ethics 670-671. Online: https://www.researchgate.net/publication/354182127_MAID%27s_slippery_slope_a_commentary_on_Downie_and_Schuklenk (accessed June 2023); See also M. Gupta, note 22.

[35] Kayla Wiebe and Amy Mullin (2023) "Choosing death in unjust conditions: hope, autonomy and harm reduction", Journal of Medical Ethics (Published Online First: April 26 2023). Abstract online: https://jme.bmj.com/content/early/2023/04/25/jme-2022-108871 (accessed June 2023).

[36] See comments by the Supreme Court of Canada in a criminal law but non-MAiD related case, *Murray-Hall*, note 24 at para. 54.

[37] Compare to other assisted death permissive jurisdictions such as certain states in the United States where the assisted death law mandates that the physician counsel/recommend to the patient that the patient notify family / next of kin of their request for lethal medication. See for example: Oregon Revised Statute: Oregon Death with Dignity Act, Chapter 127 at 127.835, at Section 3.05; See also Revised Code of Washington, Title 70, Chapter 70.245, at Section 70.245.080; See also California Health and Safety Code, Division 1, Part 1.85 End of Life Option Act at Section 443.5(5)(C).

[38] See for example: CBC Radio, "This family learned loved one had medically assisted death only after she was gone" (March 12, 2022). Online: https://www.cbc.ca/radio/whitecoat/this-family-learned-loved-one-had-medically-assisted-death-only-after-she-was-gone-1.6380470 (accessed June 2023); See also Erin Anderssen, "A complicated grief: Living in the aftermath of a family member's death by MAID" The Globe and Mail (January 18, 2023) Online: https://www.theglobeandmail.com/canada/article-maid-death-family-members-privacy/ (accessed June 2023).

[39] See for example, discussion in Claire Middleton, "Organ donation after MAid: it's not that simple" CMAJ September 23, 2019 191 (38). Online: https://www.cmaj.ca/content/191/38/E1062 (accessed June 2023); See also discussion in Madeline Li, "I am a MAID provider. It's the most meaningful—and maddening—work I do. Here's why." Macleans (February 13, 2023). Online: https://macleans.ca/society/i-am-a-maid-provider-its-the-most-meaningful-and-maddening-work-i-do-heres-why/ (accessed June 2023). It should be noted that while the author of this latter article is a MAiD provider, in no way should CHAM's inclusion of this reference be taken as an endorsement of MAID. However, the author's reflection is of relevance to this discussion and CHAM does agree with several aspects of the author's commentary including in respect of death not being a solution for societal suffering and lack of safeguards, for example.

[40] See Sharon Kirkey, "Canada's expanding MAID program leading to a crisis in supply of 'willing' doctors" National Post (October 27, 2022); See also for example Marie E. Nicolini, EJ Jardas, Carlos A. Zarate Jr., Chris Gastmans, and Scott Y. H. Kim, "Irremediability in psychiatric euthanasia: examining the objective standard" (2022) Psychological Medicine 1–19. online: https://www.cambridge.org/core/journals/psychological-medicine/article/irremediability-in-psychiatric-euthanasia-examining-the-objective-standard/39CF3F03E81053EA152C63F332478CB4 (accessed June 2023); See also Marie E. Nicolini, Scott Y. H. Kim, Madison E. Churchill, and Chris Gastmans, "Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons" (2020) Vol. 50(8) Psychological Medicine 1241-1256. Online: https://www.cambridge.org/core/journals/psychological-medicine/article/abs/should-euthanasia-and-assisted-suicide-for-

psychiatric-disorders-be-permitted-a-systematic-review-of-reasons/77AAA43479E5FB1624A1CA7990FABB10 (accessed June 2023).

[41] For a beginning discussion, see Public Health Agency of Canada, *From risk to resilience: An equity approach to Covid-19* (October 2020). Online: https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19.html#a2 (accessed June 2023); For non-Covid related discussion of the types of abuse and neglect of older persons that has occurred in care homes see Auditor General Report, Investigation of the Protection of Person's in Care Office: Independent Investigation Report (July 2023). Online: https://www.oag.mb.ca/audit-reports/report/investigation-of-the-protection-for-persons-in-care-office-ppco/ (accessed July 2023).

[42] See for example: Aaron J. Trachtenberg and Braden Manns, "Cost analysis of medical assistance in dying in Canada" (January 23, 2017) Vol. 189(3) CMAJ E101-E105. Online: https://www.cmaj.ca/content/189/3/E101 (accessed June 2023); Office of the Parliamentary Budget Officer, *Cost Estimate for Bill C-7 "Medical Assistance in Dying"* (October 20, 2020). Online: https://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-025-M/RP-2021-025-M_en.pdf (last accessed June 2023).

[43] Pope Francis, *Message of His Holiness Pope Francis to the Participants in the European Regional Meeting of the World Medical Association* (November 7, 2017). ["Pope Francis Message"]. Online: https://www.vatican.va/content/francesco/en/messages/pont-messages/2017/documents/papa-francesco_20171107_messaggio-monspaglia.html (accessed June 2023); See also Congregation for the Doctrine of the Faith, Letter, *Samaritanus Bonus, on the care of persons in the critical and terminal phases of life* (July 14, 2020). ["*Samaritanus Bonus*"]. Online: https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html (accessed June 2023); See also Catholic Health Alliance of Canada, *Health Ethics Guide*, 3rd ed. (2012) at page 66. Online: https://www.chac.ca/documents/422/Health_Ethics_Guide_2013.pdf (accessed June 2023).

[44] See *Carter* 2015, note 10 at para. 23.

[45] See for example: Second Vatican Council, *Gaudium et Spes, Pastoral Constitution on the Church in the Modern World* (December 7, 1965) at no. 27. Online: https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html (accessed June 2023); Pope John Paul II, Encyclical Letter, *Evangelium Vitae (The Gospel of Life), to the Bishops, Priests and Deacons, Men and Women religious, lay Faithful and all People of Good Will on the Value and Inviolability of Human Life* (March 25, 1995) at no. 3 . Online: https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html (accessed June 2023); *Samaritanus Bonus* note 44 at V.1.

[46] Pope Benedict XVI, Address Academy for Life, note 4. Emphasis added.

[47] Pope Benedict XVI, *Address of His Holiness Benedict XVI to Participants in the 22nd International Congress of the Pontifical Council for Health Pastoral Care* (November 17, 2007). ["Pope Benedict XVI Address for Health Pastoral Care"]. Emphasis added. Online: https://www.vatican.va/content/benedict-xvi/en/speeches/2007/november/documents/hf_ben-xvi_spe_20071117_xxii-operatori-sanitari.html (accessed June 2023).

[48] Pope Benedict XVI Address for Health Pastoral Care, note 48.

[49] Pope Benedict XVI Address for Health Pastoral Care, note 48.

[50] *Samaritanus Bonus*, note 44 at I. Emphasis added.

[51] Pope Benedict XVI, Encyclical Letter, *Caritas in Veritate (Charity in Truth),* (June 29, 2009) at nos. 1 and 6. ["*Caritas in Veritate*"]. Online: https://www.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate.html (accessed June 2023).

[52] *Caritas in Veritate*, note 52 at no. 6. Emphasis added.

[53] *Caritas in Veritate*, note 52 at no. 7. Emphasis added.

[54] Pope Benedict XVI Address for Health Pastoral Care, note 48; See also *Samaritanus Bonus*, note 44 at III and V.4

[55] Pope Francis Message, note 44. Emphasis added; See also generally *Samaritanus Bonus*, note 44; See also Matthew 25:35-40.

[56] Jos V. M. Welie, William F. Sullivan, and John Heng, "The Value of Palliative Care IACB Guidelines for Health Care Facilities and Individual Providers Facing Permissive Laws on Physician Assistance in Suicide and Euthanasia" (Winter 2016) Vol. 3 The National Catholic Bioethics Quarterly at 657-658. ["IACB"].Online:

https://www.cham.mb.ca/media/Documents/Value-of-Palliative-Care_2015.pdf (accessed June 2023).

[57] See generally *Samaritanus Bonus*, note 44.

[58] IACB, note 57.

[59] See IACB, note 57 at page 658.

[60] Catholic Health Alliance of Canada, *Statement for National Day for Truth and Reconciliation* (September 30, 2022). Online: https://www.chac.ca/documents/736/CHAC_Statement_for_National_Day_for_Truth_and_Reconciliation_2022.pdf (accessed June 2023).

[61] With respect to palliative care see for example initiative developed by the Canadian Conference of Catholic Bishops (CCCB), CCCB, "Horizons of Hope: A Toolkit for Catholic Parishes on Palliative Care". Online: https://www.cccb.ca/faith-moral-issues/suffering-and-end-of-life/horizons-of-hope-a-toolkit-for-catholic-parishes-on-palliative-care/ (accessed June 2023).