

The Quiet Expansion of Death: Canada's MAID Program and the Moral Fatigue of Modern Medicine

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I have spent most of my professional life around death. Not theoretical death. Not philosophical death. Real death. I have watched patients die in emergency departments, intensive care units, helicopters, ambulances, and operating rooms. I have watched families collapse emotionally beside ventilators. I have watched physicians sit silently after losing patients they fought desperately to save. I have also witnessed something equally important: patients survive when nobody expected them to survive. That reality changes the way one looks at medicine. It also changes the way one looks at euthanasia.

Canada's Medical Assistance in Dying (MAID) program began in 2016 under the promise of compassion, restraint, and exceptional circumstances. (1) At the time, many Canadians believed the law would remain limited to terminally ill patients experiencing unbearable suffering near the end of life. Citizens were repeatedly reassured that strict safeguards would prevent abuse and that euthanasia would remain rare.

That is not what happened. Today, Canada has one of the most permissive euthanasia systems in the

world. (2) The transformation occurred gradually, mostly through bureaucratic normalization rather than dramatic public confrontation. Even the language evolved carefully. "Euthanasia" became "Medical Assistance in Dying." Death became "healthcare." Physicians became providers of medically administered death.

And slowly, society adapted.

According to official Health Canada data, more than 15,000 Canadians died through MAID in 2023 alone. (2) This represented approximately 4.7% of all deaths in the country. Preliminary 2024 reports suggest the number continues to rise and may now exceed 5% of all national deaths. (3) Think about that for a moment. One out of every twenty deaths in Canada is now intentionally caused through a medical process.

That statistic alone should force serious ethical reflection within the medical profession.

What concerns me most is not simply the growth of the program itself. It is the speed with which society normalized it. Human beings adapt remarkably fast. Practices that once would have shocked the public gradually become routine through repetition, softened terminology, and bureaucratic familiarity. Ethical discomfort fades. The extraordinary becomes administrative. As physicians, we adapt emotionally because otherwise we could not survive professionally. But there is danger in excessive adaptation. Over time, people can normalize almost anything. Including killing.

Supporters of MAID often frame the discussion almost entirely around autonomy. They argue that competent adults should have the right to choose death when suffering becomes unbearable. In carefully selected situations, the emotional appeal of this argument is understandable. But real life is rarely simple. Patients are influenced by pain, fear, depression, financial stress, family dynamics, exhaustion, disability, isolation, guilt, and hopelessness. Human beings do not make decisions in a vac-

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uum. That reality matters enormously.

I have personally seen patients declare they were ready to die and later recover enough to enjoy meaningful additional years of life. I have watched individuals say goodbye to their families one night and request breakfast the following morning. I have watched despair improve after symptoms were treated, pain was controlled, or emotional support appeared.

Medicine is filled with prognostic uncertainty. Physicians are wrong more often than we like to admit. The difference with euthanasia is that there is no opportunity to reverse the decision afterward. Death is permanent.

Over time, Canada's MAID program expanded far beyond what many citizens originally believed they were approving. In 2021, Bill C-7 removed the requirement that a person's death be "reasonably foreseeable." (4) This dramatically broadened eligibility to include individuals with chronic illness and disability who were not terminally ill. That change fundamentally altered the ethical landscape. The discussion then moved toward allowing MAID for mental illness alone. (5) Although implementation has been repeatedly delayed because of widespread concern among psychiatrists and policymakers, the fact that society reached this point so rapidly should alarm anyone paying attention.

Because once suffering itself becomes the justification for medically administered death, the boundaries naturally continue expanding. Why exclude chronic pain? Why exclude severe depression? Why exclude disability? Why exclude loneliness? Why exclude existential despair? Once medicine crosses the line from relieving suffering to intentionally ending the sufferer, the logic becomes increasingly difficult to contain.

History repeatedly demonstrates this pattern. Every country that legalizes euthanasia begins with emotionally compelling cases. Every country promises safeguards. Every country insists the practice will remain exceptional. Then definitions broaden. Then exceptions multiply. Then society acclimates. Canada has become perhaps the clearest modern example of this progression.

One of the most disturbing aspects of the MAID debate involves reports of patients seeking euthanasia not primarily because of uncontrolled physical pain, but because of poverty, inadequate housing, loneliness, or inability to access appropriate medical and social support. (6,7) That should deeply disturb anyone working in healthcare. A disabled patient may

wait months for social assistance while simultaneously qualifying for state-assisted death. A chronically ill patient may struggle to access psychiatric support, rehabilitation, pain management, or home care while euthanasia remains readily available. That is not simply a medical problem. It is a societal failure.

Studies examining motivations for MAID requests consistently demonstrate that fear of becoming a burden plays a major role in decision-making. (8) Elderly patients worry about exhausting family members emotionally and financially. Disabled individuals absorb subtle societal messaging suggesting dependency diminishes dignity. Those fears are real. And a civilized society should never allow vulnerable people to conclude that death is their greatest contribution to others. Yet, this is precisely where normalization leads.

Medicine was never intended to function merely as a transactional system. Historically, the physician-patient relationship carried an implicit moral promise: even when cure became impossible, abandonment was not acceptable. We stay. We fight. We comfort. We accompany suffering human beings through darkness.

The Hippocratic tradition prohibited physicians from intentionally killing patients for a reason. (9) The prohibition reflected recognition that trust in medicine depends on maintaining a clear ethical boundary. Once physicians become agents of death, the relationship between medicine and society changes fundamentally. Patients may begin wondering whether they are costing too much. Families may begin questioning whether continuing care is selfish. Healthcare systems under severe financial pressure may quietly recognize that death is dramatically less expensive than long-term chronic care.

Nobody likes discussing economics in euthanasia debates, but economics always exists in the background. Canada's healthcare system faces major challenges, including prolonged wait times, staffing shortages, and rising costs. (10) Critics increasingly warn that MAID risks becoming intertwined with healthcare rationing pressures. (11) No government needs to openly promote euthanasia for financial incentives to emerge naturally within strained systems. Death is inexpensive. Complex chronic care is not. That reality alone demands extraordinary caution. Instead, Canada appears to be moving steadily toward further normalization. Government reports increasingly discuss MAID in bureaucratic language. (2,3) Provincial dashboards track euthanasia statistics with administrative efficiency. (12)

Practices that once would have generated intense moral debate now appear integrated into routine healthcare operations. And perhaps that is the most dangerous development of all.

What once produced ethical alarm eventually produces paperwork. Critics of MAID are frequently dismissed as merely religious or ideological. That characterization is inaccurate and intellectually dishonest. Serious concerns about euthanasia emerge from many perspectives, including disability rights advocates, secular ethicists, psychiatrists, and physicians themselves. Some of the strongest criticism has come directly from disability communities who fear society increasingly values independence more than intrinsic human worth. (7,13) They understand something modern culture often forgets: once dignity becomes tied primarily to autonomy and productivity, vulnerable populations become morally endangered. A disabled life still has value. A dependent life still has value. A suffering life still has value. Modern societies increasingly struggle with this concept because we have become obsessed with optimization, efficiency, control, and performance. We are uncomfortable with dependency. We are uncomfortable with prolonged suffering because it reminds us of our own vulnerability. But medicine was never meant to eliminate the human condition. It was meant to care for human beings within it.

As a critical care physician, I can say with certainty that human beings are far more resilient than textbooks predict. I have seen patients survive physiologic catastrophes that should have killed them. I have seen depression improve, pain become manageable, and families rediscover meaning during terrible illness. Human resilience repeatedly sur-

prises medicine. In fact, extraordinary examples of physiologic resilience have been documented in the medical literature, including survival and neurologic recovery in patients with metabolic abnormalities traditionally considered incompatible with life. (14) Euthanasia removes every possibility for future recovery, adaptation, reconciliation, or meaning. Once performed, there is no second chance. Some Canadian cases have already raised major concerns regarding safeguards, psychiatric evaluations, consent processes, and inadequate exploration of alternatives. (15,16) These debates are no longer theoretical. They are unfolding in real time. And still, the momentum continues. Perhaps because euthanasia is efficient. Perhaps because accompanying suffering is exhausting. Perhaps because modern societies increasingly confuse eliminating suffering with eliminating the sufferer. But those are not the same thing.

Civilizations are ultimately judged by how they treat vulnerable human beings: the elderly, the disabled, the chronically ill, the mentally suffering, and the dying. A humane society does not solve suffering primarily through medically administered death. It addresses suffering through compassion, palliative care, psychiatric support, social investment, family support, dignity, and human presence. Canada's MAID program increasingly risks sending the opposite message: that some lives have become too difficult, too expensive, too dependent, or too burdensome to continue. That is not progress. That is moral fatigue disguised as compassion. And once a society fully normalizes that idea, reversing course may become extraordinarily difficult.

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