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Original Article

The impact of the COVID-19 pandemic on medical assistance in dying in Canada and the relationship of public health laws to private understandings of the legal order

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ABSTRACT

Drawing on interviews we conducted with 15 medical assistance in dying (MAiD) providers from across Canada, we examine how physicians and nurse practitioners reconcile respect for the new, changing rules brought upon by the coronavirus disease 2019 (COVID-19) pandemic, along with their existing legal obligations and ethical commitments as health care professionals and MAiD providers. Our respondents reported situations where they did not follow or did not insist on others following the applicable public health rules. We identify a variety of techniques that they deployed either to minimize, rationalize, justify or excuse deviations from the relevant public health rules. They implicitly invoked the exceptionality and emotionality of the MAiD context, especially in the time of COVID, when offering their accounts and explanations. What respondents relate about their experiences providing MAiD during the COVID pandemic offers occasion to reflect on the role actors themselves play in giving meaning (if not coherence) to the potentially conflicting normative expectations to which they are subject.

KEYWORDS: Canada, COVID-19 pandemic, Medical Aid in Dying, professional ethics, public health

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I. INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic has produced additional normative constraints on the practice of medical assistance in dying (MAiD)—the forms of voluntary euthanasia and assisted suicide permitted in Canada. For example, public health authorities, hospitals, hospices and long-term care facilities have instituted rules that limit in-person consultations, restrict visits from family and friends, and require the use of personal protective equipment (PPE). Drawing on interviews we conducted with 15 MAiD providers from across the country in the context of a broader study on the impact of COVID-19 on their practice, we examine how physicians and nurse practitioners reconcile respect for these new, changing rules, along with their existing legal obligations and ethical commitments as health care professionals and MAiD providers.

First, we set out the specifics of the present research, which concentrates on the experience of providers during the COVID-19 pandemic. Next, we present the formal legal framework of MAiD in Canada.[1] We then describe the subject of 'rule-breaking' as it emerged in our interviews with MAiD providers. Subsequently, we consider these findings in light of the norms of professional ethics to which physicians and nurse practitioners are subject. Lastly, we reflect on what the experience of Canadian MAiD practitioners' negotiating different layers of rules may reveal about the role of state law in governing medical practice generally and MAiD in particular.

Our respondents reported situations where they did not follow or did not insist on others following the applicable public health rules. We identify a variety of rhetorical techniques that they deployed either to minimize, rationalize, justify or excuse deviations from the relevant public health rules. The exceptionality and emotionality of the MAiD context, especially in the time of COVID, underly their accounts. We aim to identify the competing ethical obligations to which health professionals are subject in the situations our respondents described. We do not prescribe a formula for how physicians and nurse practitioners may reconcile what they feel to be conflicting commitments. Rather, we try to explain why it is reasonable to anticipate some discrepancy between what the public health rules dictate and how clinicians act in particular situations.[2]

Having to make the right decision about how to interpret and apply relevant legal norms, while pursuing one's medical practice in an ethical manner, is not unique to the context of MAiD, let alone the COVID-19 pandemic. Conflict between the law and one's ethical convictions can cause health care professionals moral distress: one may feel one should do what the law prohibits or abstain from doing what the law demands.[3] Respecting either the law's prohibition, disqualification or validation of a

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1 Due to space constraints in this essay, we focus on the experience outside of Quebec, as additional rules apply in that jurisdiction on account of the province's *Act respecting end-of-life care*, c S-32.0001, 2015. See Thomas McMorrow, Ellen Wiebe, Ruchi Liyanage, Sabrina Tremblay-Huet, Michaela Kelly, *Interpreting Eligibility Under the Medical Assistance in Dying Law: The Experiences of Physicians and Nurse Practitioners*, (2020)14:1 McGill Journal of Law and Health 51 (comparing how clinicians interpret the two regulatory frameworks).

2 See Roscoe Pound, *Law in Books and Law in Action*, 44 Am L Rev 12 (1910) (for the *locus classicus* of this idea in modern legal research).

3 See Ann Marie Corrado & Monica L Molinaro, *Moral Distress in Health Care Professionals*, 86:2 UWOMJ 32 at 32 (2017) (describing moral distress as constraints (e.g. institutional, internal, legal) impeding a health

patient's request to receive medical assistance in dying may produce a psychologically and emotionally difficult situation. It will depend on the context and on the individual health care professional. The introduction of public health rules that frustrate how physicians and nurse practitioners would normally go about providing MAiD to eligible patients has the potential to impose this kind of conflict. When respondents relate their experiences providing MAiD during the COVID-19 pandemic, it demonstrates the role actors themselves play in giving meaning (if not coherence) to the potentially conflicting normative expectations to which they are subject.

II. STUDY OVERVIEW

This paper is a secondary analysis of the data gathered for a qualitative study about how the COVID-19 pandemic is affecting the practice of MAiD.[4] The interviews were conducted between April 16 and June 5, 2020, starting after restrictions were put in place and continuing during the height of the lockdown. We recruited participants from provider list-serves and from a list of previous research participants who had consented to further interviews about their experience with MAiD. The list-serves include about 180 providers and each member is screened by the sponsoring organizations (Canadian Association of MAiD Assessors and Providers and AMM-QUEBEC). According to the Canadian Institute for Health Information and the Canadian Nursing Association, respectively, there are nearly 90,000 physicians and over 6,000 nurse practitioners in the country.[5] No data are available on the number of MAiD providers, however. Our sample included physicians and nurse practitioners of different genders, age groups, practice types and practice locations. Although there were participants from six Canadian provinces, none came from the four Maritime provinces or the three territories. Significantly, participants were experienced, active providers, who as a group had completed over 2000 MAiD assessments. According to the federal government, between 2016 (the year MAiD was legalized in all of Canada) and the end of 2019, over 13,000 Canadians received MAiD. Although we do not claim our sample to be representative of all MAiD providers, based on the experiences of the specific providers we interviewed, they constitute a statistically meaningful sample of participants in MAiD provision in Canada.

Certainly, the fact that participants self-selected in deciding to speak with our research team presents a potential limitation of the study. The health professionals we interviewed differ from their colleagues insofar as every one of them both supports and provides MAiD. In comparison to their fellow providers, it is possible that many

care professional's ability or willingness to act in what one perceives as the "right" way); S Kälvemark et al., *Living with conflicts—ethical dilemmas and moral distress in the health care system*, 58:6 Soc Sci Med 1075 (2004) (emphasizing that in situations where health care professionals do act in what they consider an ethical way, the failure to comply with other norms may nonetheless cause them significant stress); Dena Davis, *Avoiding Dementia, Causing Moral Distress*, https://www.thehastingscenter.org/avoiding-dementia-causing-moral-distress/ (accessed Jul. 13, 2020) (discussing the moral distress caregivers may experience when expected to comply with an advanced directive to withhold food or simple medical interventions for patients with dementia).

4 Wiebe et al., *How the Experience of Medical Assistance in Dying (MAiD) Changed During the COVID 19 Pandemic in Canada* (forthcoming with the Canadian Medical Association Journal Open).

5 *Physicians in Canada*, https://www.cihi.ca/en/physicians-in-canada; *Nursing in Canada*, https://www.cihi.ca/en/nursing-in-canada-2019 (accessed Jul. 13, 2020).

are more outspoken in their endorsement of MAiD. It is possible that some of them may have encountered especially significant challenges with provision during COVID, which motivated them to take the time to share their experiences with our team.

In the responses given by the MAiD providers we interviewed about the impact of the pandemic, four themes were most prominent. First, the theme for which our participants used the most emotionally-laden language, was the increased suffering of their patients resulting from restrictions established in response to the virus. Namely, patients were unable to spend time with loved ones, had their procedures canceled or rescheduled, and were unable to receive other end-of-life services.

The second concerned the decrease in rapport between MAiD providers and their patients on account of the change from in-person to telemedicine assessments. Social distancing and PPE requirements, as well as restrictions on physical closeness and touching, obstructed the way they would usually offer comfort and support. Providers felt this impeded on their ability to incorporate what they saw as an essential human element into their role as MAiD providers.

The third major theme was that, although logistics and access to MAiD became more difficult due to the new restrictions when COVID-19 arrived, individuals and institutions adapted and changed to mitigate the problems around providing MAiD. In other words, there were instances of rules changing to facilitate MAiD practice in the time of COVID-19. In some cases, these rule changes are likely to endure once things return to normal.

A fourth important theme was the anxiety about the spread of COVID-19 and about observance of the relevant public health rules and institutional policies. Sometimes there were too many people and there was too little distance. Our participants varied in their comfort-level with this rule-breaking, but all participants had experience with it. There was a tension between providing the best patient-centered care and respecting public health imperatives. In some cases, providers reported bending the rules themselves and in others, looking the other way as patients or their families and friends deviated from public health orders or institutional rules around physical distancing or social gathering. This particular theme is at the heart of the questions we reflect upon in this article about the normative force of rules emanating from different authorities with differing legitimacies.

This study analyzes the experience of MAiD both from the lens of its medical practice and from the lens of the norms that surround it, including laws, regulations, institutional policies, professional oversight, and ethics. This paper is not just about how, in the wake of the COVID-19, laws, regulations and policies changed, making it more difficult for physicians and nurse practitioners to provide MAiD in accordance with their professional ethical standards. It is not just about how some rules—at least sometimes—failed to take hold and prove effective in curtailing practices that could potentially contribute to the spread of the infection. This essay is about thinking of legal normativity as a dynamic process—not just in circumstances where new formal rules are introduced or existing ones officially relaxed—but in light of legal subjects having to negotiate commitments and concerns that may exist in tension as well as outright conflict. Clearly, the disproportionate impact of COVID-19 infection and mortality rates in the US and Canada on the economically marginalized and socially vulnerable (with its intersecting racialized impact) demonstrates that the pandemic

merely foregrounds existing inequities in society. Likewise, we think, evidence that the public health rules meant to staunch the spread of COVID-19 are far from self-executing—that health care professionals are not mechanically compliant in their observance of these rules—speaks to existing features of legal normativity and the role of law in health care and medical decision making that merits attention, reflection and consideration.

III. CRIMINAL LAW FRAMEWORK

Aiding a person to die by suicide is a criminal offence in Canada. So too is ending a person's life on their behalf. In *Carter v Canada*,[6] the Court ruled that the blanket prohibition on physician assisted suicide infringed upon the claimants' rights to life, liberty and security of the person guaranteed by the country's *Charter of Rights and Freedoms*.[7] Void were the sections of the *Criminal Code* prohibiting MAiD 'for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition'.[8]

Consequently, Parliament passed *Bill C-14*,[9] which decriminalized MAiD across Canada, under specific circumstances. In the preamble it states that 'the Parliament of Canada recognizes the *autonomy* of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying' [our emphasis].[10] It also recognizes suicide as 'a significant public health issue'.[11] The Act also recognizes the federal nature of Canada's constitutional order, a complicating factor both in the governance of MAiD as well as concerns the measures to neutralize the public health threat of COVID-19. While criminal law falls under federal jurisdiction, health is an area of concurrent jurisdiction;[12] hence the MAiD law states: 'it is desirable to have a consistent approach to medical assistance in dying across Canada, while recognizing the provinces' jurisdiction over various matters related to medical assistance in dying, including the delivery of health care services and the regulation of health care professionals.'[13]

Unlike jurisdictions in the USA, which permit assisted suicide for patients who have no more than 6 months to live,[14] Canada's law does not restrict MAiD access

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6 Carter v. Canada (Attorney General), SCC 5 (2015).

7 *Id.* at para 126.

8 *Id.* at para 127.

9 An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), SC 2016, c 3 (2016) [*Bill C-14*].

10 *Id.*

11 *Id.*

12 *Constitution Act*, 1867 30 & 31 Victoria, c. 3 (U.K.), ss 91 (27), 92(7), (13) and (16). See *Carter v. Canada (Attorney General), supra* note 6 at para 53 (stating that both Parliament and the provinces may legislate depending on the circumstances and focus of the legislation).

13 *Id.* at preamble.

14 Gov. of CA (Government of California). (2015). End of Life Option Act. Sacramento (CA): Gov. of CA. Gov. of CA (Government of California). (2018); Gov. of CO (Government of Colorado). (2016). Colorado End-of-Life Options Act. Denver (CO): Gov. of CO; Gov. of DC (Government of the District of Columbia). (2016). Death with Dignity Act of 2016. Washington (DC): Council of the District of Columbia; Gov. of HI (Government of Hawaii). (2018). Our Care, Our Choice Act. Honolulu (HI): Gov. of HI; Gov. of ME

to terminally ill patients. Instead, the legislation requires that 'their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining'.[15] Although empirical evidence suggests that MAiD assessors have interpreted this eligibility criterion broadly,[16] in 2019 the Quebec Superior Court struck the provision down as an unconstitutional rights-infringement and the government decided not to appeal the decision.[17] The Government is currently seeking to pass legislation, amending the Criminal Code, that it claims will bring the law into harmony with the *Truchon* decision.[18]

IV. PUBLIC HEALTH AND RULE-BREAKING

The COVID-19 pandemic brought about a whole new set of rules related to public health in order to try to halt its progression. The federal government imposed important restrictions on who was permitted to enter the country as well as obligations upon entry, such as the duty to self-isolate upon return to Canada. Most other public health rules were adopted by provincial governments and took the form of recommendations and orders, thus varying in their degree of possible enforcement. These ranged from restrictions on gatherings, visitors in hospitals and care centers, social distancing, to the use of PPE. Such rules differed between each province, subject to additional constraints imposed by municipalities and institutions, as well as through time as the pandemic progressed or declined in each locale.[19] The rapidly changing landscape of applicable

(Maine) (2019). Death with Dignity Act. Augusta (ME): Gov. of ME; Gov. of NJ (New Jersey). (2019). Aid in Dying for the Terminally Ill Act (NJ). Trenton (NJ): Gov. of NJ. Gov. of OR (Government of Oregon). (1997). The Oregon Death With Dignity Act. Salem (OR): The General Assembly of the State of Oregon; Gov. of VT (Government of Vermont). (2013). An Act Relating to Patient Choice and Control at End of Life. Montpelier (VT): General Assemby of the State of Vermont; Gov. of WA (Government of Washington). (2009). Washington Death With Dignity Act. Olympia (WA): Gov. of WA.

15 *Bill C-14, supra* note 9 at s 241.2 (2).

16 See McMorrow et al, *supra* note 1.

17 Truchon v. Procureur général du Canada, QCCS 772 (2020).

18 Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), 2nd Sess, 43rd Parl, 2020 (Adopted by the House on December 10, 2020) [Bill C-7]. The bill would remove the requirement for a person's natural death to be reasonably foreseeable in order to be eligible for MAID; introduce a two-track approach to procedural safeguards based on whether or not a person's natural death is reasonably foreseeable; ease certain existing safeguards for eligible persons whose death is reasonably foreseeable; introduce new safeguards for eligible persons whose death is not reasonably foreseeable; exclude eligibility for individuals suffering solely from mental illness; enable eligible persons whose natural death is reasonably foreseeable and who may lose capacity to consent before MAID can be provided to waive the need to provide contemporaneous consent; expand data collection through the federal monitoring regime to provide a more complete picture of MAID in Canada. See Department of Justice Canada, 'Government of Canada reintroduces proposed changes to medical assistance in dying legislation', online: Government of Canada <https://www.canada.ca/en/department-justice/news/2020/10/government-of-canada-reintroduces-proposed-changes-to-medical-assistance-in-dying-legislation.html> (accessed Oct. 5, 2020).

19 As a result, we are not specifying the rule framework applicable to each provider whose rule-breaking we report below, for research-participant anonymity considerations.

rules, either through new rules or through upgrading recommendations to mandatory law, caused confusion among certain segments of the population.[20]

Breaking public health rules can result in dramatic consequences, in the context of a MAiD provision during a pandemic, for both the provider, the people present, as well as the people who will be in contact with each in the near future should one of them be infected by COVID-19. However, what we describe as the *exceptionality* and the *emotionality* of the situation likely led the interviewed providers to break such rules, mostly passively by not intervening in the presence of such rule-breaking, and more rarely, by actively breaking the rules themselves. Although the providers did not specifically use these terms, the words capture recurrent themes in their responses.

IV.A. Presence of Family Members: Respecting the Exceptionality of the Situation

One interviewee reported experiencing a very difficult provision at the patient's home, her first one in the context of COVID-19. Among other complicating factors, more people were present at the time of provision than allowed by the province in which it took place, which she allowed: 'I wanted to make sure that the decision-making that I was making about who could be there was as fair to him [the patient] as possible.'[21] The provider compensated for the breach in the letter of the law by ensuring everyone present was wearing masks that she provided, and by verifying medical histories to ensure no one present was suffering from respiratory symptoms or a related worrisome symptomology. The same provider reported that while she does allow more people to be present than is strictly allowed, she is not exceeding the maximum by much. In the context of another provision in a nursing home, the patient wanted to have one more person than the maximum permitted in the provincial order in effect at the time. The provider felt that if precautions are taken (such as social distancing) then it would be possible to respect the public health imperative of preventing the potential for community spread, without depriving the patient of their loved ones in their final moments. The interviewed provider states:

> Certainly the number of people and the welcoming a person's wish to make this their celebration of death, you know people get to plan their own weddings and baby showers and all sorts of things, and prior to COVID, we let people choose how many people they wanted in the room, which room they wanted it in, and now we have to really restrict the number of people, and I must say I haven't been completely adhering to the numbers.[22]

Whereas providers minimized the significance of any rule contravention, they also indicated it was not their place to intervene. One provider suggested this was because it would be disrespectful or insensitive to do so: 'if they choose to be with each other I sort of do not feel I would ever want to put a limit on the number of people.'[23] This provider feels that the pandemic creates a situation that will endure, and thus 'the idea of people dying without their loved ones, it just adds another layer of tragedy.'

20 CBC, *Confusing COVID-19 advice is undermining public trust; here's how to restore it*, <https://www.cbc.ca/radio/whitecoat/confusing-covid-19-advice-is-undermining-public-trust-here-s-how-to-restore-it-1.5755220> (accessed Oct. 9, 2020).

21 200522-MH-05.

22 *Id.*

23 200524-BS-07.

Furthermore: 'This is their moment—so much is being taken away from everyone and I don't think—I think this is one place where we need to do as much as we can to make sure that everyone's there that needs to and wants to be there.' Stating that 'this is their moment' speaks powerfully to the exceptionality of the situation. This provider feels like in the context of MAiD, 'I'm sort of the unimportant person in the room', insisting on the importance of the family members, rather. Furthermore, the provider expresses not knowing with certainty what the evolving restrictions are on people that can be present, only that 'less is better'. Likewise, another provider acknowledged that for a provision at the patient's home, there were more people present than previously discussed, but it 'didn't feel like I could say they couldn't be there', because they were close family members.[24] She did express that this made the provision more stressful. The same provider admits ambivalence about whether it should be discussed beforehand how many people can be present during provision, stating that while, at the time, gatherings of more than that many people were prohibited, this might be different because it happens in 'someone's private house'. She follows this by saying that a home environment is 'much safer' than an institutional environment, perhaps justifying, in terms of public health, why more people could be allowed to be present than permitted in other social contexts.

Yet another interviewee reported instances in which the facility itself allowed for more family members to be present (two instead of one), because the facility was 'really quiet' at the moment of provision. The provision was done in the evening, to minimize contact that would otherwise be increased during daytime. Indirectly, the moment of the provision, chosen for the provider and visitors' safety, led to an exception by the facility's administration to the general rule (in exceptional times) of one visitor.[25] The same interviewee also reports keeping the secret of the presence of four family members at the time of provision, on a weekend day during which the administration staff was absent. She additionally reports that because a facility allows family members to help with residents' care such as with facilitating physiotherapy, she told the administration that this would be the case, knowing that the patient is in their final days, to allow the said family members to spend time with the patient. This provider offered the rationale that it is unfortunate that a facility would only allow one person to be present during MAiD provision, because then, 'who's there to support that person afterwards?'

In each of these examples, where the number of people present at the MAiD provision exceeded the strict limit that had been imposed under the public health measures, the providers underscored the *exceptionality* of the situation of being at the very end of one's life. How could I exclude these persons, keep them from being present, at their loved one's death, when the patient wants them to be there? Of course, the patient's dying does not just make the context exceptional, it can lend it an exceptionally emotional charge as well.

IV.B. PPE and Social Distancing: Respecting the Emotionality of the Situation

One interviewee reported that during a MAiD provision at home, some family members were socially distanced, while the patient's wife and daughter were huddled in

24 200501-MH-12.
25 200514-MH-14.

together with them, evidently not respecting a two-meter distance.[26] The provider expressed that they could not stay away 'because they *needed* to be with their dad' (our emphasis). Another interviewee summarized why respecting social distancing during such a moment would be very emotionally difficult: 'And then the tenderness of the process itself, I haven't been particularly strict about saying to people, "You need to stay away", because I think it's really important that people get to say their goodbyes'.[27]

Another interviewee also reported seeing family members sit very close to the patient at the time of provision but 'never sa[ying] anything'.[28] Adapting her practice to the pandemic, she decided to administer the medication through extended intravenous tubing in order to be able to maintain a distance from the patient and the family. The same provider reported wearing a face shield rather than a mask, in order to let the patient see her face, while the patient's wife and the nurse removed their masks for the provision. She explains:

> the province has masks for everybody, and when I went to that long-term care centre, everybody wore masks and they all knew how to wear them, and so it was a really good experience, I felt safe and so then I had to deal with my dilemma with the provision. I just felt that it was terrible that this person was going to die with his wife and myself and the nurse there with masks on our faces.

The provider justified this choice further by saying: 'So, I guess you could say we broke the rules, but we did it because I felt that it was important. It wasn't necessary, but I just felt that it was important'. This same interviewee noted that during another provision, she had held the hand of the patient's wife, feeling in the moment that this was what had to be done and that the wife had 'appreciated' that gesture. At the same time, the provider recalled questioning herself afterwards about whether she should have done this.

Yet another interviewee reported that during a provision, no one was wearing a mask.[29] He mused that this was unsafe and that the family 'probably should have' been wearing them, considering that the family members present did not all live under the same roof, but carried on with the provision nonetheless.

A final interviewee reported that as people were saying farewell to the patient, they were hugging, and expressed that while it would have been preferable for them not to do so, the provider did not intervene,[30] justifying this by saying: 'I can't say they can't—I can't regulate that'.

These examples reported in our interviews about rule-breaking related to PPE and social distancing at the time of provision of MAiD speak to the *emotionality* of the situation of death. Interviewees thus show respect for this notion, generally by not intervening to force people to do otherwise, or more rarely, by transgressing the relevant rules themselves.

26 200414-BS-02.
27 200422-MH-05.
28 200420-MH-03.
29 200421-MH-04.
30 200424-BS-09.

V. ETHICAL DILEMMAS OF HEALTH PROFESSIONALS FOR PROVIDING MAiD DURING THE COVID-19 PANDEMIC

We can observe from these interview excerpts that providers were faced with mostly on-the-spot decisions to make in the face of rule-breaking, having to juggle quickly the dilemmas arising from their responsibilities to their patients, the public and as MAiD providers.

The preamble to *Bill-14* notes that 'the Parliament of Canada recognizes the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying'. Autonomy is thus a central consideration for legalizing MAiD. When interviewees report allowing more visitors than permitted by public health-related rules to MAiD patients, this speaks to the autonomy of these patients to die on their terms, which generally involves being with the people they love most.

Physicians and nurse practitioners providing MAiD must also, of course, act in accordance with the general rules of their professions. This may differ from province to province, but there are also codes of ethics emanating from nationwide professional bodies. For physicians, the Canadian Medical Association (CMA) publishes a *Code of ethics and professionalism*,[31] while for registered nurses and nurse practitioners, the Canadian Nurses Association (CNA) has a *Code of Ethics for Registered Nurses*.[32]

The CMA's *Code of ethics and professionalism* notes in its introduction that:

> ethical practice is understood as a process of active inquiry, reflection, and decision-making concerning what a physician's actions should be and the reasons for these actions. The Code informs ethical decision-making, especially in situations where existing guidelines are insufficient or where values and principles are in tension.[33]

Similarly to the *CMA Code*, the *CNA Code* notes that the code itself 'cannot ensure ethical practice'.[34] These passages underline how professional ethics are context-specific and must be carried out using one's judgment. Thus, these authoritative guidelines themselves acknowledge that they do not yield ready-made answers to ethical quandaries.

Both the physician and nurse codes emphasize obligations to individual patients, while acknowledging public health responsibilities. According to the *CMA Code*, the ethical physician is compassionate and prudent—with responsibilities for patient safety as well as public health. The Code's stated purpose is to '[provide] guidance for ethical relationships, behaviours and decision-making and is used in conjunction with professional standards, best practice, research, laws and regulations that guide practice'.[35] As such, it is 'both aspirational and regulatory'.[36] The *CNA Code* describes

31 Canadian Medical Association, *CMA Code of Ethics and Professionalism*, http://www.cpsm.mb.ca/assets/Code%20Of%20Ethics/cma-code-of-ethics.pdf (accessed Jul. 13, 2020) [CMA Code].

32 Canadian Nurses Association, *Code of Ethics for Registered Nurses*, https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive (accessed Jul. 13, 2020) [CNA Code].

33 CMA Code, *supra* note 31.

34 *Id.* at 4.

35 CNA Code, *supra* note 32 at 2.

36 *Id.*

an ethical dilemma as '[a]rising when there are equally compelling reasons for and against two or more possible courses of action, and where choosing one course of action means that something else is relinquished or let go'.[37]

When physicians and nurse practitioners are providing MAiD during COVID-19, they are implicitly answering the question of how to reconcile these different abstract rules in the particular circumstances of the decisions they are making. Among many other interesting elements, the interviewees reported instances of public health rule-breaking. The frequency at which these were reported resulted in this aspect becoming one of the themes selected by the team for the analysis of the qualitative data collected during this broader phase of the study, and warrants further description from a sociolegal perspective in the present paper.

V.A. Professional and Ethical Obligations as Nurses and Physicians

The *CMA Code*'s section A. provides that '[a] compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient's suffering, and accompanies the suffering and vulnerable patient'. Alleviation of suffering can be put into practice through the presence of loved ones, and through empathic touch, namely. Section B provides that physicians '[r]ecognize the balance of potential benefits and harms associated with any medical act; act to bring about a positive balance of benefits over harms'. This speaks to the balancing act providers indeed had to grapple with when deciding whether to stop public health rule-breaking to the benefit of all other considerations surrounding the patient's well-being and autonomy in a MAiD context.

The *CNA Code*'s section A.2. provides that '[n]urses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs'. This also speaks to the physical presence of loved ones and empathic touch. Section B.1. provides that '[n]urses provide care directed first and foremost toward the health and well-being of persons receiving care', no hierarchy being made between 'health' and 'well-being'. Section D.3. provides that '[i]n health-care decision-making, in treatment and in care, nurses work with persons receiving care to take into account their values, customs and spiritual beliefs, as well as their social and economic circumstances without judgment or bias'. Section D.11. provides that:

> When a person receiving care is terminally ill or dying, nurses foster comfort, alleviate suffering, advocate for adequate relief of discomfort and pain, and assist people in meeting their goals of culturally and spiritually appropriate care. This includes providing a palliative approach to care for the people they interact with across the lifespan and the continuum of care, support for the family during and following the death, and care of the person's body after death.

These sections can lead providers to acknowledge that it is part of the values of a patient to spend their last moments with their loved ones.

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37 *Id.* at 6.

Finally, specifically relevant to the COVID-19 pandemic, the *CNA Code* underscores that conscientious care amidst an outbreak requires observing the relevant public health precautions.[38]

V.B. Obligations as Members of Society and Health Professionals in the Context of a Pandemic

The *CMA Code* speaks to how providers must use their judgment and knowledge in deciding whether stopping the public health rule-breaking in question in the context of MAiD conforms with their vision of what constitutes 'exemplary medical care'.[39] At the same time, it recognizes that physicians must engage in a balancing act between the physical and the psychological safety of the patients and his or her loved ones.[40] The Code does not provide guidance specific to the end of life context; nor does it have the same binding force of explicit legal prescriptions. It does represent an official account of what ethical professional practice entails. The fact that the Code states that physicians must '[s]upport the profession's responsibility to act in matters relating to public and population health, health education, environmental determinants of health, legislation affecting public and population health, and judicial testimony' means there are limits to what providers should be willing to tolerate in terms of public health rule-breaking.[41]

The nurses' Code further specifies that whether public health rule-breaking is unsafe must be balanced with whether it would be otherwise non-compassionate.[42] The *CNA Code* provides that '[d]uring a natural or human-made disaster, including a communicable disease outbreak, nurses provide care using appropriate safety precautions in accordance with legislation, regulations and guidelines provided by government, regulatory bodies, employers, unions and professional associations'.[43] This appears rather clearly to be against any public health rule-breaking, but the introduction to the *CNA Code* is also clear as to how nurses must consider each ethical dilemmas holistically through the lens of the whole content of the instrument. In fact, Section B.3. stipulates that '[w]hen a community health intervention interferes with the individual rights of persons, nurses use and advocate for the use of the least restrictive measures possible for those in their care'. Even if MAiD providers are not called upon to treat people infected by the source virus of a pandemic, the duty to care of health care professionals can be understood as encompassing 'a requirement to pursue a variety of ends to mitigate the negative effects of a pandemic', which could conflict with breaking public health rules.[44] Furthermore, patients' loved ones breaking public health rules could be in conflict with their own duty to care towards the population, if we accept the

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38 Section D.6. provides that '[n]urses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care'.

39 *Id.* s A.

40 *Id.* s C.30.

41 *Id.* s C.39: '[physicians must s]upport the profession's responsibility to act in matters relating to public and population health, health education, environmental determinants of health, legislation affecting public and population health, and judicial testimony'.

42 CNA code, *supra* note 32 s A.4.

43 *Id.* s A.9.

44 Joint Centre for Bioethics Pandemic Ethics Working Group, *The Duty to Care in a Pandemic*, 8:8 AJOB 31 (2008).

argument that this duty extends to members of the public.[45] Concomitantly, during the COVID-19 pandemic, especially in public health rule-breaking instances, MAiD providers are perhaps putting themselves and their families more at risk. When the rule-breaking occurs from other parties than the provider, the parallel 'duty to protect' ethical concept is engaged, constituting yet another future research avenue to explore.[46]

The foregoing section speaks to how a provider might consider that the reported public health rule-breaking is in fact coherent with the individual rights of the patient receiving MAiD. Minimizing risk and maximizing safety thus have to be balanced with the patient's well-being and dignity in this particular situation.[47] Providers may experience a tension between honouring patient autonomy and respecting public health imperatives, between acting compassionately versus serving the public interest in averting community spread. It is not surprising that physicians and nurse practitioners committed to providing MAiD to patients would see these kinds of transgressions as justified or at the very least excusable, under the exceptional and emotional circumstances of a patient receiving MAiD. Respect for patient and compassion for their suffering are standard baselines for justifying not only the legalization but also the administration of MAiD. Ensuring patients are able to die at the time and in the manner of their choosing—which MAiD is meant to achieve—rubs up against rules that would restrict this choice in significant ways.

VI. DEVIATING FROM THE RULES

Ensuring research confidentiality forecloses the possibility of offering a forensic analysis of each instance of rule-breaking, with details on the specific jurisdiction, the relevant statutes, regulations and orders, as well as institutional policies. The people we interviewed were not lawyers or legal experts. Moreover, they did not expressly frame their remarks as a criticism of the law or of any dimension of the normative environment in which they were operating. Rather than make a case for modifying any aspect of the current law, the aim of this article is to inform understanding of how MAiD providers navigate new and changing legal norms and institutional policies with professional standards and personal convictions.

In his legal history of pig-keeping in 19th Century New York City, Hendrik Hartog observes: 'We all have engaged in practices—say walking a dog without a leash—which we know to violate some law yet which are also legal within our own better understanding of the legal order'.[48] When it comes to litigation, the official legal status and therefore institutional provenance of a given norm may prove determinative—likewise the constitutional validity of the statute, regulation, order or decision in question. Absent any direct involvement in the litigation process—or even any thought to the finer arguments litigants might make about a law's pedigree or applicability—many people consider competing claims on their normative commitment, mindful that not all legal rules bear the same weight. Not every transgression of the law is equally grave. There are occasions when conforming to a formal legal norm would appear

45 *Id.*

46 Bensimon et al, *The duty to care in an influenza pandemic: A qualitative study of Canadian public Perspectives*, 75 Soc Sc & Med 2425 (2012).

47 CNA code, *supra* note 32, s D.6.

48 Hendrik Hartog, *Pigs and Positivism*, Wisc L Rev 899 at 934 (1985).

absurd, even ridiculous. Thus, the implication of Hartog's observation, that law serves us best when it implicitly appeals to our better understanding, bears acknowledgement. For any rule to enjoy general applicability, there must be cases in which it admits of some exception. Hence the wisdom in the aphorism is that the exception proves the rule. The only thing standing in the way of mechanical adherence to the letter of the law crushing its spirit is the capacity of the actor to read between the lines.[49] A person is not going to abandon an infant in a bathtub the second their employer shouts: 'drop everything and come running.'[50]

Lon Fuller deploys this kind of illustration in the adjudicative context to make the point that '[t]he correction of obvious legislative errors or oversights is not to supplant the legislative will, but to make that will effective.'[51] Outside the courtroom, legal subjects encounter situations where 'the capacity to read between the lines' is essential to demonstrating respect for legal authority. Just as the judge may conceive their interpretive task as that of fostering what is 'legal within [their] own better understanding of the legal order', legal subjects do the same thing. That is, without the requisite legal training, judicial role morality or duty to provide written reasons. Absent such strictures, legal subjects do not ordinarily think of themselves as legal decision-makers. A person driving up to a stop sign on a deserted highway, for example, may factor in the fact the law says to stop, but they also may consider how morally serious the question of obeying the law is in this instance. How grave the legal sanction would be if they got caught breaking the rule may play a role in their thinking; so too may the effect on their insurance premiums—not to mention the relative seriousness of getting into an accident and arriving late to their destination. Current weather conditions, the topography, their familiarity with the intersection—as well as past experiences and habits as a driver may militate in favor of a particular outcome, just as their present circumstances, state of mind and motivations may commend another. There are, for example, deontological and consequentialist ways to reason through the manner in which the law ought to govern one's conduct. When individuals discern how to act in the spirit of the law's animating values rather than just cower in conformity to its strict letter, the rule of law maintains a vital responsivity. Indeed, being able to act according to better or worse understandings of the legal order is a measure of an individual's capacity both for personal responsibility and to contribute to society meaningfully.

But of course not everybody subscribes to the same 'better understanding' of the legal order in any given situation. Conflict is most pronounced and seemingly intractable when both sides believe they have got it right. Whether what's legal accords with our own better understanding of the legal order depends on who is 'we' and on the aims we are trying to fulfill. There are many situations we can imagine where walking a dog without a leash gives rise to fierce disagreements over whose is the better understanding of the legal order and its imperatives. Whether our own better understanding of the legal order empowers us to transgress a formal legal rule may be a function of our power within that order to not be disciplined and punished for the breach. This may owe to circumstances—nobody else is around to see—or ways in

49 Lon L. Fuller, *The Case of the Speluncean Explorers*, 62:4 Harv L Rev 616 at 625 (1949).

50 *Id.*

51 *Id.* at 626.

which a person is positioned to deploy the violence of the legal order itself to shore up and defend their interests.[52]

As much as there is wisdom in acknowledging a shared appreciation of the difference between unthinking conformity and conscientious fidelity to law, there is also a risk in overstating just how common this sense is. Law's value as a social good depends in part on the capacity of legal subjects to engage purposely, thoughtfully, even creatively with it. But it also stems from the need legal subjects have for standards to determine when any claim to engagement with law as a normative basis for conduct strains credibility, because it appears to be a bit too imaginative, calculating or self-serving. Clinicians may perceive Canada's MAiD law as more legitimate than the relevant public health rules because of the pronounced disparity in the amount of time, research, debate and deliberation—indeed, even litigation— that went into them.[53]

Understanding how providers perceive MAiD and the value they place on it can help to explain why they may have been more inclined to bend public health rules or look the other way when friends and family of patients failed to assiduously respect rules on PPE or social gathering, than physicians or nurse practitioners who are more ambivalent about MAiD might have been. If physicians and nurse practitioners regard MAiD provision as compassionate, respectful, and patient-centred, that is likely to shape the manner in which they negotiate dilemmas arising from restrictions on the practice. Conversely, if one is opposed to MAiD, or deeply ambivalent about it, one is not providing MAiD anyway, and is not likely to prioritize ensuring patients are able to choose the timing and manner of their deaths in this fashion. Indeed, some health care institutions in Canada that normally prohibit the provision of MAiD on their premises suspended their usual practice of allowing transfers for patients seeking MAiD. They justified imposing these moratoriums on patient transfers as a means of mitigating risks of viral spread. On the balance of public health and resource allocation concern, they continued to place less weight on ensuring patient access to MAiD. Meanwhile, physicians and nurse practitioners, seeing their provision of MAiD as an expression of compassion and respect for patient autonomy resolved tensions in their professional obligations in a way that they saw as maximizing their patient's interests. This ethical orientation is not shared by all health professionals, or even all MAiD providers. We argue that it is reasonable to anticipate the providers we interviewed 'bending' the rules in the manner they did, since enabling eligible patients to die on their own terms is the very *raison d'être* of MAiD.

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52 See for example the highly publicized case of Amy Cooper, a white woman, who called the police because she felt threatened by a Black man birding in Central Park: Amir Vera and Laura Ly, *White woman who called police on Black man bird-watching in Central Park has been fired*, CTV News, https://www.ctvnews.ca/world/white-woman-who-called-police-on-black-man-bird-watching-incentral-park-has-been-fired-1.4954755 (accessed May 26, 2020).

53 To date, no court has heard a constitutional challenge to the impact of public health restrictions on the provision of MAiD. The Supreme Court of Canada's relevant s 7 jurisprudence suggests the courts will not take evidence of an infringement on patient autonomy in the end of life context lightly; see *Carter, supra* note 6. Although the Supreme Court of Newfoundland and Labrador recently dismissed an applicant's *Charter* challenge to a statutorily authorized provincial travel restriction, the court found that there was no infringement of the applicant's s 7 liberty right and that the infringement of her s 6(1) right to mobility "was fleeting, as 8 days later Ms. Taylor was granted an exemption, permitting her to travel" Taylor v. Newfoundland and Labrador, NLSC 125 (2020) at paras 376 and 302, respectively.

VII. CONCLUSION

The law relating to end-of-life decision-making in Canada has changed dramatically in the last five years; so too has the status of voluntary euthanasia and assisted suicide in Canadian medical practice. Ensuring eligible patients have the ability to receive MAiD (through direct provision or effective referral) is now part of the medical standard of care. While legalization, legitimation and normalization of MAiD in Canada have proceeded, the criminal law has continued to cast its shadow over the practice. Not acting in accordance with the legislative scheme could result in prosecution for a form of culpable homicide. In addition, the MAiD law creates offences for failing to comply with prescribed safeguards, as well as forging or destroying related documents. No prosecutions have been pursued to date. Meanwhile, from a clinical perspective, the meaning of the most ambiguous aspects of the legislation has evolved. In sum, the legal story concerning MAiD has been one of flux. Change appears a constant—both for the law on the books and the law in action. Of course, not everybody is happy with the speed or direction of the change.[54] The evidence of such dynamism itself raises interesting questions, especially since law is often associated with values such as stability, certainty and predictability.[55]

Of course, it is not just the presence or absence of legal change that stands to promote or undermine these values. In effect, law's stability, certainty and predictability are really markers of its instrumental utility. These features allow law to work—not just as a means of exercising social control but of facilitating self-directed social interaction, of enabling the coordination of expectations and behavior in a large complex society. How much one values such indicia of law's instrumentality may depend in part on one's evaluation of what the law is aiming to accomplish. If the price of a stable, certain and predictable law is the maintenance of widespread injustice, it will depend on a politics of exclusion, economics of oppression and culture of denial. But not everyone sees or experiences these morally bankrupting costs in the same way.

The more immediate and pressing the need to secure the end feels, the more compelling the case for legal conformity appears. For instance, the need to protect people in the midst of a pandemic (a public good) may lead some who are otherwise skeptical of legal instrumentalism, in the form, say, of police enforcement of an injunction protecting private property interests, to stress the importance of individual behavioral conformity to the law. For proponents of liberalizing MAiD and ensuring greater access to suffering patients, establishing constitutional and legislative baselines are crucial. This way of ensuring more people can exercise their right to receive MAiD maintains the practice's legitimacy in the eyes of the public by mitigating the risk of abuse by rogue practitioners.

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54 See Joan Bryden, "Assisted-dying bill sparks ferocious debate among Canadians with disabilities", online: <https://www.ctvnews.ca/politics/assisted-dying-bill-sparks-ferocious-debate-among-canadians-with-disabilities-1.5184494> CTV News, (November 11, 2020); see also Thomas McMorrow, *Voluntary Euthanasia, Assisted Suicide & Law Reform: An Overview of the Canadian Experience,* 1 BioLaw Journal - Rivista di BioDiritto 267.

55 Lawrence B. Solum, *Construction and Constraint: Discussion of Living Originalism,* 7 Jerusalem Rev Legal Stud 17 at 34 (2013) (describing these as 'rule of law values'). But see Jeremy Waldron, *Is the Rule of Law an Essentially Contested Concept (in Florida)?,* 21 L & Phil 137 (2002) (showing just how contentious the very meaning of the 'rule of law' can be).

The de-criminalization of MAiD, and its reframing as a health care issue, mean its re-construction as a form of medical treatment has been advanced considerably but is still underway. Although the practice is governed federally, through the criminal law, there is no additional set of national health care standards or oversight body, as there is in jurisdictions such as the Netherlands and Belgium. The current law plays a major role in determining the circumstances in which MAiD is permitted, even if it is health care professionals themselves who are tasked with following the law in the course of their daily practice. The margin of maneuver individual legal subjects have when it comes to following the law comes to the fore when we think about MAiD providers tasked with providing MAiD during the COVID-19 pandemic.

This study analyzes data collected during a specific period, relatively early in the pandemic. Further research is necessary to explore subsequent changes to those experiences. The law and policy ground between total lockdown and business-as-usual is wide, complex and uncertain. Governing well during the COVID-19 pandemic means adopting—and over time adjusting— the measures that research, experience and wise political judgment commend. Being realistic about the kinds of choices people must make in these circumstances can help to ensure greater transparency, accountability and effectiveness when developing rules that promote the public interest in limiting the spread of the virus.

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