Communicating Contentious Issues in Canada: Analyzing Media Discourse of Medical Assistance in Dying (MAID)

by

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Abstract

Examining the ways medical assistance in dying (MAID) discourse is presented in the media, this thesis analyzes the key themes, issues and contentions found throughout the topic in Canada's two national papers, *The Globe and Mail* and the *National Post.* Through a mixed-methods approach of qualitative and quantitative means, this study examines the period in and around June 17, 2016 when MAID legislation came into effect up to July 1, 2019 using a thematic content analysis, framing analysis, and sentiment analysis approach. Collectively, these methods allowed for an in-depth analysis and breakdown of the ethical, moral, religious, and personal beliefs that contribute to key contentions around the topic of MAID, supplemented by five in-depth interviews among individuals with vested interest in the subject matter. Together, these methods aimed to explore the way contentious issues are presented in the media in the context of medical assistance in dying.

Keywords: Medical Assistance in Dying; Content Analysis; In-Depth Interviews; Contentious Issues; Ethics; End-of-Life Decisions

Dedication

To Sheridan, Ashley, Margy and Mia who believed in me when I didn’t. If not for you, this thesis would not exist. Thank you – for everything.

To Mom, Dad and Nik: I love you more than anything in this world. I will forever be grateful for everything you have done for me, thank you for being the best family a woman could ever want or need.

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If you had asked me a few years ago if I would ever move away from home to pursue further education, I would have laughed in disbelief at such a crazy idea. Three years later, here we are, thesis in hand as I wrap up a challenging and rewarding experience, far from home for most of it, but with the support of so many behind me.

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This is not the end. Onwards and upwards! Thank you all.

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List of Acronyms

ACP	Advanced Care Planning
ALS	Amyotrophic Lateral Sclerosis
AR	Advance Request
BCCLA	British Columbia Civil Liberties Association
CA	Content Analysis
CAE	Canadian Academy of Engineering
CAHS	Canadian Academy of Health Sciences
CATA	Computer-Aided Text Analysis
CCA	Council of Canadian Academies
CCRC	Canadian Coalition for the Rights of Children
CDA	Critical Discourse Analysis
CMPA	Canadian Medical Protective Association
DA	Discourse Analysis
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
EAPC	European Association for Palliative Care
EAS	Euthanasia and Assisted Suicide
EFC	Evangelical Fellowship of Canada
EPC	Euthanasia Prevention Coalition
HCP	Health Care Professional
MAID	Medical Assistance in Dying
MD-SUMC	Mental Disorders as the Sole Underlying Medical Condition
PAD	Physician Assisted Dying
PAS	Physician Assisted Suicide
PAS-E	Physician Assisted Suicide and Euthanasia
PHD	Physician Hastened Death
RI	Research Interview
RO	Research Objective
RQ	Research Question
RSC	Royal Society of Canada
WHO	World Health Organization

Chapter 1.

Path to Legislation

1.1. Introduction

The notion of one's right to life has been a predominant driving force behind the development of laws and legislation within Canada for decades, while its oft-forgotten partner, the notion of one's right to death by their own choosing, receives considerably less attention. The consideration for medical assistance in dying (MAID), also known internationally as euthanasia or physician assisted suicide (PAS), is one that has been fought in the courts for decades, as men and women with irremediable and incurable ailments ranging from terminal cancer to amyotrophic lateral sclerosis (ALS) fight for the right to choose how to die. In a monumental ruling on Feb. 6, 2015, the Supreme Court of Canada struck down the ban on physician assisted suicide (as it was then known), giving the Liberal Government 12 months to put legislation into place governing PAS practices (CBC News, 2015). After a request for more time to complete the legislation, the Supreme Court of Canada extended the deadline by four months and on June 17, 2016 the Medical Assistance in Dying (MAID) Act came into effect (Beaudoin, 2016) making assisted death legal via the medical profession in Canada.

Exploring media discourses surrounding this topic, this study looks to examine the way MAID was presented in Canada around the time legislation passed from June 1, 2016 to July 1, 2019 in Canada's two national newspapers, *The Globe and Mail* and the *National Post.* Looking at all articles across this three-year period that use the terms 'assisted death,' 'assisted dying,' 'assisted suicide' or 'medical assistance in dying/MAID,' an in-depth thematic content analysis is conducted on all selected 227 articles, looking at the themes, contentions and predominant issues that arise within the text, as well as the overall sentiment of the articles that influence the way the topic is presented through a subsequent framing and sentiment analysis. In addition, a discussion surrounding five ethnographic interviews is conducted as interviewees present insights and opinions on the topic that allow for further exploration both within the content and sentiment analyses, but which also provide considerations for further research and gaps within academic literature that still need to be addressed.

Broken into chapters, chapter one of this study follows the path to legislation to contextualize the themes, issues and contentions present in the data analyses in later chapters, while chapter two examines the lack of academic literature on the topic of MAID, specifically in the field of communication, as well as examines some considerations around the methods selected. Chapter three breaks down the methodologies and justifications found within this study, while chapter four presents a discussion of the findings and chapter five provides concluding remarks and suggestions for further research.

Combined together, this study brings to light and discusses issues still present within MAID legislation, provides statistical evidence of bias for and against medical assistance in dying in Canada, and highlights areas within MAID literature that are still in need of research. While this study is only a stepping stone towards bigger and broader studies on the topic, it aims to effectively fill the gap of one specific area of MAID academic literature and may in turn be used to guide future studies as Canada moves into its revision period in June 2020.

1.2. From 1991 to 2015

In December of 1992, Sue Rodriguez, who suffered from a severe form of ALS, applied to the Supreme Court of British Columbia to contest section 241(b) of the Canadian Criminal Code which prohibits a person from aiding or abetting in a suicide (Government of Canada, 1985, s. 241). In turn, the case challenged the grounds of Sections 7, 12 and 15 of the Canadian Charter of Rights and Freedoms under the grounds that Rodriguez “does not wish to die so long as she still has the capacity to enjoy life, but wishes that a qualified physician be allowed to set up technological means by which she might, when she is no longer able to enjoy life, by her own hand, at the time of her choosing, end her life” (Supreme Court of British Columbia, 1993, p. 520). Rodriguez’s primary argument focused on the alleged violation of her liberty and security to person which cannot be divorced from the sanctity of life under Section 7 of the charter. In a video sent to Parliament in 1991 proceeding her turn in court, Rodriguez noted: “If my suffering was being afflicted upon me in any other context, it would be called an abuse of human rights and might well be called a crime. But because it happens in the name of modern medicine, I’m supposed to accept whatever indignities my illness inflicts upon me and keep quiet” (Eastwood, 2016, 6:09). The Court “dismissed the appellant’s application” and the Court of Appeal later “affirmed the judgment” (Supreme Court of British Columbia, 1993, p. 520) under the basis that Section 241(b) of the Criminal Code remained constitutional, despite Rodriguez’s claims.

After losing her case in December of that year and in a subsequent appeal in March of 1993, Rodriguez turned her attention to the Supreme Court of Canada (Beaudoin, 2016). While Rodriguez brought arguments on the merits of human dignity, personal autonomy and the right to a dignified death, the Court focused heavily on the principle of fundamental justice and on striking a fair balance between interests of the state and those of the individual. Regarding assisted suicide, the Court held that:

> Assisted suicide, outlawed under the common law, has been prohibited by Parliament since the adoption of Canada’s first *Criminal Code*. The long-standing blanket prohibition in s. 241*(b)*, which fulfils the government’s objective of protecting the vulnerable, is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken. This state policy is part of our fundamental conception of the sanctity of life. A blanket prohibition on assisted suicide similar to that in s. 241*(b)* also seems to be the norm among Western democracies, and such a prohibition has never been adjudged to be unconstitutional or contrary to fundamental human rights. …Distinctions between passive and active forms of intervention in the dying process continue to be drawn and assisted suicide in situations such as the appellant’s is prohibited with few exceptions. No consensus can be found in favour of the decriminalization of assisted suicide. (Supreme Court of British Columbia, 1993, pp. 521-522)

The Court further stated that the Criminal Code did not infringe on s. 12, as the appellant was not subjected by the state to any form of cruel and unusual treatment, or punishment, and that to imply such was a stretch of the “ordinary meaning of being ‘subjected to’ … treatment” (Supreme Court of British Columbia, 1993, p. 522) under the Charter.

On September 30, 1993, the Supreme Court judges, in a 5-4 ruling, declared section 241(b) as constitutionally valid and therefore not in violation of the Canadian Charter of Rights and Freedoms in their final decision (Beaudoin, 2016). They held that the most important issue was whether section 241(b) violated section seven of the Charter, which states: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice” (Government of Canada, 1982, s. 7). While most of the judges recognized Rodriguez's right to security of the person, "they believed that the prohibition against assisted suicide upheld principles of fundamental justice, and therefore did not violate section seven of the Charter" (Beaudoin, 2016, para. 4). In his decision, Justice Allen Melvin noted that Rodriguez would not encounter the criminal justice system regardless of what actions she took, stating:

> Her fundamental decisions concerning her life are not restricted by the state. Her illness may restrict her ability to implement her decisions but, in my opinion, that does not amount to an infringement of a right to life, liberty or security of the person by the state. The interests she seeks to protect pursuant to s. 7 are not those which determine the means by which she may be brought before or within the justice system. (Supreme Court of British Columbia, 1993, p. 534)

They also rejected the claim that section 241(b) violated section 15 (the guarantee of equal rights without discrimination) of the Charter (Beaudoin, 2016) under similar grounds stating: "It is preferable in this case not to decide the difficult and important issues raised by the application of s. 15 on the *Charter*, but rather to assume that the prohibition on assisted suicide in s. 241*(b)* of the *Code* infringes s. 15 since any infringement of s. 15 by s. 241*(b)* is clearly justified under s. 1 of the *Charter"* (Supreme Court of British Columbia, 1993, p. 522). The Court further declared section 241(b) as being in direct response to this very premise on the grounds of protecting and maintaining respect for human life.

The Supreme Court argued that lifting the ban against PAS could potentially lead to abuses, particularly among the vulnerable: "…even where consent to death is given, the consent may not in fact be voluntary. There is concern that individuals will, for example, consent while in the grips of transitory depression. There is also concern that the decision to end one's life may have been influenced by others" (Supreme Court of British Columbia, 1993, p. 626). Their justification for s. 241(b) as being a protection of the vulnerable focused on two distinct concerns, namely that "the objective of this prohibition is not to prohibit what it purports to prohibit, namely assistance in suicide, but to prohibit another crime, murder or other forms of culpable homicide" (Supreme Court of British Columbia, 1993, p. 625). Therefore:

> The concern for deaths produced by outside influence or depression centre on the concept of consent. If a person of sound mind, fully aware of all relevant circumstances, comes to the decision to end her life at a certain point, as Sue Rodriguez has, it is difficult to argue that the criminal law

> should operate to prevent her, given that it does not so operate in the case of others throughout society. The fear is that a person who does not consent may be murdered, or that the consent of a vulnerable person may be improperly procured. (Supreme Court of British Columbia, 1993, p. 626)

Acknowledging that these concerns are present in any suicide, the Court noted that "this appeal is concerned with s. 241*(b)* of the *Criminal Code.* Section 241*(a)*, which prohibits counselling in suicide, remains in force even if it is found that s. 241*(b)* is unconstitutional" (Supreme Court of British Columbia, 1993, p. 626). They went on to add that the danger of improperly induced consent was one that must be squarely faced.

In concluding the case, Justice McLachlin noted "that the infringement of s. 7 of the *Charter* by s. *241(b)* has not been shown to be demonstrably justified under s. 1 of the *Charter*" (Supreme Court of British Columbia, 1993, p. 628). The minority judges argued that "the prohibition of assisted suicide was arbitrary. In effect, a physically able person can commit suicide (which is not a criminal act) while a physically disabled person commits a crime when she asks for assistance to perform the same act" (Beaudoin, 2016, para. 5). It was the minority judges' opinion that this distinction was contrary to the principles of fundamental justice as raised through the case (Beaudoin, 2016). The following February, assisted by an unknown physician and with assisted death advocate, NDP MP[1], Svend Robinson in attendance, Rodriguez died peacefully in her home in Victoria in 1994 (CBC News, 2015).

The journey from 1993 to 2011 when fellow ALS patient and British Columbia resident, Gloria Taylor, revitalized the dying with dignity debate in Canada was a long one. Though Taylor never planned to follow in the footsteps of Sue Rodriguez, after hearing on the television in 2011 that the B.C. Civil Liberties Association (BCCLA) was resurrecting the right-to-die debate, Taylor, who had been diagnosed with Lou Gehrig's Disease in 2009, immediately called the group: "It seems to me that you're missing one thing and that's the person who's dying. And I'm it" (CBC News, 2015, para. 19). That same year, on April 26, 2011, the B.C. Civil Liberties Association filed a lawsuit to "challenge the laws that make it a criminal offense to assist seriously and incurably ill individuals to die with dignity" (BCCLA, n.d., para. 18). The plaintiffs within the case were made up of Gloria Taylor, Lee Carter, Hollis Johnson, Dr. William Shoichet, and the British Columbia Civil Liberties Association (Supreme Court of British Columbia, 2011).

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[1] New Democratic Party Member of Parliament

Of these plaintiffs, Carter and Johnson represented Kay Carter who died in 2010 of a debilitating disease like Taylor and Rodriguez's (CBC News, 2015). Carter, like Rodriguez, died on her own terms, flying to Switzerland to end her life at the euthanasia clinic, Dignitas (Dying With Dignity Canada, n.d.). With these plaintiffs stood Elayne Shapray and a multitude of seriously ill Canadians who shared deeply personal stories with the Court for the sake of legalizing assisted death to end their suffering in a humane manner.

In a "Concise Summary of Nature of Claim," as seen in the 2011 BCCLA Notice of Claim to the Supreme Court of British Columbia, the claim declared: "A challenge to the constitutional validity or applicability of the provisions of the *Criminal Code,* R.S.C., 1985, c. C-46, that prohibit physician-assisted dying, including those provisions that render someone criminally liable for aiding or counselling same or otherwise render someone a party to a criminal offence for arranging, supporting or otherwise participating in physician-assisted dying" (Supreme Court of British Columbia, 2011, p. 18). The plaintiffs sought relief under "a. the *Constitution Act, 1867* and, in particular, ss. 91 and 92 thereof; b. s. 52 of the *Constitution Act 1982,* and c. the *Charter* and, in particular, ss. 1, 7, 15, and 24 thereof" (Supreme Court of British Columbia, 2011, p. 13). Of these, the primary focus lay around the treatment and management of the "physical and emotional suffering of a grievously and irremediably ill patient and, in particular, the determination of capability and consent" (Supreme Court of British Columbia, 2011, p. 13). Included were matters relating to health care, the regulation and delivery of health services, the practice of medicine, and regulation of the patient-physician relationship (Supreme Court of British Columbia, 2011) within the jurisdiction of the Province of British Columbia.

The Supreme Court of British Columbia heard the case across 23 days in November and December of 2011 through evidence presented in affidavits (BCCLA, n.d.) in a modified summary trial that was conducted in part due to Gloria Taylor's deteriorating condition, and in part due to the number of counsel working pro bono to represent their clients. For these reasons, the plaintiffs "asked to proceed with a summary trial, taking the risk that at the end of the day the Court would conclude that it was not possible to find the facts necessary to decide the issues of fact or law, or that it would be unjust to decide the issues on this application" (Supreme Court of British Columbia, 2012, p. 33). Over the course of the trial, "116 expert and lay affidavits were filed (85 of those [which] were filed by the BCCLA). Some of the affidavits ran hundreds of pages in length and attached voluminous secondary sources. Eighteen affiants were cross-examined, of those, the parties examined 11 before the court" (BCCLA, n.d., para. 19). One such affidavit was that of lead plaintiff, Gloria Taylor. In both Court documents and in news statements, Taylor made it clear that her choice to die by assisted death was her own stating: "I do not want to be a burden, not because I fear my family does or would resent me – I do *not* think that – rather, I do not want to be a burden because I *know* they love me." (Supreme Court of British Columbia, 2012, p. 17). She concluded her affidavit by furthering this sentiment, stating:

> I am dying. I do not want to, but I am going to die; that is a fact. I can accept death because I recognize it as a part of life. What I fear is death that negates, as opposed to concludes, my life. I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain. It is very important to me that my family, and my granddaughter in particular, have final memories that capture me as I really am – not as someone I cannot identify with and have no desires to become. (Supreme Court of British Columbia, 2012, p. 18)

She also noted that there was no pre-set "trigger" moment for her decision to die saying simply, "there will come a point when I will know that enough is enough. I cannot say precisely when that time will be…I just know that, globally, there will be some point when I will be able to say – 'this is it, this is the point where life is just not worthwhile'" (Supreme Court of British Columbia, 2012, p. 18). She asked the Court that in that moment, she be allowed to bring her family together to say a dignified goodbye, allowing herself and her family to obtain closure on a challenging time in their lives.

On June 15, 2012, Madam Justice Smith announced her decision regarding the case, ruling that the criminal laws against assisted dying violate the rights of the seriously ill, thus making them unconstitutional (BCCLA, n.d.). Madam Justice Smith, in her 323-page exhaustive breakdown of her justifications, presented her decision in the very first paragraph of the document, stating her ruling as follows:

> The plaintiffs have challenged the *Criminal Code of Canada* provisions prohibiting physician-assisted dying, relying on the *Canadian Charter of Rights and Freedoms.* In the Reasons for Judgment that follow, I describe the evidence and legal arguments that have led me to conclude that the plaintiffs succeed in their challenge. They succeed because the provisions unjustifiably infringe the equality rights of Gloria Taylor and the rights to life, liberty and security of the person of Gloria Taylor, Lee Carter and Hollis Johnson. (Supreme Court of British Columbia, 2012, p. 8)

In her decision, Madam Justice Smith declared the provisions as invalid, and suspended the operation of that declaration for one year to allow the Government of Canada time to develop appropriate legislation (Supreme Court of British Columbia, 2012). She further provided a constitutional exemption for Taylor to seek a physician-assisted death during that time, making Taylor the first Canadian in history to be granted such a right.

In her summary of findings of fact and legal reasoning thereafter, Madam Justice Smith made direct responses to each of the applied provisions, noting the legislation's infringement on s.15 of the Charter of Rights and Freedoms as not being demonstrably justified under s.1 of the Charter. She stated:

> The purpose of the absolute prohibition against physician-assisted suicide, as determined by *Rodriguez*, is to prevent vulnerable persons from being induced to commit suicide at times of weakness. That purpose is pressing and substantial and the absolute prohibition against assisted suicide is rationally connected to it. However, a less drastic means of achieving the legislative purpose would be to keep an almost-absolute prohibition in place with a stringently limited, carefully monitored system of exceptions allowing persons in Ms. Taylor's situation – grievously and irremediably ill adult persons who are competent, fully-informed, non-ambivalent and free from coercion or duress – to access physician-assisted death. Thus, the legislation does not impair Ms. Taylor's equality rights as little as possible. Further, the legislation has very severe adverse effects on Ms. Taylor and others in her situation, that are not outweighed by its benefits. For those reasons, and despite affording due deference to Parliament, I conclude that the legislation's absolute prohibition falls outside the bounds of constitutionality. (Supreme Court of British Columbia, 2012, p. 10)

Joseph Arvay, lead counsel for the BCCLA, while addressing the landmark decision, noted: "Madam Justice Smith's decision, I don't know if I can say it's unprecedented in its length, but it is extremely thorough, extremely thoughtful, covered all of the evidence, covered all of the arguments, it's a decision that demands the highest respect of the Government of Canada" (Eastwood, 2016, 25:44). Yet less than 30 days after the decision, the Federal Government of Canada on July 13, 2012, appealed the B.C. Supreme Court ruling, canceling the exemptions and forcing the BCCLA back into the courthouse from March 18-22, 2013. Before the appeal could be heard, however, lead plaintiff, Gloria Taylor, passed away suddenly from an infection on October 4, 2012 (BCCLA, 2012), leaving the rest of the fight to be completed in her memory.

In a divided two-to-one decision, the B.C. Court of Appeal overturned the historic Supreme Court ruling on October 10, 2013, stating: "In our respectful view, any review of the substantive *Charter* challenges, and the granting of comprehensive or limited relief from the effects of the law, are beyond the proper role of the court below and of this court. If the constitutional validity of s. 241 of the *Criminal Code* is to be reviewed notwithstanding *Rodriguez,* it is for the Supreme Court of Canada to do so" (Court of Appeal for British Columbia, 2013, para. 352). In announcing their decision, the judges provided a thorough breakdown of contentions they had with the ruling, including the principles of 'arbitrariness,' 'overbreadth' and 'gross disproportionate' in relation to fundamental justice and the Justice's take on such. In their acknowledgement of these terms, the judges noted:

> It may be that as different kinds of legislation come under scrutiny in future, other aspects of "fundamental justice" will emerge as more or less powerful "lenses" are employed under s. 7. (Counsel for the plaintiffs, citing *R. v. Arcand 2010* ABCA 363, indeed contended that "parity" has been recognized as a new principle of fundamental justice under s. 7, although not by the Supreme Court of Canada. If anything, parity would seem to be simply another lens that might be employed where criminal sentences are challenged, for assessing laws under the established principles). The point is that if lower courts are to be free to reconsider and depart from established precedent every time the Supreme Court of Canada articulates a new refinement or variant of what are now principles of fairly long standing, the role of such principles as the "shared assumptions upon which our system of justice is founded" (see *Canadian Foundation for Children,* at para. 8) will inevitably decline, along with, we suggest, the public's perception of the role of courts as the legitimate arbiters of legislation under the charter. (Court of Appeal for British Columbia, 2013, para. 313)

They further stated that with "all due respect to the trial judge, we believe that she was bound by *stare decisis* to conclude that the plaintiffs' case had already been determined by the Supreme Court of Canada" (Court of Appeal for British Columbia, 2013, para. 316). The judges were of the belief that section *241(b)* of the Criminal Code did not violate s. 7 and like previous opinions, held that any assumed violation of s.15 was justified under section one. "*Had it been necessary to consider s. 1 in connection with a violation of s. 7, the majority opined that the s. 1 analysis carried out in respect of s. 15 would have led to the same conclusion – that the 'blanket protection' of s. 241 was justified. The majority allowed the appeal on this basis* [italics in original]" (Court of Appeal for British Columbia, 2013, para. xiv). Two weeks later, on October 25, 2013 (BCCLA, n.d.), the BCCLA filed for Leave to Appeal to the Supreme Court of Canada.

The BCCLA pointed out that despite the Court of Appeal's claim around *stare decisis*, "there have not only been significant jurisprudential changes since *Rodriguez,*" but also a change "in the social and legislative facts" (Arvay, Tucker & Latimer, 2013a, para. 7). Of these, one such comparison was to that of *Ontario (Attorney General) v. Fraser, 2011 SCC 20* where the Supreme Court of Canada in its decision "outlined a number of criteria which may, depending on the circumstances of each case, be relevant in deciding whether departure from precedent is appropriate" (Arvay, Tucker & Latimer, 2013a, para. 6). The BCCLA noted that many of the criteria in *Fraser* favoured revisiting *Rodriguez* because

> (a) the significant and material change in social and legislative facts has robbed the precedent of justification; (b) the constitutional arguments in this case include ones neither advanced nor considered in *Rodriguez;* (c) a contemporary application of the relevant legal principles demands a different conclusion, undermining the validity of *Rodriguez* as precedent and demonstrating that *Rodriguez* was wrongly decided; and (d) the evidence in this case demonstrates that the absolute ban upheld in *Rodriguez* fails to reflect *Charter* values, creates unfairness and defies workability. Fundamentally, the rationales of certainty, consistency, predictability and institutional legitimacy simply do not outweigh the need to overturn *Rodriguez* as a precedent. (Arvay, Tucker & Latimer, 2013a, para. 6)

They stated that if two justices (the trial judge and the Chief Justine on appeal) had already found the impugned provisions unconstitutional when assessed on the present record and against current law (Arvay, Tucker & Latimer, 2013a), then that alone made the case worthy of Supreme Court of Canada examination.

The BCCLA went on to highlight the experience of other jurisdictions which permit or do not criminalize assisted dying as of 2013 (see section 1.6 for a comprehensive list of current jurisdictions) which included the Netherlands, Belgium, Luxembourg, Switzerland, Oregon, Washington, Montana and Colombia (Arvay, Tucker & Latimer, 2013a), none of which had been legalized during the time of *Rodriguez.* They pointed out that despite the existence of laws in these jurisdictions, current end of life practices in Canada for those in need (similar to that of any of the prior lead plaintiffs) included palliative sedation or the refusal of treatment which was worrisome as "two of the remaining five witnesses have attested that they may be obliged to end their lives prior to final judgment of this Court, should leave be granted, and without the assistance of a physician, before they would otherwise wish to, due to their declining condition and of the resulting psychological distress that this impending reality imposes on them" (Arvay, Tucker & Latimer, 2013b, para. 8). They concluded that for these reasons and many more, this matter was one of extreme urgency. A few months later, on January 26, 2014, the Supreme Court of Canada announced it would hear the case and on October 15, 2014, the two groups met back in court (BCCLA, n.d.).

In a detailed "Factum of Appellants," counsel for the plaintiffs brought to light several facets of the previous Supreme Court of Canada cases, including the fact that *Rodriguez* had occurred in a time in which laws and advances in medicine were not what they were in present day. It was noted that the Supreme Court could not solely rely on what was found in *Rodriguez* as:

> The record in this case also includes detailed evidence regarding current legal end-of-life practices and medical decision-making practices including extensive expert evidence regarding competence, independence, information obligations, patient resolve and the ability to assess these through informed consent for medical decision-making, the risks in these practices, how these practices and risks are (and are not) regulated, and the ethics of same. The record also contains extensive evidence about the actual impact of the current law. The *Rodriguez* record contained nothing comparable. (Arvay, Tucker & Latimer, 2014, para. 36)

With these additions stood the fact that there was now extensive evidence from the other jurisdictions in which some form of assisted death was decriminalized, including statistics around the people who were using the services and the lack of concern around abuses of the system. Many assumptions made in *Rodriguez* were therefore argued by the trial lawyers to have been proven invalid under this criterion.

Along with this evidence stood several considerations around the key terms associated with each of the cases from *Rodriguez* onwards, including the notion of fundamental justice and their principles thereof. Counsel for the plaintiffs noted that Justice Smith and other judges across the cases had struggled with the idea of "legislative objective" when it came time to analyze said terms, especially in relation to the impugned provisions.

> All three principles - arbitrariness, overbreadth, and gross disproportionality – compare the rights infringement caused by the law with the objective of the law, not with the law's effectiveness. That is, they do not look to how well the law achieves its object, or to how much of the population the law benefits. They do not consider ancillary benefits to the general population.

> Furthermore, none of the principles measure the percentage that is negatively impacted. The analysis is qualitative, not quantitative. The question under s. 7 is whether *anyone's* life, liberty or security of the person has been denied by a law that is inherently bad; a grossly disproportionate, overbroad, or arbitrary effect on one person is sufficient to establish a breach of s. 7. (Bedford as qtd. in Arvay, Tucker & Latimer, 2014, para. 58)

Counsel further stated that the impugned laws do not adequately give enough weight to the core values of the *Charter* which include equality, dignity and autonomy. "Prohibiting *everyone* in *every* circumstance from seeking assistance to end their suffering by dying captures a great number of individuals, who, while perhaps making a choice that not everyone agrees with and is offensive to some people, falls short of engaging the harms at which the legislation is aimed" (Arvay, Tucker & Latimer, 2014, para. 135). The Attorney General of Canada in addressing the impugned provisions conceded that Canadian criminal law does not recognize a distinction "between intentionally bringing about a prohibited consequence and doing something knowing that the prohibited consequence is virtually certain to result" (Reasons as qtd. in Arvay, Tucker & Latimer, 2014, para. 85). Many ethically and medically justified treatments are provided in similar circumstances:

> Yet, providing a fatal prescription or injection to a decisionally capable suffering patient, at their request and as medical care, is assisted suicide or murder, and the materially and morally equivalent conduct of intentionally hastening death by withdrawing treatment or administering palliative sedation at a patient's request is entirely lawful. The disparity is gross as can be: for one, the highest possible criminal sanction: murder; for the other: nothing. (Arvay, Tucker & Latimer, 2014, para. 85)

In concluding their factum, Counsel for the plaintiffs requested that if the Court were to suspend a declaration of invalidity "it should outline a mechanism whereby such individuals can seek recourse to the courts to have their right to seek to have PAD provided to them by a physician who is satisfied it is appropriate treatment in the circumstances, vindicated on an individual basis pending expiration of the suspension" (Arvay, Tucker & Latimer, 2014, para. 164). To not do so, they claimed, was to leave the grievously and irremediably ill with whom they were trying to protect, at risk.

The Supreme Court of Canada declared the main issue of the case as "whether the prohibition on physician-assisted dying found in s. 241*(b)* of the *Criminal Code* violates the claimants' rights under ss. 7 and 15 of the *Charter*" (2015, para. 40). While addressing the appellants claims around each, the Court made note of two preliminary issues: "(1) whether this Court's decision in *Rodriguez* can be revisited; and (2) whether the prohibition is beyond Parliament's power because physician-assisted dying lies at the core of the provincial jurisdiction over health" (Supreme Court of Canada, 2015, para. 41). Discussing the concept of *stare decisis*, the Supreme Court conceded that the doctrine that lower courts must follow the decisions of higher courts is fundamental to the Canadian legal system. "However, *stare decisis* is not a straitjacket that condemns the law to stasis" they noted. "Trial courts may reconsider settled rulings of higher courts in two situations: (1) where a new legal issue is raised; and (2) where there is a change in the circumstances or evidence that 'fundamentally shifts the parameters of the debate'" (Supreme Court of Canada, 2015, para. 44). They completed the sentiment by disagreeing with Canada's counsel, indicating that both conditions were met in this case and that it was open to the trial judge to reconsider s. 15 of the *Charter* due to the fundamental changes in the facts since *Rodriguez.*

Regarding the right to life, liberty and security of the person under s. 7 of the *Charter,* the Court found that the prohibition on physician-assisted dying had the effect of forcing some individuals to take their lives prematurely and that the trial judge was right in stating that the right to life was engaged through this case (Supreme Court of Canada, 2015). The Supreme Court held, however, that:

> …we do not agree that the existential formulation of the right to life *requires* an absolute prohibition on assistance in dying, or that individuals cannot "waive" their right to life. This would create a "duty to live" rather than a "right to life", and that would call into question the legality of any consent to the withdrawal or refusal of life-saving or life-sustaining treatment. The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But s. 7 also encompasses life, liberty and security of the person during the passage to death. It is for this reason that the sanctity of life "is no longer seen to require that all human life be preserved at all costs" (*Rodriguez,* at p. 595, per Sopinka J.). And it is for this reason that the law has come to recognize that, in certain circumstances, an individual's choice about the end of her life is entitled to respect. (2015, para. 63)

Furthermore, the Court held that an individual's response to a grievous and irremediable medical condition is a matter "critical to their dignity and autonomy" (2015, para. 66) and that current laws interfere "with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty" (2015, para. 66). The Court agreed that the prohibition on assisted dying limited Gloria Taylor's right under s. 7 of the *Charter* to right to liberty and security of the person.

Canada argued in their case that the trial judge made a "palpable and overriding error in concluding that safeguards would minimize the risk associated with assisted dying" (Supreme Court of Canada, 2015, para. 108). They argued that the judge was contradicting herself by stating the risk was acceptable when also stating that some of the evidence on safeguards was weak, and that the judge erred by "relying on cultural differences between Canada and other countries in finding that problems experienced elsewhere were not likely to occur in Canada" (Supreme Court of Canada, 2015, para. 108). The Court disagreed, stating that Canada's points were "unsupported, arbitrary, insufficiently precise or otherwise in error. At most, Canada's criticisms amount to 'pointing out conflicting evidence', which is not sufficient to establish a palpable and overriding error" (2015, para. 109). Similarly, the Court disagreed with Canada on arguments raised on minimal impairment, siding with the trial judge due to the exhaustive evidence analyzed in the original ruling.

On February 6, 2015, the Supreme Court of Canada, upon reviewing the substantive amounts of evidence submitted to the Court and in hearing the testimonies of several experts during the Carter v. Canada appeal, concluded that "the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced" (2015, para. 105). For this reason:

> We have concluded that the laws prohibiting a physician's assistance in terminating life (*Criminal Code,* s. 241*(b)* and s. 14) infringe Ms. Taylor's s. 7 rights to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice, and that the infringement is not justified under s. 1 of the *Charter.* To the extent that the impugned laws deny the s. 7 rights of people like Ms. Taylor they are void by operation of s. 52 of the *Constitution Act, 1982.* It is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons.
>
> The appropriate remedy is therefore a declaration that s. 241*(b)* of the *Criminal Code* are void insofar as they prohibit physician-assisted death 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. “Irremediable”, it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought. (Supreme Court of Canada, 2015, paras. 126-127)

They concluded by stating succinctly “The appeal is allowed” (2015, para. 147), voting unanimously 9-0 to allow medically assisted deaths to be an option for Canadians. In commenting on the decision moments after it was made, Grace Pastine on behalf of the BCCLA stated: “This is a tremendous victory for human rights and for compassion at the end of life. What this decision means is that Canadians who are suffering unbearably at the end of life will have a choice now” (Eastwood, 2016, 37:48). In making the decision, the Canadian judicial system put the autonomy of one’s life back in the hands of the individual, giving the government until Feb. 6, 2016 to write new laws on the matter. In December 2015, the newly appointed federal government requested a 6-month extension to finalize legislation. In January of 2016 the Supreme Court granted the government a 4-month extension to rewrite the laws, while still allowing critically ill Canadians the right to exercise a physician-assisted death as of Feb. 6, 2016 (Eastwood, 2016, 41:35). On June 17, 2016, sixteen months after the ban against assisted dying was struck down, legislation came into effect and Canadian history was made with the Medical Assistance in Dying (MAID) Act.

1.3. Medical Assistance in Dying (MAID) Act

The Medical Assistance in Dying (MAID) act made a substantial impact on both Canadians and the Criminal Code with its introduction in 2016. Bill C-14, “An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)” (Government of Canada, 2016) was a royal assent which made changes or additions to over 50 sections of the Criminal Code and resulted in the development of an entirely new section dedicated solely to medical assistance in dying. The enactment made amends to the Criminal Code to, among other things,

> (a) create exemptions from the offences of culpable homicide, of aiding suicide and of administering a noxious thing, in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying and to permit pharmacists and other persons to assist in the process;

> (b) specify the eligibility criteria and the safeguards that must be respected before medical assistance in dying may be provided to a person;
>
> (c) require that medical practitioners and nurse practitioners who receive requests for, and pharmacists who dispense substances in connection with the provision of, medical assistance in dying provide information for the purpose of permitting the monitoring of medical assistance in dying, and authorize the Minister of Health to make regulations respecting that information; and
>
> (d) create new offences for failing to comply with the safeguards, for forging or destroying documents related to medical assistance in dying, for failing to provide the required information and for contravening the regulations. (Government of Canada, 2016, p. 2)

Moreover, the enactment made related amendments under the *Pension Act, Canadian Forces Members and Veterans Re-establishment and Compensation Act* and the *Corrections and Conditional Release Act* (Government of Canada, 2016, p. 2). In addition, it was declared that at the start of the fifth year after the day in which royal assent was received, the provisions in the MAID Act must be referred to "the committee of the Senate, of the House of Commons or of both Houses of Parliament" (Government of Canada, 2016, p. 14) for the purpose of review along with the state of palliative care in Canada, resulting in a report which sets out recommendations by the committee.

In addressing changes made to the Criminal Code, Bill C-14 changed section 14, consent to death, from stating that no person may consent to death being inflicted upon them, to "no person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person giving consent" (Government of Canada, 2016, p. 3). This resulted in ancillary adjustments to the Code, namely the addition of section 227 immediately following the previously held section 226, acceleration of death, which states "where a person causes to a human being a bodily injury that results in death, he causes the death of that human being notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause" (Government of Canada, 1985, p. 339). Section 227.1, "Exemption for medical assistance in dying," therefore addressed this provision, stating "No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241.2" (Government of Canada, 2016, p. 3), while section 227.2 states "no person is a party to culpable homicide if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2" (Government of Canada, 2016, p. 3). In addition, section 227.4 specifically notes that a person seeking to use medical assistance in dying is no longer responsible for their death under s. 14 of the Criminal Code. Section 227.2 through s. 227.5 include provisions specific to the "Exemption for person aiding practitioner," "Reasonable but mistaken belief," "Non-application of section 14" and "Definitions" (Government of Canada, 2016, p. 3) applicable to the act.

Notably, Bill C-14 made significant changes to section 241 of the Criminal Code on counselling or aiding suicide. Section 241 (1) now reads: "Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not; (a) counsels a person to die by suicide or abets a person in dying by suicide; or (b) aids a person to die by suicide" (Government of Canada, 1985, s. 241). Exemptions for medical assistance in dying under 241 (2) now state: "No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2" (Government of Canada, 2016, p. 4), while subsequent additions outline exemptions for person aiding practitioners, pharmacists and person aiding patients. The result of the Medical Assistance in Dying Act therein relates directly to section 241 of the Criminal Code as sections 241.1 to 241.4 were added specifically to address MAID practices in Canada. Moreover, section 241.1 provides pertinent definitions for each of the terms relating to the act, the full breakdown which is as follows.

> 241.1 The following definitions apply in this section and in section 241.2 to 241.4.
>
> *medical assistance in dying* means
>
> (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*)
>
> *medical practitioner* means a person who is entitled to practise medicine under the laws of a province. (*médecin*)
>
> *nurse practitioner* means a registered nurse who, under the laws of the province, is entitled to practise as a nurse practitioner – or under an

> equivalent designation – and to automatically make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients. (*infirmier praticien*)
>
> *pharmacist* means a person who is entitled to practise pharmacy under the laws of a province (*pharmacien*). (Government of Canada, 2016, p. 5)

While language choices in these definitions are not consistent with other jurisdictions where physician assisted suicide or euthanasia is legal, the underlying relevance of the terms in relation to the legislation held is much the same.

Of changes and amendments made to the Criminal Code, the most pertinent can be found in s. 241.2 (1), “Eligibility for medical assistance in dying,” which reads,

> a person may receive medical assistance in dying only if they meet all of the following criteria:
>
> (a) they are eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada;
>
> (b) they are at least 18 years of age and capable of making decisions with respect to their health;
>
> (c) they have a grievous and irremediable medical condition;
>
> (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
>
> (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (Government of Canada, 2016, pp. 5-6)

From this came the addition of s. 241.2 (2), “Grievous and irremediable medical condition” in which a person is recognized as having a grievous and irremediable medical condition only if they meet all the following criteria:

> (a) they have a serious and incurable illness, disease or disability;
>
> (b) they are in an advanced state of irreversible decline in capability;
>
> (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
>
> (d) 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. (Government of Canada, 2016, p. 6)

This eligibility remains in line with other jurisdictions where some version of assisted death is legislated and demonstrates in part a framework with which MAID practices are applied. The remaining sections of the medical assistance in dying additions to the Criminal Code outline in full its process and associated terms, as well as legal exemptions relating to the 2016 act.

Health Canada, in a news release titled *Government of Canada releases Fourth Interim Report on Medical Assistance in Dying,* notes that “there have been at least 6,749 medically assisted deaths in Canada since the legislation was enacted in June 2016” (2019, para. 4). The Honourable Ginette Petitpas Taylor, Minister of Health for Canada, in the release states: “I would like to thank the provinces and territories for their collaboration in producing this series of interim reports on medical assistance in dying in Canada. The Government recognizes that monitoring and reporting are critical to ensuring transparency and trust in the legislation” (2019, para. 3). The topic of safeguards, consent, independence, guidelines and punishment surrounding the notion are further outlined in the Criminal Code and on the Government of Canada website.

1.4. The Council of Canadian Academies

While legislation in Canada changed with the addition of the medical assistance in dying act, the debate around eligibility criteria and safeguards remained active. Among these issues were three primary areas of concern, “including the criteria that people under the age of 18 are not eligible for MAID; that it is not possible for a person to consent to MAID through an advance request; and that very few people with a mental disorder as their sole underlying medical condition will meet eligibility criteria for MAID (e.g., that natural death must be reasonably foreseeable)” (Council of Canadian Academies, 2018a, p. 2). In questioning whether to prohibit or permit MAID for individuals who fall within these three categories, the Ministers of Health and Justice, on behalf of Health Canada and the Department of Justice Canada called upon parliament to conduct “independent, evidence-informed reviews of the state of knowledge on MAID as it related to these three topic areas” (Council of Canadian Academies, 2018a, p. 2), herein referred to as debates around advanced directives (distinct from advanced requests), mature minors and mental disorders.

The task fell to the Council of Canadian Academies (CCA), an "independent, not-for-profit organization that supports independent, science-based, authoritative expert assessments to inform public policy development in Canada" (Council of Canadian Academies, 2018a, p. iii). Led by a Board of Directors and a Scientific Advisory Committee, "the CCA's work encompasses a broad definition of science, incorporating the natural, social and health sciences as well as engineering and the humanities" (Council of Canadian Academies, 2018a, p. iii) and is supported by its three founding academies: The Royal Society of Canada (RSC), The Canadian Academy of Engineering (CAE) and The Canadian Academy of Health Sciences (CAHS) (Council of Canadian Academies, 2018a).

In order to address the questions as laid out by Parliament, with the objective of gathering information and evidence relevant to the three topic areas to inform a "national dialogue among the Canadian public, and between the public and decision-makers,"

> the CCA assembled a multidisciplinary panel of 43 experts from Canada and abroad (the Panel), divided into three Working Groups. Each Working Group focused on one of the three topic areas. The Panel's expertise covered academic, clinical, legal, and regulatory fields from the disciplines of medicine, nursing, law, bioethics, psychology, philosophy, epidemiology, anthropology, and sociology. Each member served on the Panel on a *pro bono* basis as an informed individual, rather than as a representative of a particular community, discipline, organization, or region. (Council of Canadian Academies, 2018a, p. 4)

Throughout the process, the Panel was asked to identify the range of knowledge and evidence related to the charge, examine all evidence held and interpret it in the form of findings which resulted in three bodies of work: *The State of Knowledge on Advance Requests for Medical Assistance in Dying; The State of Knowledge on Medical Assistance in Dying for Mature Minors;* and *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition* (Council of Canadian Academies, 2018a; 2018b; 2018c). Given the complex nature of the topics, the Panel "recognized the importance of interpreting evidence broadly and included empirical evidence such as peer-reviewed research and grey literature, normative evidence such as bioethical argumentation, and other forms of evidence such as lived experiences" (Council of Canadian Academies, 2018a, p. 6). To complete these tasks, the Panel "identified and assessed evidence that was found in, but was not limited to, peer-reviewed publications from health disciplines, ethics, social sciences, humanities, and law; professional standards and guidelines; regulatory, legislative, and compliance materials; policy documents; and media reports" (Council of Canadian Academies, 2018a, p. 6). With these was a "Call for Input" inviting written input from "500 groups and organizations across Canada, affected by, or involved in, MAID" (Council of Canadian Academies, 2018a, p. 7). Together, these reports are a synthesis of knowledge combined through academic and policy literature, the results from the call for input and the diverse interdisciplinary and professional expertise from the individuals making up the Panel and Working groups.

The Panel made several key distinctions in the three reports, most notably around the understanding of the topic and the terminology found within the three topic areas. The Working Groups also made note that "the gathered evidence often used alternative words and phrases, including *euthanasia, assisted suicide, physician-assisted suicide, physician-assisted death,* or *medical aid in dying"* (Council of Canadian Academies, 2018a, p. 5). Depending on the jurisdiction being referenced in the specific report (see section 1.6), terminology used was specific to each jurisdiction.

1.4.1. The State of Knowledge on Advance Requests for Medical Assistance in Dying

In the report, *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, the Panel defines an "advance request (AR)" for MAID as

> a request for MAID, created in advance of a loss of decision-making capacity, intended to be acted upon under the circumstances outlined in the request after the person has lost decisional capability.
>
> ARs for MAID should be distinguished from provincially and territorially regulated *advanced directives*, which are documents that "allow a decisionally-capable individual either to designate someone to make decisions about health care on his or her behalf, or to specify types of treatment to be accepted or rejected, should the need arise, or both," (Gilmour as qtd. in Council of Canadian Academies, 2018a, p. 5) in the event the individual loses decision-making capacity. (2018a, p. 5)

In more recent history, Canada's healthcare system has identified two approaches with which ARs would be situated: patient-centred care and advance care planning (ACP). In patient-centred care, while patients cannot demand treatments outside the standard of care, a patient-centred approach "values communication, partnership, and health promotion – the relationship between the healthcare practitioner and patient is one of collaboration towards the common goal of patient-well being" (Constand as qtd. in Council of Canadian Academies, 2018a, p. 36). ACP on the other hand, is a "process of thinking about and sharing your wishes for future health and personal care" (Speak Up as qtd. in Council of Canadian Academies, 2018a, p. 3), which can be informal (conversations with family) but may also include formal documentation in the form of advanced directives.

As noted by the Supreme Court of Canada in their 2015 decision on the matter, "the ethical similarity between MAID and the refusal or withdrawal of treatment is questionable and often contested. Respecting patient autonomy recognizes a patient's authority over their bodily integrity and their right to accept or refuse a healthcare intervention" (as qtd. in Council of Canadian Academies, 2018a, p. 37). Both advanced directives and advanced requests for MAID can include decisions that result in a person's death. "ARs for MAID differ from advance directives in that they inevitably involve a third party who must, based on a documented request, determine the exact timing and circumstances of a person's death" (Council of Canadian Academies, 2018a, p. 39). This is in comparison to advanced directives which "do not compel a third party to decide that another person is ready to die, though the withdrawal or withholding of treatment may certainly result in death" (Council of Canadian Academies, 2018a, p. 39). Were ARs for MAID allowed in Canada, "it is unclear how their regulatory framework would differ from that of advanced directives. On the one hand, healthcare regulation falls largely under provincial/territorial jurisdiction, and advance directives legislation varies considerably among provinces and territories…ARs for MAID would require a regulatory framework that involved both criminal law and provincial/territorial regulation" (Council of Canadian Academies, 2018a, p. 169). Allowing ARs for MAID would require newly formed legal considerations for the limits of effective consent, as well as amendment to the *Criminal Code.*

With ARs for MAID comes the notion of risks and safeguards, along with concerns that must be addressed before changes can be made. Of these:

> The primary risk involved in ARs for MAID is the risk that a person will receive an assisted death against their wishes. This risk is influenced by systemic and societal pressures, such as accessibility or availability of care, stigma associated with a loss of decision-making capacity, or biased

> assumptions about quality of life, and may manifest in either the motivations of the person writing the AR for MAID or in a third party's interpretation of the request. Case-specific pressures, including uncertainties about the AR for MAID itself, the patient's condition, and relationships among the patient, SDM, and healthcare team, also affect this risk. (Council of Canadian Academies, 2018a, p. 173)

There is also concern that by allowing ARs for MAID, that there may be an impact on the way that society values individuals who suffer with a loss capacity, signalling that it is acceptable to consider a life with capacity loss as one not worth living (Council of Canadian Academies, 2018a). The main issue with ARs for MAID, however, remains the uncertainty faced by those responsible on gauging when or whether the patient desires an assisted death. While many people may fall under the eligibility criteria, many things must be considered first, such as whether an advance request for MAID written at the age of 30 should still be honoured at the age of 65? Safeguards represent an effort to mitigate said risks, but policy makers need to judge whether they believe safeguards can sufficiently outweigh all risk, or whether mitigating some risk is enough to justify adjusting the law. In addition, there is still current disagreement in the medical and legal communities around the extent to which MAID should be a standard medical practice, a topic which must be addressed before any adjustments to legislation can be made.

1.4.2. The State of Knowledge on Medical Assistance in Dying for Mature Minors

In the report titled *The State of Knowledge on Medical Assistance in Dying for Mature Minors*, the Panel denotes several key terms applicable to the topic area, including those differences between *minors, mature minors,* and *adults.* Adults are defined as "people who have reached the age of majority" while minors are defined as "people under the age of majority, which is 18 or 19 depending on the province or territory" (MacIntosh as qtd. in Council of Canadian Academies, 2018b, p. 36). Mature minors, however, are not defined by their age, but rather by their ability to make informed decision-making. To have such capacity, a person must be able to "understand and appreciate the information relevant to a particular decision or type of decision, and the consequences of making that decision (or of not making a decision)" (Council of Canadian Academies, 2018b, p. 36). While there is no universally accepted definition of the term 'mature minor,' Canadian courts, common law, and health law and policy generally view a mature minor as "a person under the age of majority with the capacity to make an informed healthcare decision and the ability to act voluntarily with respect to that decision" (Gilmour as qtd. in Council of Canadian Academies, 2018b, p. 36). Other related terms include those distinctions between a *child, adolescent* or *youth*, all of which are terms found within the report. The term 'child' is usually used in a general context to refer to a person under the age of 18, however the World Health Organization (WHO) uses the age range of 1-10 years to distinguish children from adolescents, the latter of which they define as individuals who are 10 to 19 years in age (Council of Canadian Academies, 2018b). Youth on the other hand, fall within a much broader and harder to pin down age range, as studies have disagreed many times on whether to define youth based on biology, psychology, social standards, or other criteria. Taking this into account, the WHO places 'youth' in the range of 10 to 24 years (Council of Canadian Academies, 2018b), whereas mature minors in this context are considered to fall into the same range as adolescents.

The Supreme Court of Canada recognizes that the healthcare decision-making capacity of minors is not solely determined by age, but also tied to their evolving maturity (Council of Canadian Academies, 2018b). In most non-medical contexts, an age cut-off is commonplace, such as in driving, voting, consumption of alcohol and so forth. The Working Group on this topic notes that unlike the aforementioned contexts, "denying someone the ability to make healthcare decisions has potential implications for their bodily integrity…if a minor were faced with a terminal condition and not permitted to make their own end-of-life decisions, this right would be forever taken from them" (Council of Canadian Academies, 2018b, p. 38). This concept of decisional capacity is central to the definition of a mature minor and is also a key element of informed consent. Voluntariness and information disclosure are two other important elements of consent as "the patient must make a voluntary choice, free from duress or coercion, and must be provided with information in a way that facilitates understanding" (Council of Canadian Academies, 2018b, p. 45). As part of informed consent, healthcare practitioners are obligated to discuss the nature and purpose of a proposed treatment, its potential risks and benefits, and available alternatives or options (Council of Canadian Academies, 2018b). This must be provided in a way that facilitates understanding by avoiding ambiguity and jargon and for minors, means providing developmentally appropriate information (i.e., scaling down complicated terms to the age and capacity of the minor in question).

The adage that one way to protect people from being coerced into something is to not allow them the opportunity holds true with MAID. One method of protecting people from being coerced to end their lives is to exclude them from accessing MAID at all (Council of Canadian Academies, 2018b). However, “excluding mature minors from MAID also means that someone who is a few months short of their 18th birthday, but meets all other eligibility criteria, is not able to access a medically assisted death, regardless of how reasoned and thoughtful their request may be, whether their family supports the request, and whether their healthcare team is willing and able to provide such assistance” (Council of Canadian Academies, 2018b, p. 119). As the Right to Die Society of Canada notes “while minors may ‘awaken ‘protective’ feelings in others,’ they have not signed a duty-to-live contract with the universe any more than adults have” (as qtd. in Council of Canadian Academies, 2018b, p. 124). The Canadian Coalition for the Rights of Children (CCRC) echoes this sentiment, pointing out that there is “no evidence that the intolerable suffering of mature minors, who are equally aware of their current condition and what they face in the future, is any more tolerable than that of the similarly situated capable person over 18 years of age” (as qtd. in Council of Canadian Academies, 2018b, p. 120). It also questions whether an individual is any more mature the day before their 18th birthday than they are the day of it.

While decisional capacity holds a developmental component, “minors must not be understood as a homogenous group in terms of their development because cognitive and psychosocial development varies. Furthermore, the capacity to make healthcare choices is also a product of factors that are not dictated by chronological age, such as social and cultural environments and personal experience with illness and medical settings” (Council of Canadian Academies, 2018b, p. 146). The hesitancy to allow MAID for mature minors reflects uncertainty about their ability to fully appreciate the consequences of such a decision and to make it without impulsiveness. There is also concern that some terminally ill mature minors may feel pressured to request MAID, not for themselves, but to protect their families from financial burden or emotional distress.

> Another concern is that allowing mature minors to request MAID might also normalize suicide among young people, especially those who struggle with mental disorders and may be considered vulnerable. However, rather than focusing on the inabilities of certain groups, it is important to recognize vulnerability as a social construct generated by society’s treatment of these groups. Thus, there is a social responsibility to those who may be perceived as vulnerable by facilitating their ability to make informed, autonomous

> decisions, rather than diminishing their rights and limiting their options. (Council of Canadian Academies, 2018b, p. 149)

Additional considerations revolve around how to address the requirements for respecting individual autonomy in health-related decision-making, promoting equity, and alleviating intolerable suffering while also taking every measure to prevent harms to mature minors (Council of Canadian Academies, 2018b). The fact that only two jurisdictions allow euthanasia for minors, and even then, very rarely, means little is known for certain about the practice. The views of young people are critical in moving forward with this issue.

1.4.3. The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition

In the final report, *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition,* the phrase "sole underlying medical condition" is used to differentiate between cases in which a person with a mental disorder already meets eligibility criteria for MAID (e.g., death is reasonably foreseeable) from those cases in which a mental disorder is the only illness, disease or disability that motivates the request (Council of Canadian Academies, 2018c). Shorthand for this phrase refers to this topic as MAID MD-SUMC for the remainder of the report with special weight given to the terms *prohibiting* (refers to the status quo in Canadian law and restricting MAID MD-SUMC further) and *permitting* (acknowledges that the current law allows MAID MD-SUMC, provided a person meets all of the eligibility criteria) (Council of Canadian Academies, 2018c). Important to note, Working Group members did not come to a consensus on most issues found within the report:

> These issues include the weighing of different outcomes resulting from prohibiting or permitting more MAID MD-SUMC, the ethical and practical significance of the reasonable foreseeability of a person's death in the context of MAID, the distinction (or lack thereof) between suicide and MAID MD-SUMC, the impact of permitting more MAID MD-SUMC on current suicide prevention strategies, and the distinction (or lack thereof) between MAID and other highly consequential decisions that may result in a person's death (e.g., refusing life-sustaining treatment). (Council of Canadian Academies, 2018c, p. 36)

Working Group members did, however, collectively rely on the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) to determine which conditions should be considered under the umbrella of "mental disorders" (Council of

Canadian Academies, 2018c). In this report, the term “mental disorders” includes the full range of conditions from this Canadian psychiatric diagnostic classification scheme.

Mental disorders can be defined as “health problems that disturb or impair a person’s thoughts, experiences, emotions, behaviour, and/or ability to relate to others” (Council of Canadian Academies, 2018c, p. 37), a broad definition that includes hundreds of conditions across a diverse clinical profile. Mental disorders may be characterized as being of a relapsing and remitting course, a stable course, a course of progressive decline or an unpredictable course (Course of Canadian Academies, 2018c). Notably:

> The threshold at which an experience or behavior becomes pathological is often determined not only by biological and psychological factors, but also by social factors and cultural norms. In short, the identification, classification, and diagnosis of mental disorders are not exclusively scientific, objective, and value-neutral; rather, some normative, subjective, or value-laden sociocultural conception of what counts as normal often frames society’s and clinicians’ perceptions of mental health and mental disorders. (Perring as qtd. in Council of Canadian Academies, 2018c, p. 37)

Certain conditions may impact a person’s ability to function personally or professionally, while people with many other conditions can function well to the extent that their mental disorder does not significantly impact their life. “It can be difficult to determine whether a problem is in fact a mental disorder (diagnosis), and how that problem will evolve over time (prognosis)” (Council of Canadian Academies, 2018c, p. 40). It may also be difficult to treat the condition to relieve the person’s suffering (i.e., treatment effectiveness).

In its preamble, Bill C-14 acknowledges the connection between suicide and MAID, noting that “suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities” (Government of Canada as qtd. in Council of Canadian Academies, 2018c, p. 41). While suicide historically was considered a sin or immoral act for religious reasons, the justification for criminalizing the act followed the belief that the threat of punishment might reduce suicides (Council of Canadian Academies, 2018c). However, data collected from studies over the years do not support this theory and over the last century, the modern understanding of suicide has changed. Now, suicide is generally considered to be associated with “mental disorders and difficulty coping with social hardships, rather than as an offence against moral or religious interdictions" (Council of Canadian Academies, 2018c, p. 41). Other explanations of the relationship between mental disorders and suicide suggest that "psychosocial factors resulting from living with a mental disorder (e.g., social isolation, stigma, unemployment, poor social supports)" (Council of Canadian Academies, 2018c, p. 43) also increase suicide risk.

The presence of mental disorders is strongly related to certain social, economic, and environmental inequalities, such as poverty, unemployment, homelessness, and violence (WHO as qtd. in Council of Canadian Academies, 2018c). There is also evidence to show that different gender, ethnic, cultural, socio-economic, and demographic groups experience differences in the prevalence of risk factors for mental disorders (Council of Canadian Academies, 2018c), as well as access to mental healthcare and social supports. "Canadian data shows that women, youth and Indigenous people have higher rates of mental health problems than the Canadian average. Depression, anxiety disorders, and eating disorders are more common in women, and are strongly associated with women's greater exposure to poverty, discrimination, socio-economic disadvantage, and gender-based violence" (Council of Canadian Academies, 2018c, p. 45). However:

> The relationship between social factors and mental disorders is complex and bi-directional: social factors can increase a person's risk of developing a mental disorder, and having a mental disorder can increase a person's exposure and vulnerability to social factors that are detrimental to their mental health. As Chandler (2016) writes, 'while social marginalization can raise the risk of experiencing a mental health disability, those disabilities also often lead to social marginalization, with higher rates of homelessness and incarceration than the rest of the population.' (as qtd. in Council of Canadian Academies, 2018c, p. 45)

Individuals with mental disorders also face additional challenges in relation to their physical health and are at higher risk for developing chronic physical disorders such as diabetes, heart disease, stroke, and respiratory disease (Council of Canadian Academies, 2018c). They are also less likely to receive treatments for these disorders.

The primary concern surrounding mental disorders in Canada, which are legally and medically complex as well as problematic in many cases, is centred within the current medical landscape. Because of this, "prohibiting or more broadly permitting MAID MD-SUMC is a question that must be considered alongside key issues such as eligibility criteria, including capacity to provide consent; vulnerability and autonomy; the state of mental healthcare and treatment in Canada; and the realities of suicide" (Council of Canadian Academies, 2018c, p. 62). As part of the eligibility criteria for MAID includes providing informed consent, an individual must be capable of making decisions related to their health by being mentally competent or capable. "A person is mentally competent or capable when they have the capacity to understand the nature and consequences of their actions and choices, including decisions related to medical care and treatments" (Council of Canadian Academies, 2018c, p. 64). As mental disorders can affect decision-making in many ways, it is important to consider the individual conditions at hand, such as neurocognitive disorders like dementia which result in a clear decline in cognitive abilities versus more anxiety-based disorders such as depression which can impair a person's capacity for decision making based on their mood and emotions (Council of Canadian Academies, 2018c). Other considerations include the number of symptoms which vary from condition to condition and are often found in multiple conditions, making assessment challenging.

Therefore, the evaluation of capacity is not straightforward, even when tools are used, "because these tools provide data on a scale of a person's abilities (such as the ability to understand and appreciate information, to think and reason rationally, and to communicate a stable choice), whereas the task of the evaluator is to generate a categorical yes or no judgment about the patient's capacity to make a particular decision" (Council of Canadian Academies, 2018c, p. 66). Even if tools are reliable, this does not mean that they are valid. *Reliability* "is the degree to which an assessment test or tool produces stable and consistent results" whereas the *validity* of the capacity assessments – "how well they actually measure the capacity to make decisions – cannot be measured by agreement amongst capacity assessors…Reliability does not guarantee validity, although reliability is a necessary condition for validity" (Council of Canadian Academies, 2018c, pp. 67-68). There is no objectively correct answer to the question of whether an individual has capacity, which further muddles decision-making.

One unique challenge in assessing decision-making capacity for MAID MD-SUMC for people with mental disorders is that their desire to die could be a symptom of their condition (Applebaum as cited in Council of Canadian Academies, 2018c). At the same time, a desire to die may reflect a person's well-thought out decision to end their life, with or without a disorder, and therefore isn't necessarily pathological or nonautonomous. “However, it may be difficult even for experienced clinicians to distinguish between (i) an autonomous, well-considered decision to die in a person with a mental disorder, and (ii) a pathological desire to die that is a symptom of that person’s mental disorder” (Council of Canadian Academies, 2018c, p. 68). Some experts suggest that in order to determine whether a patient’s decision to die is a symptom of their mental disorder, assessments of capacity must consider not only the cognitive abilities, but also the emotions, values, and valuing abilities of the patient (Council of Canadian Academies, 2018c), in tandem with the thoughts they express.

> Clinicians may also assess the long-term stability of a person’s desire to die in order to determine whether it is pathological. A desire to die that decreases as the episode of the mental disorder responds to treatment is more likely to be pathological, and less likely to be an autonomous, well-considered decision. The trajectory of the desire to die is not included as a criterion of the understand/appreciate test for decision-making capacity found in Canadian law; however, stability of choice is part of the most widely used clinical model of capacity. (Council of Canadian Academies, 2018c, p. 69)

In order to be eligible for MAID in Canada, a person must have a serious and incurable condition, however, in medicine, there is no single, universally agreed upon definition of said term. The Stedman’s Medical Dictionary defines *cure* as “[t]o heal; to make well” and “[a] restoration to health” whereas the Oxford English Dictionary defines *incurable* as “cannot be cured; incapable of being healed by medicine or medical skill” (Council of Canadian Academies, 2018c, p, 70). Another consideration is that of *treatment resistance,* “i.e., the absence of meaningful symptom reduction following a certain number or type of interventions under appropriate conditions” (Council of Canadian Academies, 2018c, p. 70). A person’s mental disorder may be considered incurable when “the goal or treatment cannot be achieved, which may or may not include symptom reduction” (Council of Canadian Academies, 2018c, p. 71). Treatment success or failure is often evaluated in terms of functional improvement, symptom reduction or improvement in quality of life (Council of Canadian Academies, 2018c), rather than in terms of “curability.”

The scope of mental disorders is large and covers a wide and diverse range of conditions. In addition, “there is wide variability in symptoms and clinical presentation even with individual diagnostic categories, and the impact of a mental disorder on a person’s thoughts, emotions, behaviour, functioning and quality of life is highly individual.

As such, it is difficult to make any generalizations about this broad category" (Council of Canadian Academies, 2018c, p. 192). Potential implications for a topic area such as this are vast and there are many impacts related to prohibiting or permitting MAID MD-SUMC. "Those who could be impacted include people with mental disorders, healthcare practitioners, people with chronic conditions, and the family and friends of those with mental disorders. Impacts on society include those on the mental healthcare system, suicide prevention, and discrimination and stigma against people with mental disorders" (Council of Canadian Academies, 2018c, p. 193). The main risks of prohibiting or further expanding MAID MD-SUMC relate to the ideas of over- and under-inclusion. "*Over-inclusion* refers to people receiving MAID in cases where it should not occur (due to ineligibility or under influence), while *under-inclusion* refers to capable, eligible individuals not being able to receive MAID. Existing safeguards in Canada's MAID law prevent eligibility for most people with a mental disorder…though there is not a specific blanket prohibition for people with such conditions" (Council of Canadian Academies, 2018c, p. 194). Knowing this, there are several knowledge gaps related to both the effectiveness and legality of certain safeguards surrounding MAID MD-SUMC:

> …even if a safeguard has been implemented elsewhere, its relevance and effectiveness in the Canadian context are unknown. Important contextual factors include: cultures; geographies; demographics; healthcare systems; and legal systems such as different laws, differing judicial approaches, and differences in jurisdictional divisions between the federal government (which is responsible for the *Criminal Code*, which sets out the legal conditions under which MAID is provided) and provincial and territorial governments (which are responsible for the provision of healthcare and mental health law). (Council of Canadian Academies, 2018c, p. 196)

Working Group members disagree about how to balance two main risks: "ending the life of a person with a mental disorder whose condition would have improved and who would have regained the desire to live, and denying MAID MD-SUMC to a person whose condition would not have improved and who would continue to live with intolerable suffering" (Council of Canadian Academies, 2018c, p. 197). Further, the Working Group disagrees about how to interpret and assess the evidence as it relates to the potential implications of prohibiting or permitting more MAID MD-SUMC, though they agree on the need for more research to "understand better, and to a greater depth, the implications for individuals with mental disorders, healthcare practitioners, and society of permitting more or continuing to limit MAID MD-SUMC" (Council of Canadian Academies, 2018c, p. 198).

At time of writing, there have been at least 6,749 medically assisted deaths in Canada since legislation was enacted in June 2016 (Health Canada, 2019), though there are some limitations in the data for the three territories which did not share data due to small numbers reported and Quebec, which has alternative reporting procedures. This lack of consensus is indicative of a larger need for increased study ranging across disciplines before the mandatory review period begins on June 18, 2020.

1.5. Objections to Medical Assistance in Dying

Though legislation is in place for MAID in Canada, the objections to the practice are strong and date back decades for reasons that vary from personal moral objection, to faith-based instruction, to everything in between. As the Canadian Euthanasia Prevention Coalition (EPC) argues, “euthanasia and assisted suicide should continue to be treated as murder/homicide, irrespective of whether the person killed has consented to be killed” (2019a, para. 4). The present law in Canada, as they see it, “does not distinguish between euthanasia, assisted suicide and other forms of murder. The key consideration is the intention to cause death. Consent or motive – even one of compassion – does not change the reality of killing a human being” (Euthanasia Prevention Coalition, 2019a, para. 5). Their concerns regarding MAID are with the perceived promotion of “mercy killing” as a solution to various forms of suffering (pain, aging, mental or physical challenges, social issues etc.), to abuses of the vulnerable, lack of training for medical professionals, depression as a motivating factor for requests and, most prudently, threats to advances in hospice/palliative care (Euthanasia Prevention Coalition, 2019b). MAID in the eyes of the coalition, is a detrimental and dangerous threat to all of these.

Yet as Dr. Will Johnston, chair of the Euthanasia Prevention Coalition, expounds:

> We are forgetting that there is such a thing as natural death and we are sensationalizing death and we are sensationalizing disability, so that now some people who have a disability situation that others are coping with and finding meaning in their lives despite of, are saying ‘it’s intolerable; I should have the right for the state to endorse that my life is not worth living.’ It’s that kind of, essentially, discrimination against the disabled, that kind of tunnel vision - that we are being herded into by the clever propaganda of the pro-euthanasia and pro-assisted suicide movement. (Eastwood, 2016, 8:15)

This notion of abuses of the vulnerable, namely those with disabilities, is one that weighs heavily on the minds of those who are against the idea of medical assistance in dying, particularly the EPC who work to represent this demographic. As Dr. Johnston notes, “the poster cases for assisted suicide are, by the very nature of the fact they’re being used, they’re charismatic people. If I believed what they believed, those are exactly the stories I would choose to publicize. What we have is a triumph of public relations and an abject failure of wisdom” (Eastwood, 2016, 17:59). Moreover as Dr. Johnston further adds, “we have to be very careful about lionizing, idolizing, glamourizing suicidal people. We have a worldwide problem with what we call suicide contagion, copycat suicides” (Eastwood, 2016, 18:21). His belief then, and the belief of the coalition, is that by sensationalizing suicide, we raise the suicidal person to the status of a hero (Eastwood, 2016), which in turn encourages others to cut their lives short.

Margaret Somerville, founding director of the Centre for Medicine, Ethics and Law and professor emerita at McGill University adds in her article *Killing as Kindness,* that while we must take into account these types of stories from affidavits and those presented in the media, they are not the only thing that we should consider.

> There is also a paradox here. The focus is on individual persons’ suffering and, hence, vulnerability. This focus, which is meant to protect vulnerable people, is being used to place them at risk from assisted suicide by legitimizing it. The same reversal of an initial protective goal has occurred with the concept of quality of life. Initially ‘quality of life’ was developed as a concept intended to protect and promote life through the argument that everyone had a right to the resources, especially healthcare resources, needed to maintain an acceptable ‘quality of life.’ Now, the concept is often used to achieve the exact opposite outcome, namely, that a person’s ‘quality of life’ is so poor that they are better off dead, or, at the least, do not merit the expenditure of resources needed to keep them alive. (2016, p. 4)

She goes on to add that just as troubling is the lack of the word “people” or “person” used when discussing these individuals. She notes that this practice is “dehumanizing, depersonalizing, and allows easier dis-identification from the person or people concerned. The ‘end-of-life’ population is a term that marks off the people labeled as such from the general population. They become ‘them,’ in contrast to the ‘rest of us’” (Somerville, 2016, p. 5), which Somerville sees as a deeply unsettling problem.

This carries forward with the notion of suicide overall. As Somerville notes, the difference between suicide and physician-assisted suicide is fundamental. “Suicide is a solitary act we may try to prevent, but which is carried out by the individual, usually in despair. Physician-assisted suicide is a social act in which medical personnel licensed and compensated by the state are involved in the termination of the life of a person with the approval of the state” (2016, p. 6). In doing so we no longer attempt to preserve life, but rather accept and act upon a person’s judgement that his or her life is “unworthy of continuance. It is to see the infliction of death as an ethical, appropriate and justified response to suffering. This is exactly the message that those trying to prevent suicide want to negate totally” (Somerville, 2016, p. 7). Dr. Johnston adds to this by noting that suicide, while not illegal, is very much not desirable. “We’ve simply recognized that the law is a bad instrument in the sense that making suicide be illegal is missing the point because the fact of the matter is, that a disabled person doesn’t need to commit suicide either. It’s because we look with horror on the lives of the disabled that we would suggest that there may be some of them that have a need to commit suicide” (Eastwood, 2016, 20:11), something he and many Canadians are vehemently opposed to.

Catherine Frazee, professor emerita at Ryerson’s School of Disability Studies and Officer of the Order of Canada furthers this sentiment in a 2018 opinion piece in *The Star* by mentioning Roger Foley who “reported that although his claims for disability support arrangements of his choosing have been denied, he is free to pursue a medically assisted death. Assisted life, no. Assisted death, yes” (para. 11). She goes on to add that

> the act of ending the life of another human being raises fundamental questions of human dignity and rights. How will the most vulnerable members of our community be protected from the ultimate harm? How will persons with authority and power be held accountable? How will the kindly but insidious forces of inducement to MAID be kept in check? (Frazee, 2018, para. 16)

As a disabled woman herself, Frazee draws attention to instances in which people with disabilities have suffered violence at the hands of doctors, parents or caregivers. “Sometimes, as with Satoshi Uematsu – who killed 19 disabled people in Japan in 2016 in order to ‘save’ them – the world has instantly recoiled in horror,” she notes, showing one extreme of the spectrum before moving to the other. “Sometimes, as with Robert Latimer, a Saskatchewan farmer who killed his disabled daughter in 1993, a court of law may ultimately uphold a conviction, but not before public opinion solidifies in support of the perpetrator" (Frazee, 2017, para. 8). In both instances, the end-of-life decision has been made by the outside party and not the individual experiencing the disability themselves, a concern which she brings forward with the legislation of assisted death.

Even though end-of-life decisions are deeply personal, in some instances, outside forces are strict in their refusal to understand or accept MAID, such as religious teachings, which are clear in their mandate against the notion of suicide, let alone that of assisted suicide. One such example is that of a document titled *Guidelines for the Celebration of the Sacraments with Persons & Families Considering or Opting for Death by Assisted Suicide or Euthanasia* by The Catholic Bishops of Alberta and the Northwest Territories. Regarding the legislation of assisted suicide in Canada, the document states:

> These grievous affronts to the dignity of human life from beginning to natural end are never morally justified. The legal permission now granted to these practices does not change the moral law. The teaching of the Church on these matters is clear. Euthanasia is a 'grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person.' Since suicide, objectively speaking, is a gravely immoral act, it follows that 'to concur with the intention of another person to commit suicide and to help in carrying it out through so-called 'assisted suicide' means to co-operate in, and at times be the actual perpetrator of, an injustice which can never be excused.' (2016, p. 2)

Addressing this in the body of the document, the text notes that in some cases, family members who plan to or have already attended an assisted suicide may request for the Sacrament of Penance. The text states that if someone who was present at an assisted suicide asks for penance, the priest should be willing to accept their real contrition to allow them to have a right conscience. "The penitent should be encouraged – but not required – to make public their own conversion and rejection of these procedures, to pray fervently for the forgiveness and eternal salvation of the deceased, and to refuse to participate in any conversation that promotes this moral injustice" (The Catholic Bishops of Alberta and the Northwest Territories, 2016, p. 21). However, those who have directly or indirectly assisted another person to commit suicide (medically assisted or otherwise), have committed a morally evil act. "The confessor must be careful to determine the culpability of the penitent in these actions and presume that in the very act of approaching the priest for reconciliation, there is the prompting of the Spirit at work in their lives” (The Catholic Bishops of Alberta and the Northwest Territories, 2016, p. 22). Variations of this are carried forward throughout the remaining document.

The Evangelical Fellowship of Canada (EFC) mirrors the sentiment that all human life is precious as seen in most other religious teachings by stating that

> life is a gift from God for us to respect and protect through all its stages. Each person’s life has worth, regardless of their age or ability, because they are made in the image of God and loved by him. This belief in the sanctity of all human life compels us to completely oppose euthanasia and assisted suicide. (2020, para. 2)

They go on to note that “God calls us to care for those who are vulnerable, including those who are ill or near the end of life. The EFC supports palliative care as a compassionate response that supports and cares for those who are suffering or terminally ill” (Evangelical Fellowship of Canada, 2020, para. 3).

Covenant Health, one of Canada’s largest Catholic healthcare providers who are “called to continue the healing ministry of Jesus by serving with compassion, upholding the sacredness of life in all stages and caring for the whole person – body, mind and soul” (2020, para. 2), states clearly in their *Responding to Requests for Medical Assistance in Dying* that their beliefs are similar. In their policy statement on the matter, they specify:

> As a Catholic health care organization, Covenant Health is committed to uphold the inherent dignity of every human being throughout the entire continuum of life from conception to natural death. Therefore, Covenant Health will not provide nor explicitly refer for MAID given the incompatibility of MAID with the organization’s mission and ethical tradition. At the same time, Covenant Health is committed to the principles of justice and non-abandonment, and thus must ensure persons in our care seeking further information, assessment, and potentially, provision of MAID are able to access navigation resources within the health system which can facilitate these processes independently of Covenant Health. (Convenant Health, 2018, p. 1)

Though written in 2018 as a direct response to outside pressures from other healthcare organizations, Covenant Health has made no further motions to allow medically assisted deaths on their premises. This was followed by religious leaders from the Catholic and Orthodox Churches joining with representatives from the Muslim and Jewish faiths to sign a joint declaration stating clear opposition to euthanasia and physician-assisted suicide in November 2019 (Glatz, 2019, para. 1). Beyond those listed here, most world religions similarly condemn suicide completely, though religions are in fact getting better at providing resources for those dealing with suicidal tendencies.

1.6. Assisted Dying Around the World

While Canada has had medical assistance in dying since 2016, Oregon was the first jurisdiction to have some form of assisted death when they passed the Death With Dignity Act in 1997, after a three-year appeal process aimed at overturning the law (Death with Dignity, 2019b). Oregon was soon followed by the Netherlands and Belgium in 2002. In Oregon, media terminology lists the practice as either physician assisted death (PAD) or physician assisted suicide (PAS), whereas the state officially uses the term ‘death with dignity.’ The Netherlands and Belgium use the terms ‘euthanasia and assisted suicide’ (EAS) and ‘termination of life on request and assisted suicide’ to define their requests, the latter term being specific to the Netherlands (Council of Canadian Academies, 2018a, p. 241). In Belgium, the Belgium Act only includes euthanasia, however, “assisted suicide is not expressly prohibited in criminal law…The Federal Control and Evaluation Commission on Euthanasia has stated that it considers assisted death to fall within the definition of euthanasia, and has approved cases of assisted suicide in Belgium as meeting legal requirements” (Nys as qtd. in Council of Canadian Academies, 2018a, p. 241).

Washington State joined Oregon in 2009 with the Washington Death with Dignity Act, using the same terminology as Oregon with the recognized terms of death with dignity, PAD and PAS (Death with Dignity, 2019a). Luxembourg legislated euthanasia and assisted death in 2009, with the distinction that euthanasia was “the act performed by a physician, which intentionally ends the life of a person at the express and voluntary request of that person” while assisted suicide is witnessed when “a doctor intentionally helps another person to commit suicide or to provide another person with the means to that end, at the express and voluntary request of the latter” (Council of Canadian Academies, 2018a, p. 241). In 2009, Montana legislated assisted death by Supreme Court ruling, known officially as physician aid in dying (Death with Dignity, 2019a). Though not explicitly defined, through physician aid in dying “the patient – not the physician – commits the final death-causing act by self-administering a lethal dose of medicine” (Council of Canadian Academies, 2018a, p. 240). As the Supreme Court of the State of Montana specifies, “the provision of physician aid in dying is permitted through the Supreme Court of the State of Montana ruling that found a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply" (Council of Canadian Academies, 2018a, p. 240). Montana does not hold a death with dignity statute but does have end-of-life alternatives through its Supreme Court ruling.

In 2013, the state of Vermont legislated the Vermont Patient Choice and Control at the End of Life Act, which is known more broadly as 'patient choice at the end of life' (Death with Dignity, 2019c). Though not explicitly defined, "physicians are allowed to prescribe medication to a patient with a terminal condition for the purpose of hastening the patient's death if they meet certain criteria, but may not be involved in the administration of the medication" (Council of Canadian Academies, 2018a, p. 240). Prior to the MAID act coming into effect in Canada in 2016, the province of Quebec legislated medical aid in dying back in 2014, which included "care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death" (Council of Canadian Academies, 2018a, p. 240). Following this was Colombia where the Ministry of Health and Social Protection "issued a regulation on the fundamental right to die with dignity in 2015. The legal judgment that first recognized such a right in Colombia occurred in 1997" (Council of Canadian Academies, 2018a, p. 240). Colombia's terminology follows as 'the fundamental right to die with dignity,' though the procedure is not defined.

The year 2016 saw three jurisdictions in the United States pass legislation related to assisted dying: Colorado, California and the District of Columbia. Colorado uses the term 'medical aid-in-dying,' whereas California uses 'end of life option: aid-in-dying' and the District of Columbia uses the more commonly used term, 'death with dignity' (Council of Canadian Academies, 2018a). In 2019, Hawaii, New Jersey and Maine joined alongside other states in legislating assisted death under the terms 'medical aid in dying,' 'aid in dying for the terminally ill' and 'death with dignity,' respectively (Council of Canadian Academies, 2018a). Despite variations in the names of the legislating acts and common terminology, all six states involve similar practices in which "a qualified patient may request and obtain a prescription for medication that they may self-administer to end their life in a humane and dignified manner" (Council of Canadian Academies, 2018a, p. 239). In total, 10 of 50 American states now hold some form of assisted dying within state lines.

Alongside Hawaii, New Jersey and Maine, the state of Victoria in Australia legislated their own version of a Voluntary Assisted Dying Bill in 2017 which came into effect in 2019. Labeled ‘voluntary assisted dying,’ the term is defined as the “administration of a voluntary assisted dying substance and includes steps reasonably related to such administration” (Council of Canadian Academies, 2018a, p. 239). Australia marks the most recent country to pass assisted dying legislation, however some countries, like Germany and Switzerland, have allowed assisted death for many years, though in the case of Switzerland, drugs may be dispensed to a Swiss person or foreigner only where the individual accepting the drugs takes an active role in the procedure. Article 115 of the Swiss Criminal Code states, “any person who for selfish motives incites or assisted another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty” (Council of Canadian Academies, 2018a, p. 216). Similarly, a 2015 law in Germany made it illegal to assist in suicide for commercial intent, though relatives or close friends of an individual who commit suicide are exempt. Therefore, “suicide is exempt from criminal punishment, as is aiding suicide. However, killing a person at the express and earnest request of the victim (‘mercy killing’) is a criminal offense” (Council of Canadian Academies, 2018a, p. 216). Various other jurisdictions around the world allow passive euthanasia, which like other forms of euthanasia, means to hasten death in the patient’s best interest. However, “what is standardly taken to mark off passive as opposed to active euthanasia is that the former hastens death by not providing something which would, if provided, delay death – that is, passive euthanasia involves withdrawing or withholding life-prolonging medical treatment” (Garrard & Wilkinson, 2005, pp. 64-65). While these jurisdictions allow some form of passive euthanasia, none currently have developed legislation for the passing of statutes relating to assisted dying.

1.7. Summary

To truly understand the contentions around medical assistance in dying in Canada, one first needs to contextualize and develop an understanding of the many facets that were part of the path to legislation and the ways in which these facets contributed to the overturning of the ban against physician assisted suicide. While MAID has been legal in Canada since June 2016, as evidenced here, there is still significant work that needs to be completed to get MAID legislation to a place where ailing Canadians who want to - and need to - may take advantage of medical assistance in dying as a medical service in our country. Though there are three key areas of focus moving forward, specifically the notions of advanced directives, mature minors and mental disorders, review is not mandatory until June 18, 2020, giving legislators and interest groups time to let their voices be heard on the matter, so that changes can be made in a way that is considerate of those most impacted. As this thesis aims to fill a gap in the current MAID academic literature, it is the hope of the researcher that the conclusion of this thesis will allow for support in making future revisions to legislation.

The remainder of this thesis further contextualizes medical assistance in dying by noting the importance of other studies on the topic; by presenting the methodological choices relevant to the elaboration of my analysis; and by discussing in detail the ways in which MAID has been presented to the Canadian public since the Act came into effect in 2016. Examining discursive practices related to MAID alongside sentiment analysis and framing theory, this thesis aims to tangibly demonstrate the way MAID has been presented over the years and to represent the distinct changes in MAID discussion over the time period of study. By locating medical assistance in dying in historical context, readers and researchers can better understand the meaning of the principal themes, issues, and controversies in relation to MAID in Canada, especially as we move forward to better improve the legislation.

Chapter 2.

Literature Review

To better locate medical assistance in dying within its current context, I first had to conduct an examination of existing MAID studies. One of the first problems I encountered is the fact that many assisted dying studies are either not focused on Canada, or more worryingly, not recent. During a preliminary study I completed at the undergraduate level, the primary challenge I faced was the lack of studies on physician assisted suicide (as it was then known) to draw on for my study. Often, I found myself looking at abortion rhetoric, stem cell research or even sex work analyses in order to examine similarly contentious issues to better contextualize the topic at hand. Though many assisted dying in Canada studies are less current than one would hope, recently there has been a surge in MAID studies that have appeared since medical assistance in dying was legislated in 2016, which are slowly helping to bring the subject matter to focus as an important site of study. What follows in this chapter is an examination of current academic literature about medical assistance in dying, as well as literature about the methodologies of choice that together look to help locate medical assistance in dying in the greater context of MAID research in Canada.

2.1. Academic Literature on Medical Assistance in Dying

A search through academic literature on the topic of assisted dying provides a range of material, though very little within the field of communication. While ample material exists on topics such as intention rates (Falconer et al., 2019), emotional and psychological effect on patients (Wilson, 2018; Dees et al., 2011), their families and attending physicians (MacDonald et al., 2018; Goldberg et al., 2019; Brown et al., 2020), how information is communicated to key audiences such as physicians themselves or those who meet the required criteria to receive MAID is surprisingly sparse. Furthermore, while academic literature recognizes that social renderings, political discourse, and religious, moral, and ethical narratives have influenced the controversial discussions surrounding the topic, discussions around implementation and communication of PAS or MAID practices have been largely ignored.

The European Association for Palliative Care (EAPC), in a white paper written in 2002, made a point to highlight the distinction between key terminology within the PAS discussion. Notably, the EAPC defined the term euthanasia as “a doctor intentionally killing a person by the administration of drugs, at that person’s voluntary and competent request,” while physician assisted suicide was defined as “a doctor intentionally helping a person to commit suicide by providing drugs for self-administration at that person’s voluntary and competent request” (Materstevedt et al., 2003, p. 98). Along with Jablonski, Clymin, Jaconson & Feldt (2012) and Levy, Azar, Siegel & Strous (2013), the EAPC were some of the first who deemed it necessary to define the terms at all and were also some of the first to provide a framework on how best to understand and communicate terminology to relevant stakeholders. As indicated in section 1.6, these terms have since been expanded to include phrases such as ‘patient choice at the end of life,’ ‘medical assistance in dying,’ and ‘death with dignity’ across various jurisdictions. Though varying in each jurisdiction slightly, the basic distinctions remain centered between ‘patient administered’ or ‘physician administered’ aid in dying, with language choices in each jurisdiction highlighting these differences.

In Canada, while medical assistance in dying means “(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)” (Government of Canada, 2016, p. 5), a more workable definition is one provided by Vancouver Coastal Health, which states: “Medical Assistance in Dying refers to a doctor or nurse practitioner helping a person, at the patient's capable, voluntary, and explicit request, to end their life” (2020, para. 1). Of note is the use of the words ‘capable, voluntary, and explicit request’ in this workable definition, which relates directly to Bill C-14’s eligibility criteria requirements. Also of note, is the conscious stepping away in most jurisdictions from the term “euthanasia,” which carries several negative connotations, including that of ‘murder’ and ‘intentional killing,’ especially when used by parties who oppose the notion of assisted dying. This is seen in the fact that since Luxembourg in 2009, no country has used the term ‘euthanasia’ to define the act of legislating assisted dying.

While an evidently contentious topic due to its ethical, moral, and religious connotations, Beuthin (2018) uses an autoethnographic approach to explore and describe their experiences in implementing a new MAID program in a local health authority, from their perspective of being a health care professional (HCP) in order to expand the working MAID literature. As Beuthin notes, “although HCPs could legally hasten death for those with great suffering prior to MAID by several means (e.g., honoring a patient’s right to decline treatment by palliative sedation or by using dosages of pain medication that might hasten death) … MAID presents new practice challenges and ethical reflection” (2018, p. 1682). In a reflective analysis of the author’s journey through the development of MAID practices, Beuthin relates:

> So much happens in the first few days, public calls come in, requests are voiced. The calls seem to have a sense of urgency, and this surprises me. Maybe it shouldn’t. Seriously ill persons have conceived of this moment for a long time and are ready to act. It is as if once they have made the decision that this is right for them, it becomes urgent. I imagine the relief that they are seeking, how they want to leave their body as it is now. So much transpires, quickly, and already I am wondering, worried, how I will, how will we keep the profound close, how can we not forget that this is a final ritual? I have a deep knowing that I must prepare a way to offer support and listen to those who will be directly involved, to bear witness to what they will enact, to invite their stories. (2018, p. 1684)

Beuthin follows up on the sense of uncertainty that remains within the profession. “It seems, regardless of the view held, that there can be an element of sadness; sadness that there isn’t better access for those seeking an assisted death, or sadness that the choice for an assisted death now lives in our society. And there are so many views in-between, many are still sense making and will overtime” (Beuthin, 2018, p. 1686). Using a narrative ethnography approach, Beuthin connects the personal to the cultural to portray storied encounters that contextualize a difficult topic, and which gives voice to an insider perspective on front line operations.

Building upon this notion, a scoping review conducted between December 2016 and February 2017 analyzing the implementation of MAID from a health system’s perspective notes that while most literature thus far has focused on moral and ethical concerns of ‘right’ or ‘wrong,’ another needed focus for future studies is whether health systems can ensure that MAID is carried out systematically, equitably, safely, and within the ethical framework of the jurisdiction (Fujioka et al, 2019). As the authors note, “implementation barriers traverse regulatory, legal, financial, logistical, and social aspects of end-of-life care, and present multiple challenges. Alongside ethical and moral tensions are pragmatic barriers, such as adequately determining capacity and consent, safeguarding patients from harm, determining access, administration of the lethal dosage and processes of regulatory and legal oversight" (Fujikoa et al., 2019, p. 212). They also go on to note that the protection of patients' rights to confidentiality must be balanced against the need of professionals and institutions to know about the patients' choices. Insurance coverage and managed care options may be affected and may lead to harm for disadvantaged populations and health services, particularly those serving patients at end-of-life, who must readily adopt practice guidelines and streamline responses to the growing number of MAID requests (Fujikoa et al., 2019). Guidelines and supportive consultation resources are important necessities to mitigate policy ambiguities.

Keeping the focus within hospitals, a cross-sectional study examining 247 residents' attitudes towards physician hastened death (PHD) and MAID sought to determine the willingness and proportion of residents who agreed with different activities across the spectrum of end-of-life care (Wong, Hsu & Tanuseputro, 2019). Willingness to participate decreased with more direct forms of end-of-life care. For example, "while 52.0% of residents were willing to withdraw treatment for a patient meeting eligibility criteria, fewer residents were willing to actively participate in PHD (40.9%), or participate in MAID by lethal prescription (30.9%) and lethal injection (24.3%) (Wong et al., 2019, p. 3). This willingness differed across demographics. Caucasian residents, for example, were less willing to withdraw treatment, while male residents were more willing to withdraw treatment. The greatest difference in willingness to participate between demographics was in that of religious residents. "Non-religious residents (53.9%) and those from other religions (50.0%) were more willing to participate in PHD compared to Christians (29.0%)" (Wong et al., 2019, p. 3). Residents who were not or not "strictly" practicing their faith were more willing to participate in PHD than those with strict adherence to religious practices. "The willingness to participate in MAID by lethal prescription was also notably higher among residents who were 'not' (34.6%) or 'not strictly' (27.8%) practicing their religion compared to those with strict adherence to religious practices (6.7%)." Similarly, the proportion of residents who were willing to participate in MAID by lethal injection was higher among those who were not religious (31.6% vs 17.0% for Christians) or 'not practicing' their religion (26.9% vs. 3.3% for residents with strict adherence to their religious practices) (Wong et al., 2019, p. 3). Another notable statistic in relation to residents' willingness to participate was that of exposure to death and dying, with those with higher exposure holding greater odds of agreeing to participate. Experienced residents with 11+ cases of declaring death, completing death certificates, and talking to families after death were more likely to participate in MAID by lethal prescription or by lethal injection than residents with less experience (Wong et al., 2019). Though the study demonstrates that residents are mostly still hesitant to provide MAID itself, a major predictor of such was religious views held, which remains consistent with other literature.

Christie et al. (2016) add to this in their study looking at an ethical analysis of religious and conscientious objection. Referencing Wesley Hohfeld's (1913) analysis of legal rights, the authors explain the differences between 'claim rights' and 'privilege rights.' In the context of MAID, the right to MAID is technically considered a claim right, which has two important properties. The first is that claim rights are passive; the individual does not have to do anything to activate the right as every person who meets the eligibility criteria will possess the right simply by virtue of the legal structures within Canada (Christie et al., 2016). A necessary condition of a claim right is that it imposes an active 'duty' on someone else. "This means that the patient's passive claim right to MAID places an active duty on the government (which typically delegates healthcare responsibilities to the provinces or health authorities) to provide this procedure when requested" (Christie et al., 2016, p. 3). The right to freedom of conscience and religion on the other hand, is an active privilege right. This right is 'active' in the sense that one must act according to his or her conscience or religion to exercise it. The state does not determine the content of these rights, rather, the individual is free to choose the content of these beliefs. For these reasons, "the 'structure or form' of the right to freedom of conscience or religion is that it is a 'legal privilege right' but the content of the right is idiosyncratic and determined by the individual" (Christie et al., 2016, p. 3). That is to say that it is the individual who determines the tenets of his or her conscience and the individual who decides to which religion, if any, to subscribe.

Deontological ethics, which Christie et al. (2016) use in their study, notes that moral worth is determined by examining the motivation/intentions of the person for his or her conduct. To be moral, one must act according to the proper motivation, with the right intentions, out of a sense of duty, and out of respect for the moral law. According to this moral law, some actions are intrinsically ‘right’ and some actions are intrinsically ‘wrong.’ This is explored in the secular approach of deontological ethics by Immanuel Kant, who argued that the source of the moral law is not a ‘divine will,’ but rather it is accessible by all rational beings if they think carefully enough and use the rules of logic (Christie et al., 2016, p. 5). As Kant notes in the *Fundamental Principles of the Metaphysic of Morals* (1785),

> Since every practical law represents a possible action as good and, on this account, for a subject who is practically determinable by reason, necessary, all imperatives are formulae determining an action which is necessary according to the principle of a will good in some respects. If now the action is good only as a means to something else, then the imperative is hypothetical; if it is conceived as good in itself and consequently as being necessarily the principle of a will which of itself conforms to reason, then it is categorical. (para. 21)

This notion of the ‘Categorical Imperative’ “declares an action to be objectively necessary in itself without reference to any purpose, i.e., without any other end, is valid as an apodeictic (practical) principle” (Kant, 1785, para. 23). As an illustration of the categorical imperative, consider Sections 2 and 7 of the Charter. The categorical imperative asks if one could, as a universal law, will that everyone everywhere has the rights to life, liberty, security of the person and the right to freedom of religion and conscience. Since these could be willed as a universal law, they would pass the first and second formulations of the categorical imperative. Providing these rights to individuals would be an example of respecting individuals as ends in themselves and not treating them as a means only (Christie et al., 2016, p. 5). MAID, however, would not pass this test. In MAID, the patient either ends her life herself, or her life is ended by a healthcare professional for compassionate reasons. Hence, the ‘act’ of killing is considered ‘bad,’ and it is this ‘bad’ action that is used to achieve the desirable consequence of compassion (Christie et al., 2016, p. 6). Deontological ethics therefore rejects any consideration of consequences when determining the moral worth of an action.

A similar argument also connects abortion to assisted dying and conscientious objection. As Schuklenk & Smallng (2016) note in their scathing critique of medical professionals who use conscientious objection to avoid providing legal and necessary medical services, women are legally entitled to access abortions in Canada and typically, these abortions are fully funded by provincial public healthcare systems, making them monopoly providers (Schuklenk & Smallng, 2016). In the case of abortions, “it remains unclear why untestable conscience claims from privileged professionals who voluntarily chose to join a particular profession, and who have been endowed by society with a monopoly on the provision of particular procedures, should be accommodated, given that this toleration subverts the very objectives the profession is designed to achieve (Schuklenk & Smallng, 2016, p. 236). One such example is that of the Canadian province Prince Edward Island, which as of 2016 required women who wished to have an abortion to leave the province. Empirical evidence suggests, however, that travel is a barrier to accessing legal abortion (Schuklenk & Smallng, 2016), a situation that is far too common worldwide. But the real issue, the authors suggest, is the conflict between patients’ access rights to medical services such as MAID and the conscientious objection accommodation demanded by monopoly providers of said medical service.

> We recognize that conscientiously objecting healthcare professionals can have various rationales to support their opposition to the participation of doctors, in particular medical procedures. They include typically a recourse to tradition, the Hippocratic Oath, the Bible, the Quran and any number of other documents that have no legitimate bearing on the practice of 21st century medicine. It is easy to show that even the objecting doctors’ standard recourse to the Hippocratic Oath when it comes to abortion and assisted dying is not always credible. It is evidently the case that other ideological convictions held by particular doctors motivate their deployment of the argument from tradition, in the guise of the Hippocratic Oath, because only the lines from the Oath that suit a particular objecting doctor’s interests are typically cited, while those they disagree with are quietly ignored. But in any case, the Oath is not a defensible ethical guide to modern medical practice. (Schuklenk & Smallng, 2016, p. 235)

They also suggest that a society that allows conscientious objection in the medical field must then as well accept suboptimal health outcomes with regards to procedures that are part of good professional healthcare practice, largely in part due to what they consider to be a lack of patient rights consideration.

A parallel argument from within the medical profession declares “withholding and withdrawing” treatment as ethically distinct from physician-assisted suicide and euthanasia (PAS-E). For many years, this withholding of treatment was known medically as ‘passive euthanasia,’ and the confusion lay with what is and is not considered to fall under euthanasia. This uncertainty was resolved when consensus developed that “justified limitations of such treatments were not euthanasia, but rather the acceptance of the human condition in the face of death” (Sprung et al., 2018, p. 198). In Sprung et al’s analysis of emerging issues surrounding PAS from a global perspective, the authors list slippery slopes, lack of self-determination, inadequate palliative care, medical professionalism and differences between means and ends as just five reasons why medical professionals should be moving away from providing assisted dying as a medical service (2018). In action, PAS undermines the patient-physician relationship and erodes patients' and society's trust in the medical profession. "Patients and families depend on physicians for guidance, especially when inadequate information, fear, and other considerations limit their decision-making capacity and independence. By allowing doctors to participate in PAS-E, patients and families may become suspicious about the doctor's intentions at a time when they have the greatest need for help from a trusted medical professional" (Sprung et al., 2018, p. 200). The euthanasia debate, therefore, is not about *if* we die, but rather *how* we die, the distinction being between natural death and hastened death and who is in control of such a decision within the final moments.

2.2. Content Analysis

One of the most popular and rapidly expanding techniques as an area of research is that of content analysis, one that has even expanded to include assisted dying studies. With a long history of use in communication, journalism, sociology, psychology, business, and computer science to name a few, content analysis has gained its hold in numerous fields of research, with expansions into medical fields such as nursing, psychiatry, and pediatrics (Neuendorf, 2017). "In the field of mass communication research, content analysis has been the fastest-growing technique over the past 40 years or so (Yale & Gilly, 1988). [For example], Riffe and Freitag (1997) noted a nearly sixfold increase in the number of content analyses published in *Journalism & Mass Communication Quarterly* over a 24-year period—from 6.3% of all articles in 1971 to 34.8% in 1995, making this journal one of the primary outlets for content analyses of mass media" (Neuendorf, 2017, pp. 3-4). Present studies, including those looking at the overall total number of papers and theses that cover content analysis, show the same results: never has content analysis received more attention than it is currently.

Although the term 'content analysis' did not appear in English until 1941 (Waples & Berelson as qtd. in Berelson & Lazarsfeld, 1948), "the systematic analysis of text can be traced back to inquisitorial pursuits by the Church in the 17th century. Religions have always been captivated by the written word, so it is not surprising that the first known dissertations about newspapers were defended in 1690, 1695, and 1699 by individuals pursuing academic degrees in theology" (Krippendorff, 2004, p. 3). As different scholars including Eugen Lobl (1903), Max Weber (1911), Andrei Markov (1913) and others started working with content analysis and bringing it to the forefront of research methods, developments and changes within the field allowed the method to flourish, which contributed to the definition shifting multiple times across the years. As Riffe et al. (2019) highlight, these definitions also show the distinctions between quantitative and qualitative forms of content analysis in their approaches. Berelson (1952), to start, considered content analysis to be a "research technique for the objective, systematic, and quantitative description of the manifest content of communication" (as qtd. in Riffe et al., 2019, p. 22). Kerlinger (1973) two decades later believed content analysis should be treated as a "'method of observation' akin to observing people's behavior or 'asking them to respond to scales,' except that the investigator 'asks questions of the communications'" (as qtd. in Riffe et al., 2019, p. 22). Krippendorff in 1980 placed an emphasis on reliability and validity by stating that "content analysis is a research technique for making replicative and valid inferences from data to their context" (as qtd. in Riffe et al., 2019, p. 22). A decade later, Weber (1990) defined content analysis as "a research method that uses a set of procedures to make valid inferences from text" (as qtd. in Riffe et al., 2019, p. 22) while Stempel followed in 2003 by suggesting, rather broadly, that content analysis be seen as "a formal system for doing something we all do informally rather frequently – draw conclusions from observations of content" (as qtd. in Riffe et al., 2019, p. 22).

Contemporary definitions of content analysis suggest that "quantitative content analysis is the systematic and replicable examination of symbols of communication, which have been assigned numeric values according to valid measurement rules, and the analysis of relationships involving those values using statistical methods, to describe the communication, draw inferences about its meaning, or infer from the communication to its context, both of production and consumption" (Riffe et al., 2019, p. 23). One shortcoming of this definition outside of its length, is the stringent focus on the 'quantitative' nature of the theory, which Neuendorf (2017) follows. Neuendorf defines content analysis as the "systematic, objective, quantitative analysis of message characteristics. It includes both human-coded analyses and computer-aided text analysis (CATA)" (p. 1). One strength of this definition in comparison to Riffe et al. is the acknowledgement of the various forms of content analysis, specifically the human versus computer nature of the analysis method which is expansive in what it allows researchers to do. A particularly relevant definition is found in the *SAGE Encyclopedia of Communication Research Methods* by Melissa Maier (2017) which presents content analysis as “a systematic, quantitative approach to analyzing the content or meaning of communicative messages. Content analysis is a descriptive approach to communication research, and as such is used to describe communicative phenomenon … In many communication studies, scholars determine the frequency of specific ideas, concepts, terms, and other message characteristics and make comparisons in order to describe or explain communicative behavior” (pp. 242-243). This latter definition acknowledges the qualitative nature of content analysis along with the quantitative making it more applicable under current study conditions.

As a technique, “content analysis provides new insights, increases a researcher’s understanding of particular phenomena, or informs practical actions” (Krippendorff, 2004, p. 18). As Krippendorff outlines, techniques are expected to be reliable, replicable and must yield valid results. That is, “researchers working at different points in time and perhaps under different circumstances should get the same results when applying the same technique to the same data” (2004, p. 18). Riffe et al. (2019) expand on this observation, noting that findings should not be based on the hopes or beliefs of the researcher and that the research process and definitions must be expanded in full so that readers can understand how and why decisions were made. “Other researchers applying the same system, the same research design, and the same operational definitions to the same content should replicate the original findings. Only then can a discovered relationship be generalized at a high level of probability” (p. 24). More to the point:

> What represents appropriate and meaningful communication for content analysis must be based on the research task and specified clearly and without ambiguity. However, even that straightforward requirement is made complex because processes in communication involve questions of medium (if any) of communication (e.g., print versus broadcast versus mobile versus social media) or different functions (e.g., entertainment versus news versus social networking), to name only two. The issue is compounded further by potential differences in the symbols examined and the units used for coding (e.g., themes, frames, or entire news stories, or 280-character message strings). (Riffe et al., 2019, p. 26)

This is worthy of note when considering that social scientists who use content analysis techniques generally seek to do more than describe. “Content analysts – whether conducting applied or basic research – typically do not collect descriptive data and then ask questions. Instead, they conduct research to answer questions” (Riffe et al., 2019, p. 31). But one must also consider the issue of the “lone scholar approach.” As Tankard (2001) describes, a lone scholar is an individual researcher working alone, as the expert, to identify the frames in media content. As Tankard questions, “Does one reader saying a story is using a conflict frame make that really the case?” (2001, p. 98).

One thing to consider with the popularity of content analysis in recent years is that while anyone can do content analysis, especially considering the myriad of sub-methods that fall within the umbrella term of CA, for it to be done well, researchers need to take a serious stock of their own training and abilities. “Just as no researcher would attempt to execute a true experiment without having studied some widely accepted text on the topic, the content analyst should be guided by one or more accepted reference texts on the methodology” (Neuendorf, 2017, p. 8). As Neuendorf goes on to showcase,

> while the individual who designs a content analysis must have some special knowledge and preparation, a central notion in the methodology of content analysis is that all individuals are potentially useful “human coders” (i.e., people who make judgments about variables as applied to each message unit). The coding scheme must be so objective and so reliable that, once they are trained, coders from varied backgrounds and with different orientations will generally agree in its application. (2017, p. 8)

Riffe et al. (2019) expand on this by mentioning that the reliability of content analysis data is invested in the protocol and not just the coders. “The consistency of the application by many coders can be measured within and across studies using the same protocol. This ability adds to establishing the validity of the reliable variables in the protocol” (p. 34). One consideration for this is within the analyst’s reading (i.e., the units, syntax, and narrative structures that embody the text in the mind of the analyst) as these naturally differ from the reading and interpretation of ordinary readers, even including the authors. “It follows that an analyst’s reading must never be taken as the only legitimate one, nor should content analysts assume the sole power to determine the forms of the texts they analyze.” As Krippendorff goes on to add, “although content analysts are not bound to analyze their data with reference to the conceptions or intended audiences of their texts' authors, they must at least consider that texts may have been intended for someone like them" (2004, p. 31).

In an updated definition, Krippendorff (2013) listed content analysis as a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use" (p. 24). As he notes, "the phrase 'or other meaningful matter' is included in parentheses to indicate that in content analysis works of art, images, maps, sounds, signs, symbols, and even numerical records may be included as data – that is, they may be considered as texts – provided they speak to someone about phenomena outside of what can be sensed or observed" (2013; 2004, p. 19). In understanding the concept of a text in content analysis versus a text in other research methods, a text means something to someone, "it is produced by someone to have meanings for someone else, and these meanings therefore must not be ignored and must not violate why the text exists in the first place. Text – the reading of text, the use of text within a social context, and the analysis of text – serves as a convenient metaphor in content analysis" (Krippendorff, 2004, p. 19). The context in which texts are used is equally as significant, as the ways in which texts acquire their meanings, contents, symbolic qualities, and interpretations contributes to how researchers view the texts. "A context is always someone's construction, the conceptual environment of a text, the situation in which it plays a role. In a content analysis, the context explains what the analyst does with the texts; it could be considered the analyst's best hypothesis for how the texts came to be, what they mean, what they can tell or do" (Krippendorff, 2004, p. 33). As such, the context of a text is an integral component in understanding both the overall meaning and the applicability to the research overall.

There are many forms of content analysis both quantitative and qualitative, but as text is always qualitative to begin with, categorizing textual units is considered the most elementary form of measurement (Stevens, 1946). "Using numbers instead of verbal categories or counting instead of listing quotes is merely convenient; it is not a requirement for obtaining valid answers to a research question" (Krippendorff, 2004, p. 87). In comparing the two,

> Although qualitative researchers compellingly argue that each body of text is unique, affords multiple interpretations, and needs to be treated accordingly, there is no doubt that the proponents of both approaches sample text, in the sense of selecting what is relevant; unitize text, in the

> sense of distinguishing words or propositions and using quotes or examples; contextualize what they are reading in light of what they know about the circumstances surrounding the texts; and have specific research questions in mind." (Krippendorff, 2004, p. 87)

One difference between the two comes down to the fact that qualitative researchers search for multiple interpretations within a text by considering diverse voices (readers), alternative perspectives (from different ideological positions), oppositional readings (critiques), or varied uses of the texts examined (by different groups)(Krippendorff, 2004, p. 88). This is in comparison to the measurement model of the natural sciences which assigns unique measures, typically numbers, to distinct objects, but not to their ability to use more than one context for justifying multiple inferences from texts.

Underneath the umbrella term of 'content analysis' fall numerous forms of analysis that may be applied to the human production of messages. In the overarching scheme of methods available to researchers, content analysis is a technique presented as systematic and quantitative, but in the field of communication, researchers often turn to qualitative content analyses which includes a variety of analysis methods. These include, but are not limited to rhetorical analysis, narrative analysis, discourse analysis, semiotic analysis, interpretative analysis, conversation analysis, critical analysis, normative analysis, and computer mediated message analysis (Neuendorf, 2017). Each analysis focuses on a different subset of text, from the macro to the micro, taking into consideration contexts and situating the texts within greater political, ethical, and moral conversations. Discourse analysis and critical discourse analysis are just one example of this. "Generally, discourse is defined as text above the level of sentences. Discourse analysts tend to focus on how particular phenomena are represented" (Krippendorff, 2004, p. 16). The technique aims at typifying media representations (i.e., communicator motives, ideology) and the focus is on the researcher as a competent language user (Neuendorf, 2017). This particular method focuses primarily on analyzing public communication and tends to lean towards media texts.

The emergence of Critical Discourse Analysis (CDA) as a field of practice originated from the collective works of a network of scholars who endorsed CDA as "not interested in investigating a linguistic unit *per se*, but in studying social phenomena which are necessarily complex and thus require a multidisciplinary and multi-methodical approach" (Wodak & Meyer, 2009, p. 2). Following a symposium hosted by the

University of Amsterdam in 1991 (Wodak & Meyer, 2009), the scholars in attendance – Norman Fairclough, Gunther Kress, Teun van Dijk, Theo van Leeuwen and Ruth Wodak – confronted the very different and very distinct approaches to Discourse Analysis (DA), which in turn developed into our modern understanding of CDA (Wodak & Meyer, 2009). Discourse, not to be referred to [as] the distant presence of the origin, but treated as and when it occurs, and discourse analysis were most notably defined in Michel Foucault's *The Archeology of Knowledge* published in 1969, which separates the two.

> The analysis of thought is always allegorical in relation to the discourse that it employs. Its question is unfailingly: what was being said in what was said? The analysis of the discursive field is orientated in quite a different way; we must grasp the statement in the exact specificity of its occurrence; determine its conditions of existence, fix at least its limits, establish its correlations with other statements that may be connected with it, and show what other forms of statement it excludes. (Foucault, 1972, p. 19)

As Fairclough and Wodak (1997) outline, "CDA sees discourse – language use in speech and writing – as a form of 'social practice.' Describing discourse as social practices implies a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s), which frame it" (p. 258). The differences between CDA and other DA approaches whether pragmatic or sociolinguistic, therefore distinguish between approaches which proceed deductively by choosing a more inductive perspective and which oscillate between theory and data analysis (Wodak & Meyer, 2009).

Differentiating between CDA and DA, the term "critical" can be traced back to its roots in Critical Social Theory, which includes contributions from the Frankfurt Institute for Social Research, Jürgen Habermas and, most relevantly, from Max Horkheimer's 1937 essay *Traditional and Critical Theory* (Thompson, 1981). Oriented towards an understanding of society, both to understand and explain its process, Critical Theory's practical workings also seek to explain the critique of reason. As Horkheimer and Adorno (1944) observe, "what appears to be the triumph of subjective rationality, the subjection of all reality to logical formalism, is paid for by the obedient subjection of reason to what is directly given…Hence enlightenment returns to mythology, which it never really knew how to elude" (pp. 26-27). Critical theories therefore aim to produce and convey knowledge that allows human beings to free themselves from forms of domination. "One of the most significant principles of CDA is the important observation that use of language is a ‘social practice’ which is both determined by social structure and contributes to stabilizing and changing that structure simultaneously” (Wodak & Meyer, 2009, p. 7). In our modern conception of the term ‘critical,’ we now consider the notion in a broader sense with its connection of social and political engagements and its construction of society.

Of these methodologies, one method more relevant to the study at hand is that of thematic content analysis. “At its core, the method relies on identifying thematic patterns in a text (i.e., message or set of messages). The themes are not imposed upon the text from outside (e.g., via a theoretically informed coding mechanism or past studies) or a priori, but they emerge as the researcher undertakes a close reading of a text. Once themes are identified, the analyst looks for thematic patterns in the text” (Neuendorf, 2017, p. 10). Frames, themes, and discourse are also related to communication formats, which in the case of mass media refer to the selection, organization, and presentation of information (Altheide & Schneider, 2013). As the authors note:

> Obviously, themes and frames are related, but they are not determinate. Different frames can be used within the same theme—for example, punishment and suffering. Themes are the recurring typical theses that run through a lot of the reports. Frames are the focus, a parameter or boundary, for discussing a particular event. Certain themes become appropriate if particular frames are adopted. Thus, within the criminal justice frame, which implies a discourse of punishment, themes of health care, including treatment, intervention, and even education, seem a bit out of place. (2013, p. 54)

The significance of the relationship between frames, themes and discourse for content analysis cannot be understated. Theoretically, “frames and themes are crucial in defining situations and provide much of the rationale for document analysis. These are the most powerful features of public information, and the study of their origins, how they change over time, and their taken-for-granted use in everyday life is essential to understanding the relevance of communication media for our lives” (Altheide & Schneider, 2013, p.53). This is why many authors, including the author of this study, use these methods in tandem so that they can complement and enhance the results with a multi-faceted approach towards different forms of textual analysis.

2.3. Framing Theory

The way in which issues are framed has been a central undertaking of political conflict for decades and is present often in their eventual resolution. As Joslyn & Haider-Markel (2006) outline, frames serve to organize an individual's thinking on an issue, weaving various threads of content and context into a coherent storyline that "suggests what the controversy is about, the essence of the issue" (Gamson & Modigliani as qtd. in Joslyn & Haider-Markel, 2006, p. 85). Framing analysis and framing theory involve examining pre-existing patterns that can be applied to new ideas. "How an issue is framed promotes particular problem definitions, casual interpretations, moral evaluations, or treatment recommendations for what is being described, while ignoring other modes for understanding the issue" (Holody, 2009, p. 7). Holody continues in noting that the news media, historically being one of the only sources through which people gain knowledge on contentious issues, use framing to influence the general understanding of a subject and that news stories compete for the use of their preferred definitions and perspectives (2009). However, in the post-broadcast media environment in which we see a shrinking audience for traditional mass media due to the advent of social media, "this environment limits the long-held ability of the mass media to help set the public agenda and promote general agreement about the issues that are important to society" (Feezell, 2018, p. 490). As Feezell notes, "instead we see increasing reports of divided and self-contained media ecosystems, some of questionable quality, that limit the ability of the public to accurately assess the world around them and the issues that are important to society as a whole" (2018, p. 490). Thus, the need to study the way MAID is presented in Canadian papers is only one component of study in a much larger media ecosystem.

As Holody (2009) states, frames vary in their substance, which is why "frames used in a newspaper article or press release have valence, a specific interpretation is suggested while discouraging other ways of understanding the issue" (p. 8). Furthermore, the type of frame impacts how readers interact with the content of the article:

> A substantive frame is detailed and informative, offering meaningful information that leads toward strong understanding of an issue. A substantive conflict frame, for example, suggests a particular understanding of an issue and is used throughout the overall length of a

> text. In contrast, an ambiguous frame is less distinct, providing context to a story, but lacking clear information. This type of frame would represent only a small part of a text's overall length, serving strictly as a rough map for its audience to follow toward basic understanding of an issue. (Holody, 2009, p. 8)

Framing theory itself emerged in the 1970s during an influx in mass media. As the *Encyclopedia of Communication Theory* outlines, "framing theory aims to identify schemes in which individuals perceive the world…Frames help to reduce the complexity of information, but serve as a two-way process: Frames help interpret and reconstruct reality" (Volkmer, n.d., para. 1). In addition to agenda-setting, framing theory "studies the different schemes in which issues are told" (Volkmer, n.d., para. 5).

Early studies in framing theory identified key frames such as television news which include "an episodic frame – definition of a particular event frame – and a thematic frame, which positions an issue in a wider context of public discourse" (Volkmer, n.d., para. 5). Tankard's (2001) definition of framing in news is illustrative of this: "A frame is a central organizing idea for news content that supplies a context and suggests what the issue is through the use of selection, emphasis, exclusion, and elaboration" (pp. 100–101). By the early 20th century however, Walter Lippman in his book *Public Opinion* had declared that "the world is perceived through stereotypes that serve as pictures in our heads" (Volkmer, n.d., para. 7). Because of this notion and due to the technological changes that have occurred since framing theory was first introduced, work needs to be completed to reposition framing theory to include the individual as an actor within the framing process. "More recent approaches to framing theory highlight these social constructions of frames. In these debates, frames are viewed as organizing principles that structure the social world" (Volkmer, n.d., para. 7). As Benjamin Cohen argued (Volkmer, n.d., para. 3), although media are not especially effective at telling us what to think, they do tell us what to think about.

In most framing studies, news frames are coded with indicator questions in manual content analysis (Burscher et al., 2014). As the authors point out, "human coders can be properly trained to code frame indicators, and through training their performance can be improved until accuracy and reliability reach satisfactory levels. However, human coding is a time-consuming and costly process. This limits the scope of CA in framing research" (Burscher et al., 2014, p. 190). Previous studies on the topic of news frames indicate that frames in news take a central position in framing models, i.e., they are the dependent variable when studying how frames emerge (frame building) and the independent variable when studying effects of frames on predispositions on the public (frame setting)" ((Burscher et al., 2014, p. 191). In communications research especially, various methods are applied to a content analysis of frames in news:

> When investigating the framing of news coverage, we distinguish between frame identification and frame coding. While frame identification includes operations aimed at retrieving and defining frames adopted in the news, frame coding is the annotation of frames defined earlier as content analytical variables. Coding a frame requires an operationalization, which enables the methodological assessment of the frame and allows other scholars to reliably study its use across issues, time, and space. Currently, the two most popular frame operationalizations are human coding with indicator questions and dictionary-based computer-aided coding. (Burscher et al., 2014, p. 191)

Haller & Ralph (2001), in a similar article, note that "news stories, and the frames within them, help define public discourse around a social issue, such as physician-assisted suicide" (p. 408). They continue by stating that "journalists emphasize and de-emphasize the most salient aspects of a news event, thereby presenting various interpretations of the event…previous research has confirmed that journalistic conventions send them to official sources and societal elites, rather than minority/non-mainstream sources" (Haller & Ralph, 2001, p. 409). They note, "with an issue such as assisted suicide, news frames enable us to understand a larger symbolic system of cultural representations of disabled people. Bird and Dardenne (1988) assert that news frames provide understanding of the values and symbols in a culture" (Haller & Ralph, 2001, p. 409). More notably, they discuss how news frames in the 90s focused on big picture individuals, forgoing the analysis of voice given to the 'little people' in search of the services in question.

As Kalwinsky (1998) adds, stakeholders most impacted by physician assisted suicide are often heard from the least, which is consistent with research undertaken in an undergraduate capacity by the author of this study. Kalwinsky notes:

> The voice of the aged, disabled, and/or the terminally ill are remarkably absent in a story that greatly concerns them…When patients are mentioned, they are briefly positioned through name, age, and disease, but their story is unheard…The frame has yet to include people in a way that creates a human face for the social issue: It is still being played out of the institutions and the authority figures of health care. (1998, pp. 105-106)

Complicating this process, is the esoteric nature of medicine that ensures that laypeople will more “readily submit to technocratic authority. These all cause difficulties for public accounts in the media and create significant gaps in discourse” (Kalwisnky, 1998, p. 108). Moreover, he notes that PAS therefore becomes reified and the individual’s impotence heightened: “the issue is relegated to institutional authority as an avenue of action, and community is swallowed in narratives that resonate with a focus on individual autonomy while ironically denying it” (Kalwinsky, 1998, p. 108). This lack of understanding on a topic as contentious and as complicated ethically, morally, legally, and otherwise, as Kalwinsky notes, contributes to the silencing of much needed voices.

Pollock & Yulis (2004) in their analysis of Kalwinsky’s work, note that “regarding reporting on suicide, newspapers can ‘overpublicize’ suicide in the expectation that newspaper over reporting can act as a deterrent, with journalists acting as editorial ‘gatekeepers’” (p. 282). They also note that media framing has a substantial impact on public opinion, behavior and/or voting regarding domestic issues (Pollock & Yulis, 2004). Media, they note, can play varied, influential roles in framing critical health issues of any kind such as Magic Johnson’s HIV announcement, the Harvard Medicine Project, controversial issues including abortion, the 1994 health care reform debate, Mad Cow disease, breast implants, and more. Indeed, “exploring issue ‘framing’ is now an established subfield in communication research, an alternative to viewing reporting bluntly as either ‘biased’ or ‘objective’” (Pollock & Yulis, 2004, p. 282).

They further note that “mainstream media are agents of social control for dominant institutions and value systems” (Demers & Viswanath as qtd. in Pollock & Yulis, 2004, p. 285). As Demers & Viswanath indicate:

> We in the communication field…need to give more consideration to processes of social change, especially secular social change and public policy. Only then will it be possible to initiate structural or cultural changes that will enable mass media to be more responsive to the needs and goals of disadvantaged and repressed groups. (as qtd. in Pollock & Yulis, 2004, p. 285)

More to the point, the authors indicate that a failure to examine framing within wider political and social contexts, is a failure to incite social movements demanding political and social change. While change, at least in Canada, has been reached, how that discourse was shaped and formulated will be an important site of study for many years to come.

Lee, McLeod & Shah (2008) build upon this notion of discourse by noting that “mass media often play a role in presenting policy conflicts to the public for consideration” (p. 695). Lee et al. discovered that “policy controversies may be presented as a clash of political interests and competing political strategies (i.e., a strategy frame), as a clash of moral principles or basic values (i.e., a value frame), as an assessment of economic consequences (i.e., a material frame), or as rationales behind various policy alternatives (i.e., a[n] issue frame)” (2008, p. 696). These frames can be seen in practice in such instances as Ireland’s workplace smoking ban, which came into effect March 29, 2004. In their article on the matter, Fahy, Trench & Clancy (2012) note how “’frames’ offer a centralising organising idea or storyline that provide meaning to an unfolding series of events, suggesting what the controversy is about and the essence of an issue” (p. 332). Of note in this study is how “competing interests frame issues in ways that strategically advantage their political positions, emphasising certain aspects of an issue over other considerations, influencing estimations of the causes, consequences and solutions to a policy problem” (Nisbet & Lewenstein as qtd. in Fahy, Trench & Clancy, 2012, p. 332).

Furlan (2012), in focusing on the effects medical news stories can have on the public and therefore on practicing physicians, builds upon this by discussing trust versus mistrust when it comes to medical communication. As outlined, “the miscommunication of medical news which is inaccurate, sensational or biased has inherent implications for public access to reasoned, informed debate. The reporting of medical news has an added sense of responsibility given the public is susceptible to changing behaviours, medications and opinions on the basis of a published story, often with regrettable consequences” (2012, p. 113). Trust is therefore an important construct, not only to facilitate collaboration between the professions in order to produce a comprehensive, balanced, reliable news story in context, but also as “a core journalistic obligation to maintain the public’s collective trust, not necessarily on an individual level, but on the ‘system of expertise that produces and maintains the role-appropriate behaviour’ of those within the profession” (Furlan, 2012, pp. 113-14).

2.4. Sentiment Analysis

Understanding the sentiment in media tone is a newly developing area of research and one that has yet to reach the field of medical assistance in dying. Sentiment analysis, also known as opinion mining, "is the systematic use of methods to identify, classify, and extract subjective information from written sources" (Gale Business Insights, 2013, p. 325). Developed first by Peter Turney and Bo Pang, Turney and Pang analyzed movie reviews and product reviews at the document level. Turney (2002) introduced a simple unsupervised learning algorithm for rating a review as what he called, a 'thumbs up or a thumbs down.' His algorithm had three steps: "(1) extract phrases containing adjectives or adverbs, (2) estimate the semantic orientation of each phrase, and (3) classify the review based on the average semantic orientation of the phrases" (Turney, 2002, p. 424). Pang (2004), in a cooperative work with Lillian Lee in a follow up to his own study in 2002, proposed a novel machine-learning method instead that applies text-categorization techniques to just the subjective portions of the document, to determine sentiment.

The main focal point of sentiment analysis is on the attitude of the writer regarding the topic at hand and detects, reports on, and quantifies opinions and emotions in any given information source (Gale Business Insights, 2013). The intention behind this attitude differs depending on the type and source of the writing. Social media posts, for example, have drastically different attitudes than that of marketing material or business promotion, as the nuances between the two formats differ and thus the attitudes presented differ also. As it stands:

> Emotion has been the subject of academic study in many fields. Although there is no hard and set list of primary human emotions, most authoritative sources agree that love, hate, happiness, sadness, fear, and surprise are the most basic human emotions. Each of these has many sub-emotions and can be experienced in different intensities. These six basic emotions can be expressed in almost unlimited ways using language; deciphering the range and intensities of emotions expressed by language is the challenge of sentiment analysis. (Gale Business Insights, 2013, p. 327)

Sentiment analysis can work in both basic and advanced forms. A "basic" analysis consists of classification of a text's polarity, the latter of which is defined as "the state in which two opinions or ideas are very different from each other" (Gale Business Insights, 2013, p. 327). The focus here is whether the opinion, idea or attitude that is expressed in any given sentence or feature is positive, negative, or neutral. This does not mean simply counting the number of positive and negative words and phrases used in a document, but also in analyzing the concept that the sentiment words describe alongside one another. Sentiment analysis can also be used to classify sentences as either subjective or objective. “This is useful for sentiment analysis because, once classified, the objective sentences can be removed from the analysis. This is a way of distilling the sentiment in a piece of writing” (Gale Business Insights, 2013, p. 328).

As Lyu & Kim (2016) note, “a word, as the smallest constituent of a document, is used for analyzing and extracting information in natural language processing and data mining. In recent years, studies have increasingly focused on sentiment analysis – a process that extracts sentiment information that is different from statistical, syntactic, or semantic information” (p. 942). As the authors mention, sentiment analysis is an essential part of opinion mining. Specifically, “sentiment analysis is used to determine the perception of a specific topic, product, or person by people and the strength of the sentiments in terms of their positive or negative nature” (Lyu & Kim, 2016, p. 942). One such subtopic within sentiment analysis is that of sentiment weight. This is the idea that the strength of a sentiment can be numerically expressed across a scale and is closely related to the concept of word polarity. This can be viewed through the phrases ‘75% positive’ or ‘100% negative’ to assign a sentiment score/weight to a word that can then be used to better analyze the overall sentiment of the document. This process is just one step in constructing what is known as a sentiment dictionary, a relatively new concept within sentiment analysis research. Through their study of creating a sentiment dictionary and their analysis of a large volume of lexical resources, Lyu & Kim discovered that in addition to verbs or adjectives, nouns can also be used for sentiment analysis (2016). “Although nouns have a weaker sentiment weight than adjectives, which signify the quality or state of the modified noun, we observed that sentiment analysis can be performed with nouns (Lyu & Kim, 2016, p. 956). In a sentiment analysis, nouns are generally used to identify a person, place, or thing and because of that, are used less frequently than verbs or adjectives. However, “nouns such as sky, child, or family have more positive connotations than nouns such as death, darkness, or grave. Additionally, some colors such as white, pink, or green elicit more positive emotions than other colors such as black or gray” (Lyu & Kim, 2016, p. 950). This is important to note when applying sentiment analysis to news articles and taking into consideration media tone, especially when considering letters to the editor and editorials which carry much more personal opinions than that of objective fact found in standard news stories. Because of this, we can expect that personal opinions will carry a higher degree of emotion and opinion and will therefore, carry a stronger definitive sentiment, no matter the polarity.

When considering polarity analysis, one important consideration is that of the type of sentiment analysis method used to achieve the results. As Gonçalves et al. (2013) point out, there exist two types of sentiment analysis: machine-learning-based and lexical-based. In machine-learning "methods often rely on supervised classification approaches, where sentiment detection is framed as a binary (i.e., positive or negative). … While one advantage of learning-based methods is their ability to adapt and create trained models for specific purposes and contexts, their drawback is the availability of labeled data and hence the low applicability of the method on new data" (Gonçalves et al., 2013, p. 27). Lexical methods on the other hand, make use of predefined word lists where each word is associated with a specific sentiment. Although lexical methods do not rely on labeled data, it is hard to create a unique lexical-based dictionary to be used for different contexts (Gonçalves et al., 2013). In their study on the matter of best methods used in sentiment analysis, however, the authors discovered that most methods, whether machine- or lexical-based, presented more positive values than negative values. "This bias towards positive polarity showed by most of the methods might be a trick for real time polarity detecting tools, as they might simply apply these methods in real time data … We can see [for example] that most of the methods show very positive results, even for datasets like H1N1" (Gonçalves et al., 2013, p. 33). Because of this, the authors conclude that there is no one method that is best across different text sources and suggest using multiple sentiment methods to achieve the highest coverage and to obtain the greatest reliability within datasets.

While sentiment analysis has yet to reach medical assistance in dying, it has become a major interest in communication research in the meantime, including the analyses of media tone, agenda setting, election forecasting and candidate evaluations, to name a few (Rudkowsky et al., 2018). Until recently, sentiment analysis in the social sciences almost exclusively relied on the bag-of-word approach in which bag-of-words representation of text treats words as independent units and few studies look at the semantic or syntactic relations between words (Rudkowsky et al., 2018). As the authors note, "semantic models offer an improvement as they take relationships between words into account, but they have been rarely used in communication research. This is surprising because Harris' (1954) distributional hypothesis that words occurring in the same or similar contexts tend to have similar meanings is old and well known to computational linguists. Such word context information can be fruitfully employed for sentiment analysis" (Rudkowsky et al., 2018, p. 141). Moving sentiment analysis in communication research forward, Rudkowsky et al. present a new approach to sentiment analysis that has become popular in natural language processing and computer science: the use of distributed word embeddings (2018). "Word embeddings represent (or embed) words in a continuous vector space in which words with similar meanings are mapped closer to each other. New words in application texts that were missing in training texts can still be classified through similar words, an advantage compared to the bag-of-words approach in which new words encountered in application texts are a nuisance" (Rudkowsky et al., 2018, p. 140). The major advantage of using word embeddings, as indicated by the authors, is their ability to detect and classify unseen or out-of-context words that are not included in training data. While not used in this study, this work is outlined here because it showcases the myriad opportunities within sentiment analysis for future research and future research development when applied to media discourse and MAID.

2.5. Summary

Encompassing a small sample of academic literature on the topic of MAID, as well as discussions around all of the selected methodologies, this chapter aimed to contextualize and locate medical assistance in dying in the broader academic literature, to gain a better understanding of the ways medical assistance in dying is highlighted in Canada and the areas in which more information is needed, which is explored later in this thesis. While obvious gaps still exist within the literature, especially in the context of studies from a communications perspective, recent years have shown an uptick in the overall number of MAID studies and as MAID legislation is still a highly contentious topic in Canada, there is still a wealth of knowledge to be gained from studying such a topic. While this study aims to fill one such gap, there is still a long way to go in bringing more focus to medical assistance in dying and ensuring that researchers are helping to strengthen and improve MAID legislation for ailing Canadians who need access to the service.

Chapter 3.

Methodology

The path to legislation from the late 1900s to June 2016 when the Medical Assistance in Dying Act came into effect was a long one filled with many challenges and obstacles that hindered the arrival of recognized legislation within Canada. However, though legislation has been achieved within our country, this does not change the contentiousness that surrounds the notion of assisted death, nor does it miraculously erase opposition to medical assistance in dying or its acknowledgement of MAID as a recognized medical service. This is due in part to the ethical, moral and religious contentions that surround the topic, as well as concerns around the form of legislation that was brought through the legislative assembly, but also in how current restrictions in the legislation's eligibility criteria leave many who aim to use the service ineligible to do so. For these reasons (along with a vested interest in the subject matter), this study examines the ways in which discursive practices around medical assistance in dying in Canada are presented to the public through news media, after the period in which legislation came into effect, and to examine the themes, sentiments and key considerations presented throughout the topic. What follows is a step-by-step breakdown of the decision-making process from selecting and narrowing down the study period, to lessons learned from the interviews, to working with NVivo as coding software, which together outline the methodology of this study.

3.1. Scope of the Study

In deciding how best to approach the study, a decision needed to be made around the types of data that were to be analyzed and the ways in which they would be analyzed. The first selection was around which news media to include as the main point of study, and a discussion around scope commenced with senior faculty and a department liaison librarian regarding the time, effort, and researcher capabilities needed to complete a well-written, impactful study worthy of a master's degree. Keeping in mind the average length of a master's thesis, as well as my intent to pursue further education in the form of a PhD within the field of communication, boundaries were set to allow myself to participate in a study that could later be used as a stepping stone and foundation to further academic research.

Mindful of the requirements of a 100-page thesis, the scope of study was restricted to that of assisted dying in Canada alone, ignoring assisted death legislation in other jurisdictions outside of mentions in both the path to legislation and the study's literature review. The second restriction came in the form of the type of media that were analyzed, as discussion focused on whether news media studied should be conducted at the local, provincial or national levels, along with whether or not the media should be in print, radio or broadcast format. After discussion between my senior supervisor, the liaison librarian and myself, the scope was narrowed to national print media in the form of news articles written in *The Globe and Mail* and the *National Post*, as a cursory examination through local papers in Calgary and Vancouver showed significant crossover between articles from the two national papers. After some pre-analysis of YouTube searches relating to MAID broadcasts commenced, it quickly became apparent that to include radio or broadcast media would be both redundant in relation to messaging, but also unnecessary when considering the amount of data garnered by the selected print medium alone. Therefore, analyzing all news articles from the two national papers within the chosen time frame resulted in a large enough body of work on the topic of MAID discussions in Canada, to be considered an appropriate-sized data pool for the purpose of a master's thesis and to yield meaningful answers for the research questions I sought to pursue.

The last major consideration for restricting the scope of the study focused on the period for which data analysis would be conducted, a period which shifted twice during the actual research process itself. Originally, the intent of the researcher was to examine the period from Feb. 6, 2015, when the ban against physician assisted suicide was struck down by the Supreme Court of Canada, to June 17, 2016, when the Medical Assistance in Dying Act came into effect. This was selected initially to focus on discursive changes within the topic's discussion after the act was no longer deemed "illegal" as a medical service, up to the period in and around the time when MAID would officially become legislated. However, an interaction with another research team during the interview recruitment process (discussed further in section 3.4.1.) revealed a soon-to-be published study looking at discourse about assisted dying in all Canadian papers from 1976 to 2016 in both the English and French language. Though the study was not quite the same as what I had planned and had a few key differences, as the intent of this study is to fill a gap in academic literature on the topic of MAID, retaining the original period of study would have proven to counteract such a goal. With this similar study in mind and in an effort to make a new contribution to the literature, the time frame of study for this thesis was therefore shifted from Feb. 6, 2015 – June 17, 2016 to June 1, 2016 – June 30, 2017, with key dates studied around the months of February and June for every year thereafter. But as the research process progressed and time passed, an opportunity presented itself for the research to be expanded further and fill more of a gap in the literature than what would have been achieved using a smaller data pool. Taking my capabilities into consideration, along with the use of search logs to obtain the optimal number of results, an expanded period of study was selected from June 1, 2016 to July 1, 2019. This three-year window allowed me to not only expand the discussion within a bigger body of work to better support my findings, but also aimed to contribute to an area of literature that had not been analyzed yet. Combining this information with ethnographic interviews aimed at better contextualizing and situating these news articles in the bigger picture of MAID debate, this third revision of the study's scope best addressed my goal of creating a meaningful master's thesis.

3.2. Research Questions

To best complete the research study, four research objectives were considered as the primary focus for both the research method and data selection stages. These research objectives aimed:

RO1. To examine data sets across selected time periods to identify discursive practices present within the material;

RO2. To examine data sets across selected time periods to identify key framing and sentiment schema as found within the material;

RO3. To allow key individuals with vested interest and/or involvement in PAS/MAID in Canada to assist in the generation of themes and categories to be used within the coding schema; and

RO4. To analyze the shift (if any) present within the evolution of PAS/MAID discourse in Canada over the period of time the study addressed.

Completing these objectives required the use of a multi-faceted triangulation approach that incorporated quantitative and qualitative elements which also helped to increase the credibility of the research by lessening the potential for bias resulting from a single method and/or single coder, as the different forms of coding required multiple close readings of the texts, which allowed for the elimination of most errors.

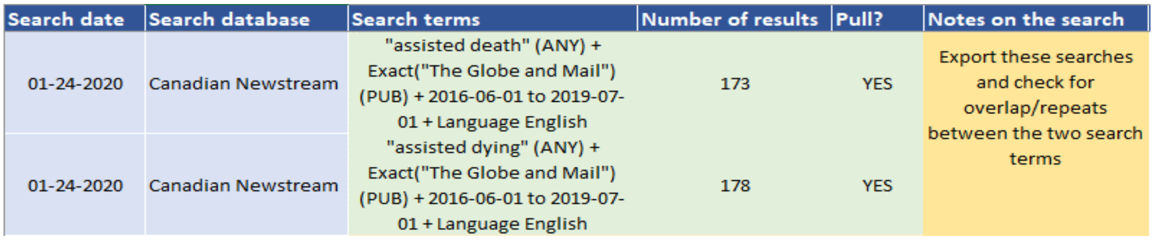
Following the outlining of the study's research objectives, four research questions emerged as the point of focus. These questions helped guide the researcher throughout the research process and contributed to the decision-making behind most selections during the time of study, which better strengthened the results and findings. These research questions are as follows.

> RQ1. What themes, issues and contentions do individuals with vested interest in the topic of MAID identify as the most important areas of focus within the framework of MAID discussion?
>
> RQ2. How does the framing and sentiment behind media messages impact the way MAID is represented within Canada?
>
> RQ3. What discursive practices and framing schema are present within MAID debate in Canada since legislation came into effect?
>
> RQ4. Has the way in which MAID has been discussed and presented to the public changed since the introduction of the Medical Assistance in Dying (MAID) Act in 2016?

These questions served to guide the researcher throughout the entire research process and contributed to the strength of the results (see Chapter 4). Though limited in their analysis due to the nature of research being conducted by an individual (as opposed to a full research team), these questions are some of the first of their kind within the field of communication with a focus on medical assistance in dying and may hopefully act as a guide for future studies on the topic of MAID.

3.3. Article Selection

Using the Canadian Newsstream: ProQuest database, articles were collected from *The Globe and Mail* and the *National Post* after conducting a thorough search of the selected database that was tracked using a search log, which can be seen in full in Appendix A. This search log tracked the date of the search, the database used, the proposed search terms, the number of results, as well as whether or not the results were pulled for study, notes on the search itself and notes from the database, an example of which can be seen in Figure 1 below.



Search date	Search database	Search terms	Number of results	Pull?	Notes on the search
01-24-2020	Canadian Newstream	"assisted death" (ANY) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-07-01 + Language English	173	YES	Export these searches and check for overlap/repeats between the two search terms
01-24-2020	Canadian Newstream	"assisted dying" (ANY) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-07-01 + Language English	178	YES	

Figure 1. Search Log Tracking Number of Results for News Articles[2]

As seen in Figure 1, the search parameter was further narrowed to only look for studies between June 1, 2016, and July 1, 2019, to specifically restrict the results to the three-year period immediately after MAID legislation came into effect. As the full search log in Appendix A shows, some searches such as “physician assisted suicide” in *The Globe and Mail* netted very few results (in this case, only 3), which was not enough to warrant pulling and compiling the results. For continuity sake, the same search terms were tested on both papers and the same results pulled from each. In the end, all results were pulled for both *The Globe and Mail* and the *National Post* which used the terms “assisted death,” “assisted dying,” “assisted suicide” and “medical assistance in dying” at any point within the documents and were saved in separate folders within the study’s hard drive.

Results from these search logs were exported individually and imported into a Microsoft Excel document where they were separated into master sheets by publication: a master sheet for *The Globe and Mail* results and a master sheet for the *National Post*

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[2] The search parameter (ANY) indicates that the selected database can look for the selected terms in any of the following areas: in the author category, under the document text, in the document title or within the publication title. The phrase ‘Exact’ requests the database to look for the exact publication title, which is indicated by the parameter PUB, while the last parameter shown asked the database to look for studies that were in the English language.

results. Within these sheets, all information was tracked for each article, including the author, the title of the article, the section it was published in, the date of publication, the publication itself, the word count, which of the four search terms had resulted in the articles' inclusion and a category called "notes" that was later repurposed for the sake of inclusion and exclusion. Since the results were exported individually and saved by author name and date (i.e., John Doe 6.1.16), excluding duplicates was a simple and efficient process, specifically considering the search results were exported from oldest to newest within the database and the master sheets sorted by publication date also, making crossover unlikely. However, the researcher did take time at a later date to verify that no articles had been missed by independently doing a search-and-compare between the results in the database and the results exported into an Excel document, as well as a second review of the final results to ensure no duplicates had been missed from removal. Once completed, the final inclusion/exclusion criteria stage commenced.

3.3.1. Article Inclusion/Exclusion

After entering all information into the Excel spreadsheet and cross-checking for duplicates, a total of 285 articles from *The Globe and Mail* and 126 articles from the *National Post* remained. Applying a rather rudimentary stoplight system to the results, all 411 articles were then read and categorized as either red, yellow, or green. Red articles were articles that mentioned any of the four selected search terms at least once which was not the focus of the article and was usually mentioned in passing in relation to other legislative changes. These articles were indicated in the Excel spreadsheet in the notes column by applying the colour red to the selected notes box and labeling the field as "Not the focus." Yellow articles were articles that mentioned any of the four selected search terms at least one time, making them partially on topic, but were ultimately excluded due to their focus on individual's personal lives. The large majority of these articles were obituaries for individuals who had used the MAID service (the number of which rose dramatically after July 2016), but the 'extra' content in the form of the individuals' personal lives were considered to be a distraction from the study's intent. Thus, a yellow colour was applied to the notes column in the Excel spreadsheet, along with the description "One mention; Slightly on topic" within the field. These articles, while not further coded, were still imported into NVivo 12, where the percentage of articles and use of search terms was tracked for further analysis and to help better represent the ways in which medical assistance in dying has been portrayed in the media since June 2016. Green articles were articles that mentioned any of the four selected search terms at least one time and were the primary focus of the article at hand. These articles were indicated by applying a green colour to the box in the notes column and indicating in the notes field that the article was "On topic." These indications made restricting the files by specific variables much easier, which also allowed for easier tracking of article totals.

Table 1. Total Number of Articles by Category and Percentage

	Globe and Mail (n)	Percentage (%)	*National Post (n)*	Percentage (%)
TOTAL ARTICLES:	285	100	126	100
Total Includes	166	59	61	49
Total Partial Includes	33	11	9	7
Total Excludes	86	30	56	44

In the end, Table 1 above shows the final number and percentage of articles included. After applying this high-level stoplight system to the 411 articles, 166 *The Globe and Mail* (or 59% of the total articles) and 61 *National Post* articles (or 49% of total articles) remained. These articles, along with the partial includes, were then imported into NVivo 12, where they were separated into folders listed as "*Globe and Mail* Includes," "*Globe and Mail* Partial Includes," "*National Post* Includes" and "*National Post* Partial Includes." All 'red' article PDFs were then moved to a separate exclude folder on the study's hard drive and were no longer relevant towards the focus of the study.

3.4. In-Depth Interviews

While the focus of this research study mainly entailed a thematic content analysis with a look at media frames and sentiment analysis, a small number of in-depth interviews were undertaken. These interviews were conducted in the hopes of contextualizing and locating the research within the larger scope of MAID academic literature and in providing suggestions for how to proceed with the coding schema in the next stage of research. One unexpected result of these interviews was that they also cast a light on further gaps within MAID discussions that could and should still be addressed in future research. These findings are presented in more detail in the conclusion in Chapter 5.

These interviews were intended to be held with key individuals within the MAID debate, both for and against the notion of assisted suicide. Initially, I had hoped to interview individuals such as the family of Kay Carter, a spokesperson for Dying With Dignity Canada, the B.C. Civil Liberties Association, the Euthanasia Prevention Coalition or even Russell Ogden, famously known for his involvement in an ethical rights case at Simon Fraser University on the matter back in 1994, while pursuing a degree in Criminology. These interviews were to follow a strict interview protocol in the form of an interview guide (which can be viewed in full in Appendix B3) and were aimed at providing insider perspectives on an intensely convoluted issue. As seen in the following sections, however, this process proved to be challenging, though end results were remarkably rewarding all the same.

3.4.1. Recruiting Participants

On account of the very public nature of MAID discourse and the very vocal arguments both for and against the service from different interest groups, finding individuals to reach out to for the purpose of securing an interview presented itself as a relatively straight-forward process. Names were collected from internet searches that used key terms for and against assisted dying, as well as from internal links and suggestions from the contact pages of interest groups both opposed and in favour of MAID. This information was compiled into a list that tracked the name, the person/group's public perception on MAID (for or against), and their involvement in the process to ensure that a mix of viewpoints was considered before contact with potential interview subjects was made. Emails and contact information were later collected and added to this document as well. However, it quickly became apparent during the email recruitment stage that followed, that access and interest were both very real barriers to obtaining participant consent that the researcher had not foreseen.

As seen in Appendix B1, a recruitment email was created, which was sent to all prospective participants using the subject line “Interview Request for Master's Thesis: Medical Assistance in Dying.” This subject line was written with the intent of being transparent regarding the researcher's intent in contacting different individuals and organizations and the only method of contact to prospective participants was made via publicly available means, such as business emails or business social media channels. Sent on the same day in the first week of December 2018 were 10 emails to various interest groups with varying public viewpoints on the subject matter, with a secondary list of ‘replacement’ options waiting in the case of refusal. Shortly after the initial batch of emails were dispatched, however, several barriers began to present themselves.

The first barrier was the standard “no answer” response, in which the subject title or the recruitment email were not sufficient in catching the attention of whatever interest group had been contacted. Though this was certainly disheartening, it had been expected in the context of a large-scale research study which is exactly why a second list of options had been created before recruitment started. Shortly thereafter, however, several more challenging barriers arose. One such barrier was timing, which, reflecting on the conclusion of the study, easily could have been avoided if as much effort had been put into *when* recruitment occurred and not just *how* recruitment occurred. Several responses were received during this initial recruitment period all indicating the same thing: yes, the person or organization was interested in participating, but no, they could not find time right now.

This presented an unexpected challenge for the researcher as the timing of the study had not accounted for such a large delay in the beginning of the interview process. Of the 10 initial recruitment emails, 5 responses expressed interest and asked for a follow-up in January 2019, while 2 people kindly turned down a chance to participate and 3 contacts simply did not respond. Of those that turned down a chance to participate, one such prospective participant was Russell Ogden, who indicated in his response that he had left his struggles around assisted dying and the issues it caused him at Simon Fraser University behind, though he wished the best in finding alternative contacts who would be interested. With these 6 responses in mind, the study was halted for the holiday period and picked back up in January of 2019.

Understandably, following up produced its own set of challenges, including lost connections, either intentional or unintentional, and long delays in responses. This required some creativity on the part of the researcher who turned to business social media accounts to send out a quick message of greeting, indicating an email had been sent in hopes the two could connect. Luckily, this tactic resulted in a secured participant and an interview was set-up for late January, though this was still at a much later time than had been expected in the initial study design. Along with this secured interview came a number of responses along the lines of “let me send this to my superior so we can find a contact for you" that never came back and follow-ups that also eventually followed the no response path. However, one key organization did manage to respond during this time and a second interview was set-up for the middle of February 2019.

Another barrier that presented itself during this time was a mix of access and interest issues. On more than one occasion that contact was made, the prospective participant indicated that they knew somebody besides themselves who was better suited for the study in question and asked for permission to connect the new prospective participant and the researcher together. On one account, this resulted in a secured interview that occurred in the middle of February 2019, but in another instance, this connection proved troublesome. In the case of the second instance, the new prospective participant turned out to be a fellow MAID researcher, who not only had interest in studying discourse surrounding medical assistance in dying, but had already completed and submitted an article for publication that encompassed the *exact* period of study that the current researcher hoped to analyze. Though the participant recruitment stage continued regardless of this setback, the knowledge of the completed study was a major blow to the morale of the researcher, and the situation required significant consideration in choosing how to handle it. As seen in section 3.1, the eventual solution was to adjust the period of study, moving the time period selected for study forward from the period in which the ban against PAS had been struck down, to the period after legislation had come into effect. While in the end this turned out to be the best case scenario and allowed the researcher to present a study which would better fill one of the gaps in academic MAID literature, it was also a valuable lesson in facing adversity in academia and one the researcher wishes they could have handled in a more timely manner. Though not a limitation per se, the time it took the researcher to connect with the ethics department to ensure a change in study design was permissible, as well as the time it took in finding and making adjustments to the period of study overall took quite awhile and was a major contributor to why the researcher ended up moving into a third year of study. At the end of the day, however, the benefits of the change in study far outweighed the negatives, which can be seen in the results and findings in Chapter 4.

A second round of recruitment emails was sent in late February 2019 which resulted in no secured interviews. Shortly thereafter, however, a personal connection to the researcher indicated they knew a prospective participant who may be willing to take part in the study and once a connection was made via the same recruitment email (with slight personal adjustments made), an interview was quickly set-up and completed a few days later in March 2019. At this point, after no more successful connections after months of trying, the researcher decided to switch to focusing on transcribing and moving into the data analysis stage with the articles, as the point of the interviews was not a major focal point of the study, though it resulted in several findings of key importance as seen in Chapter 4. In a surprise turn of events, months later in October 2019, that same personal connection who connected the researcher to the fourth interviewee also learned of a possible fifth connection who would be able to fill the gap in the types of interviews conducted. After putting the two in contact, a fifth interview was quickly set-up and thankfully, this fifth interview provided a wealth of knowledge and content that covered all the areas of interest that had yet to be addressed, and provided significant guidance in addressing problems in the path to legislation chapter that were filled-in and amended at the conclusion of the interview.

3.4.2. Recruitment Considerations

Though the recruitment process was challenging and costly regarding the time it took to set up and conduct interviews, one interesting development presented itself during this period that the researcher had also not foreseen. The intent of the researcher when reaching out to individuals and organizations had been to provide a variety of perspectives on the topic of assisted dying in Canada, whether for or against, as objective studies require the discussion of both sides of an argument in order to truly be objective. But of all the participants willing to participate in this study, in the end not one of them was an adamant opposer of medical assistance in dying. In fact, of all the individuals and organizations contacted for the sole purpose of providing an anti-assisted dying point of view, not a single one responded, including organizations, religious groups, and individuals quite vocal in their distaste towards MAID. This development, though an obvious limitation to the merit of the interviews, was interesting in the sense that opposition groups were not willing to speak to me on the matter. Perhaps this was in part due to the fact that MAID had already been legislated in Canada, so a critique would not hold the same weight as it would have prior to June 2016, or perhaps it was simply a matter of poor timing or lack of key talking points. Whatever the case, though the final interviews resulted in five individuals who held neutral or positive viewpoints on the topic of medical assistance in dying, there was no need to delay the study further to find oppositional perspectives as the lack of perspectives was not the fault or result of biased views held by the researcher, but rather a lack of willingness by oppositional parties. Though a challenging situation as participation in studies must be completely voluntary, the lack of oppositional arguments was an interesting development all the same and one that may be a possible area of research in the future if other researchers should be interested in exploring it.

3.4.3. Description of Participants and Study Consent

Of the five interviews that were successfully held, the range of occupations of the respondents provided a well-rounded mix of backgrounds and perspectives that resulted in little to no overlap in knowledge gained. The first interviewee was held with an established columnist at one of the two sites of study who has written a significant number of articles on the topic of MAID and who possesses a vast amount of subject matter expertise. The second interviewee spoke on behalf of the Canadian Medical Association and provided a neutral discussion that took into consideration the opinions of physicians who are for and against medical assistance in dying within the medical profession. The third interviewee was with a PhD candidate (at the time of writing) who had a background teaching the history of PAS and MAID and who presented a policy perspective on the topic as well as a personal perspective as someone more advanced in age then that of the researcher. The fourth interview was held with an individual who had a family member use the MAID service close to the time of the interview, and was therefore able to provide personal insight into the process and the thoughts behind making such a decision. The final interview was held with a Director of Operations at a local facility that provided MAID within that region, who was able to speak to many decisions that happen behind the scenes leading up to MAID occurring. Together, these five interviews covered almost all boxes within the ideal list of participants and outside of speaking with a conscientious objector, worked perfectly within the context of this study.

Though each of the five participants signed a consent form (which can be viewed in full in Appendix B2) stating that confidentiality would not be provided to them as they had all spoken publicly on the matter of medical assistance in dying at one point or another, the discussion in the findings made one question prominent: did knowing the names of the interviewees change at all how we view their perspectives? Though the answer may be yes in some cases, it is the opinion of the researcher that since the interviews were not a main point of focus for this particular study and were instead used to enhance and contribute to the coding and to supplement discussions found in Chapter 4, the identity of the interviewees was therefore not relevant to the conversation as a whole. Regardless of this, each of the five interviews provided a wealth of knowledge that was invaluable to the researcher, and the insights gained from these discussions can be felt throughout the study as a whole, whether it be through added references and points of focus, or through minor tweaks in how information is presented. Even though their names are no longer included, the effects of their participation are evident and gratitude must be expressed, as this study would not exist in the form that it does if it were not for each of the individual interviewees and the time given to the researcher for the sake of this thesis.

3.4.4. Interview Process

Due to geographical differences between the researcher and the interviewees, all five interviews were held over the phone at the interviewees' earliest convenience and conversations lasted from 37 minutes during the shortest interview, to an hour and 24 minutes as the longest. Consent forms were signed prior to the conversations being held and a verbal consent was received at the beginning of the call before the researcher began recording to ensure the interviewee still felt comfortable with participating. As a result of the nature of the interviews being via phone, the researcher's laptop computer was used to record the calls, using the embedded voice recorder function and the audio files stored within the encrypted hard drive at the conclusion of the call. Alongside the audio files was a stored copy of the consent forms, as well as the eventual transcriptions.

To better prepare participants for the interview, a copy of the interview guide was sent ahead so those representing organizations could get organizational approval on which questions they were willing to answer, and also to ensure that respondents felt comfortable with the content. This proved effective as in all five cases, both the respondent and the researcher had a copy of the interview guide open in front of them during the interview itself, which allowed for better understanding of the direction of the questions, as well as ensured that no confusion arose during the asking of the questions. Because the researcher was able to direct respondents to a specific question, the flow of the conversations was quite natural, and over the course of the interviews, all respondents combined questions in their responses to make the process more effective. As well, because interviews were held with a variety of individuals and organizational representatives, respondents were able to follow along if the researcher ever skipped a question either because it had previously been answered, because the question was not relevant to that particular respondent, or for the sake of timing in instances when the conversation needed to be cut down as a result of the interviewee's availability.

For the most part, the researcher was able to sit back and allow respondents to speak as freely as possibly, with minimal interruptions and very few instances in which they needed to press for more information. While there were a few instances in which the conversation deviated away from the interview guide for a period of time in order to expand on a thought that was of interest to the researcher, most conversations followed the order of the guide. This proved to be effective considering the number of questions asked, as well as the heavy nature of the questions related to assisted dying. At the conclusion of the interviews, all interviewees were asked if they would like to see the completed thesis and all five agreed, expressing interest in viewing a completed thesis on the topic of medical assistance in dying, which for some may be of specific interest in light of their occupations. Once interviews were completed and respondents had signed off, the researcher then began transcribing interviews, taking care to remove all personally identifiable information and tracking only the conversation at hand, along with the name of the interviewee, the date the consent form was signed, the interview date and a transcript legend which would make readability easier. At the end of the transcription period, the researcher then re-listened to all the audio files from the beginning and followed along with the transcript to ensure nothing had been missed, making changes where necessary, though these were usually in the form of transition words and not anything to do with the body of the interviews themselves. Though this transcription process took quite some time to complete due to the complexities of the conversations at hand, as well as the length of the interviews, this process enhanced the researcher's perception of the material and allowed for a more comprehensive understanding of the matter overall, heading into the coding stage of the study. At the end of the transcription period, updated files were stored on the study's encrypted hard drive and PDF versions of the transcripts uploaded into NVivo 12, where they were later analyzed following a similar thematic content analysis to that used on the newspaper articles, both to develop stronger coding schema, as well as to supplement discussions found in Chapter 4.

3.5. NVivo Analysis

NVivo 12, a qualitative data analysis computer software package produced by QSR International, was used for this study due to its versatility and ability to handle large data pools. Uploading the interview transcripts and *The Globe and Mail* and *National Post* articles into the NVivo software, folders were created to keep files organized, including a folder for *The Globe and Mail* and for the *National Post* with subfolders labeled "includes" and "partial includes," as well as a folder labeled "interviews." These folders were organized by author name and by date (John Smith 6.1.16) which made recognizing authors with multiple articles easier and allowed for patterns to be assessed when examining the coding.

3.5.1. Creating Coding Categories

Using a thematic content analysis approach that looked specifically at the framing of the articles, as well as the key themes, issues and contentions presented throughout the texts, a reading was done through each article, starting with *The Globe and Mail,* in which the researcher developed coding based on the content of the articles. For example, in the following excerpt from an article in *The Globe and Mail,* the content of the excerpt indicated that the specific passage was focused on eligibility criteria relating to the MAID Act and was therefore coded as such.

> You see, under Canada's MAID rules, to be eligible a patient must have a "grievous and irremediable medical condition," their death must be "reasonably foreseeable," they must be capable of informed consent, they must have the approval of two independent physicians (or nurse practitioners), make the request in writing in the presence of two witnesses, have an unofficial cooling-off period to be sure their decision is final and then give "late-stage consent" just prior to the injection of the drug cocktail that will hasten death. (Picard, 2018a, para. 4)

However, because these eligibility criteria are specific to the MAID Act itself as indicated by the phrase "under Canada's MAID rules" as seen above, this excerpt was also coded as related to legislation. During this process, it was the opinion of the researcher that it was better to 'over-code' than it was to 'under-code' and in many instances, specific excerpts were therefore coded multiple times, though never more than three on any given occasion. In doing so, this allowed the researcher to take stock of some of the prevalent issues within the texts, which are more of note in the findings in Chapter 4, and also allowed the content of the articles to code themselves, as opposed to trying to force content to fit into pre-defined categories.

Once this initial coding of the articles was completed, it quickly became apparent some of the coding decisions, namely those around the names of the coding categories, were not truly indicative of the content found within the categories. More to the point, as the read through of the 227 articles progressed, a distinction was noted between the content of *The Globe and Mail* articles and the content of the *National Post* articles that would require a re-code, as well as a re-naming, of several of the categories. Discussed further in Chapter 4, one example of this can be found in a category that had initially been labeled “Patients vs. Practitioners.” This category was created during the coding of *The Globe and Mail* articles and was coded as such due to the content of the articles suggesting a disconnect in the relationship between physicians and patients, as well as the presence of a debate around whether the patient or the physician has more rights in the case of MAID. Because of this, all text that related to either physicians or patients were coded into the same category where the intent had been to compare the language used in a simple quantitative word frequency. However, in the *National Post* articles, the content of these articles presented the topic as a distinct and notable difference between physician rights and patient rights that made it so placing the two codes into the same category would detract from the presentation of the issue at hand. The initial “Patients vs. Practitioners” category was therefore changed to two separate categories, one labeled “Patient Rights” and one labeled “Conscientious Objection.” While some may wonder why the second category was not labeled as “Physician Rights” or “Practitioner Rights,” the un-coding and re-coding of the “Patients vs. Practitioners” category made one fact very clear: the primary issue referenced by physicians in the texts was around the idea of physicians being able to decide for themselves whether they conscientiously objected or conscientiously accepted the notion of recognizing and participating in MAID as a medical service. Because of this, a category labeled “Conscientious Objection” was more representative of the issues and themes within the text than that of “Physician or Practitioner Rights.” As well, in doing so, this allowed the coding process to work organically so that content was not placed into incorrect categories and was able to be adapted if the situation called for it.

3.5.2. Adjusting the Coding Categories

Following this interactive coding, the next step for the researcher was to read through each individual node consecutively to get a better feel for categories that were either incorrectly labeled, not representative of the content found within them, or would benefit from the creation of a new category that was better suited to the themes, issues and contentions found within. As seen in Table C1 in Appendix C1, the initial coding categories were much broader than those found in Table C2 in the same appendix, the latter of which are representative of the final coding categories. This second read through presented a perfect opportunity to adjust and expand these categories, as reading through each individual category brought to light other issues like the initial category “Death With Dignity,” which encompassed content both in relation to the groups Dying With Dignity Canada and Death With Dignity (US), as well as the larger concept of wanting to or experiencing a dignified death. Because of this, it made more sense to un-code the Death With Dignity category and re-code two new separate categories labeled “Death With Dignity (Groups)” and “Dignified Dying” and to delete the initial category once all references had been re-coded, than it did to leave everything where it was and have the abandoned coding categories misrepresented. This second round of coding allowed for the creation of several new categories above what’s been mentioned here including “Logistics of MAID,” “Patient Rights” and “Providers,” the latter of which has a focus more on the physical institutions providing or objecting to MAID, as opposed to the practitioners themselves who were given their own category.

Upon the completion of coding using these new expanded categories, time was taken to go through each individual category and define them, the definitions of which can be found in Tables C3 and C4 in Appendix C2. In doing so, the researcher hoped to gain a more explicit understanding of what content belonged in each category and allowed for a clearer look at the themes, issues and contentions within to ensure that nothing was missing based off what was presented in the articles and interview transcripts. This process also contributed to a final coding run through, once all the individual categories had been un-coded, re-coded or adjusted to fit the expanded categories after definitions were created, as it made sense for the researcher to go back and ensure that nothing had been missed. In doing so, the researcher was able to confirm each of their final coding decisions and once no more changes were made, switched to coding the interview transcripts where a similar process occurred. Seen in both Tables C3 and C4, the interview categories created were slightly different to that of the news articles, as the focus of the interviews had been on contextualizing the key themes, issues, and contentions on the topic of MAID, as opposed to focusing on the way information was framed or the sentiment behind the articles. To ensure that none of these coding choices were incorrectly labeled, independent coding categories such as "Interviews – Contentions" were created specifically for the transcripts which ensured that they could be analyzed separately from the news articles. These categories were then able to be analyzed independently and specific excerpts from the five interview categories could be pulled out to enhance the discussions found in the next chapter.

3.5.3. Understanding Media Frames

Due to the main point of study focusing on news articles in Canada's two national papers, it is a given that this study looks specifically at media frames. However, since the majority of this study's methodology focuses on variations of content analysis (thematic content analysis, framing and sentiment analyses), it became apparent that a more in-depth breakdown of framing categories was needed to better contextualize the ways in which medical assistance in dying is being presented in Canada, outside of standard media frames. To operationalize this, each article was analyzed individually to examine the themes that were present (i.e., conscientious objection, ethics, religion) as well as the overall sentiment (i.e., positive, negative, neutral). Though the researcher easily could have created frames based on their own individualized reading of the articles, a more systematic way of deciding upon the final framing was to count up the individual codes and themes (re: references) found within each article and focus on the highest number of coding categories to decide upon the frame. This was a very clear way of assigning frames to each article, as the higher proportion of themes and issues present in any given category, the more indicative it was of that article's overall focus.

The difference between the themes and issues found within an article versus the overall framing are highlighted in the central focus of the text, along with the headline, lede and key talking points. In this study, the headline and lede alone were relatively indicative of what the article's central talking points were about, and complemented by the themes and issues present, the focus was obvious. In the case of analyzing the frames, the difference in comparison of the themes were that the frames encompassed much broader categories. For example, while an article might discuss patient rights, eligibility criteria and advanced directives within the body of the text, the overall frame of the article might have been a legislative issue which highlights restrictions within the eligibility criteria that are leaving many individuals who wish to use the service ineligible to do so. Even though multiple themes and issues were present, and the article is presented with a negative sentiment as a critique of MAID legislation, this doesn't change the fact that the central focus was around issues with MAID legislation. This can also be seen in the number of times references are coded in the legislation category within that article, as well as through the headline and key talking points.

To track these frames, an additional column was added to the master sheet within the Excel spreadsheet, in part because it allowed easier access to restricting variables in order to quantify the results, but also because the process of coding for themes and issues was an essential part of the framing process and was already completed at this stage. Taking into consideration these themes, issues and the overall sentiment, frames were organically selected based on this information and tracked in a new column labeled 'Framing Category.' In total there were five distinct framing categories: ethical frames, legislative frames, logistics frames, personal rights frames, and religious frames. These framing categories and their criteria can be seen in full in Appendix C3 and further discussion around the framing of news articles on the topic of MAID can be found in Chapter 4.

3.5.4. Sentiment Analysis

One development that occurred during the initial coding phase was the analysis of the very distinct tone that was associated with each individual news article, as many articles were heavily in favour of medical assistance in dying, while other articles were adamantly opposed. While it was not the original intent of the researcher to examine the articles for their overall sentiment, once it became obvious that there were very different methods of presenting information to the public, and that the types of articles written were contributing to the tone (i.e., letters to the editors, versus front page stories), enough interest was piqued that during the second phase of coding, an additional coding method was added specific to analyzing the articles' sentiments. Using a Likert scale of

“Very Positive – Positive – Neutral – Negative – Very Negative,” each article was then coded based on the tone of the article as being either for or against MAID. This meant that a letter to the editor whose focus was on how the MAID process had allowed a parental figure to experience a dignified death could be coded as “Very Positive,” whereas an article that critiqued the eligibility criteria (depending on the severity of the language) would be coded as “Negative” or “Very Negative.” In doing so, the researcher was able to recognize some patterns in how articles were being presented between the two national papers, a discussion of which is expanded on in Chapter 4.

Initially, this sentiment coding occurred within the NVivo software itself and had four categories, which included: very positive, positive, negative, and very negative. However, during the second overall coding phase that included the first round of sentiment coding, several articles were recognized as being completely neutral. In most of these cases, these neutral articles were more factual articles presenting numbers or statistics as opposed to opinions or critiques. One limitation of the NVivo software was the inability to add additional categories within the tab for sentiment analysis. Because of this, a decision needed to be made on whether to continue using the NVivo software, or whether to adapt to something that would allow for the creation of a neutral category, so that it could be tracked and compared to the other four. While one possibility was to create a node within NVivo that was labeled ‘neutral,’ this also created a limitation as it would not allow for the providing of a reason for why each article fit into each respective sentiment, which would result in the creation of even more categories within the software. For this reason, I decided to shift back to the Excel spreadsheet and add two new columns to the “Master (Includes)” sheet: one labeled sentiment and one labeled reasoning. After making this decision, previously coded articles had to be re-coded for their sentiment and an explicit reason added for why each article was coded in each position. This was also a lesson learned on the part of the researcher, who should have been listing the reasoning for their decisions in the first place, though the results were well worth the time that was lost during re-coding.

The next step in the process was to select five different colours to represent each of the selected sentiments, the final results of which were dark green for very positive, light green for positive, yellow for neutral, light red for negative and dark red for very negative. In doing so, the researcher was able to better visualize the number and percentage of articles which fit into each sentiment, and this process allowed for the easier restriction of variables so that numbers could be tracked and added to the statistics page on the Excel spreadsheet. Along with the colour coding and the adding of the category name in the first new column, the second column ‘reasoning’ was also colour coded and a quick description written for why each article fit within said sentiment. One example of this is an article by Chris Purdy in *The Globe and Mail* titled “Hospital apologizes to family of patient who had assisted-death assessment on sidewalk” (2018). This article was coded as ‘Very Negative’ as it was a strongly worded critique surrounding the irresponsibility of those involved with the individual’s assessment, which took place outside of the hospital in which they were receiving inpatient care for religious reasons. Though it was published in the “News” section of the publication, the tone was very direct and very heated, which can be seen in the individual language choices within the article. While this sentiment coding was more fluid than a standard sentiment analysis, which may use the sentiment dictionary approach and therefore be more quantitative, the qualitative approach taken in this study was still highly effective in furthering discussion on how MAID has been presented in Canada since 2016 and may act as a stepping stone for further research should other researchers find this of interest. As it stands, a discussion around the final sentiments can be found in Chapter 4 and more suggestions for further research can be found in the conclusion in Chapter 5.

3.6. Summary

As a way to justify and describe the means in which qualitative and quantitative methods were used for the sake of the study, this chapter examines in detail the decision-making process made by the researcher and highlights key decisions that contributed to the final methodological approach employed. Though some limitations presented themselves over the course of the methodological journey, for the most part, the research process was a straightforward and systematic examination of media discourse on the topic of medical assistance in dying in Canada, the results of which are discussed in the following chapter. While the intent of this chapter was to be as transparent as possible with the decisions that were made, the hope is that by breaking down each of the steps, other researchers who may be interested in completing similar studies will be able to build and improve on the decisions made here, or perhaps even replicate some of these decisions on a grander scale than what is seen in this study. By viewing the methodological choices made, readers can gain a greater understanding of the researcher’s thought process and better prepare themselves for the discussion in the following chapter.

Chapter 4.

Data Analysis & Discussion

As this thesis has so far suggested, the way assisted dying practices are discussed in Canada remains contentious owing to the influence of various moral, ethical, and religious concerns. This chapter explores the key themes, issues, and contentions concerning physician assisted dying by isolating them into smaller components that are then discussed individually to get a better sense of the current status of MAID opinion in Canada. Furthermore, while media discourse on the topic of MAID is convoluted, the following sections aim to successfully take complex topic pieces and present them in a manner which is straightforward and which weaves a cohesive narrative across the different areas of focus.

Taking into consideration the divide between the five in-depth interviews and the 227 news articles analyzed, these data types will be combined for the ease of discussion, using the two data sources hand-in-hand to highlight and expand key topics found within the various analyses. Interview quotations, for the sake of clarity, will be modified only to remove pauses, stutters and inputted laughing indications, while quotes from news articles will be cited as they stand, with reference to the original articles on account of their public nature. Though it is the belief of the researcher that the data will be better presented if methods are mixed in their discussion, what follows is a rather chronological breakdown of methodological decisions and the knowledge gained from the data analyses.

In order to keep the identities of the five interviewees outside of this study, each of the five interviews are coded as RI1, RI2, RI3, RI4 and RI5 respectively, the acronym ‘RI#’ standing for “research interview one,” “research interview two,” “research interview three” and so on. This aims to make sure all interviews are referenced in a logical manner that is easily tracked and that the order of these interviews is the same as is found in section 3.4.3. While some discussion around data will exist at a broader, more upper-level format, the following sections will primarily focus on exact excerpts and quantifiable numbers to get points across and present data in a way that can be both visualized and understood simultaneously.

4.1. Examining MAID Discourse

Discourse surrounding assisted dying goes back hundreds of years, and while medical assistance in dying is still a relatively new concept, the same contentions that characterized previous discussions of assisted dying are present in MAID discourse today. As Crumley et al. (2019) highlight in their study looking at newspapers' portrayal of MAID in Canadian papers from 1972 to 2016, the way physicians' role in MAID was portrayed changed depending on the era.

> The long debate about MAiD over time was crucial: newspapers kept Canadians current about developments by regularly publishing articles about polls, legislation, court cases and public perceptions about suffering and dying. Additionally, the press continuously reported the disconnect between physician opposition, Canadians' growing support and politicians' attempts to legalise MAiD. Although religious groups and many physicians opposed MAiD, newspapers primarily focused on portraying MAiD developments positively. (p. 17)

Of note in this excerpt is the concluding line which indicates that MAID was portrayed positively across the years in Canadian newspapers. But as seen in section 4.3, since MAID legislation has come into effect in Canada, this positive sentiment is not the case for the period after 2016. While not necessarily negative, there are many aspects of MAID legislation that groups deem unacceptable and many individuals are vocal about their concerns on the topic, which is explored further in later sections of this thesis.

Crumley et al. (2019) analyze several different eras of assisted dying rhetoric in their study, looking specifically at periods from 1972-1990, 1991-1995, 1996-2004, 2005-2013 and 2014-2016, the latter period leading up to the point of MAID legislation. In summary of their study, the author's note that

> the portrayal of physicians' role in MAiD evolved from: stage 1) a descriptive look at physician actions (ie, number of physicians secretly performing MAiD) and public opinion of whether they believe MAiD should be legalized; to stage 2) a passionate ethical debate of defining what a physician's role is in end-of-life care and legal ramifications of changing their role; to stage 3) addressing the physician's role in policy change and professional obligation to relieve patient suffering and respect patient choice and dignity and then back to stage 2) the portrayal of the physicians as conservative/resistant to adopting MAiD, but legally required to define and educate role change in order to provide service. (p. 18)

This is relevant as the authors note that a physician's role has been characterized into seven main areas: medical expert, communicator, collaborator, leader, health advocate, scholar and professional (Crumley et al., 2019). Of these, the roles that could change with the legalisation of MAID include "collaborator (ie, shared decision-making), leader (ie, patient safety), health advocate (ie, partnership) and professional (ie, commitment to saving or prolonging life for patient, ethical judgement, personal well-being)" (Crumley et al., 2019, p. 18). Though there is not yet a follow-up to this data in the period after 2016, these roles are seen throughout the data analyses in this current study, especially regarding physicians and their right to conscientious objection.

The most pertinent point addressed in Crumley et al. (2019) is one that deals with the period from 2014-2016. As the authors note: "The biggest shift in newspaper discussions in this era was from *whether* to legalise MAiD to *what* the legislation should contain, *who* should be included and *how* it should be accessed [italics in original]" (p. 17). This notion is consistent with that of data found in this study, as the researcher discovered that since legislation came into effect, the concerns about legislation existing have lessened and instead shifted to qualms *about* the legislation and the manner in which it restricts or inhibits access to the service. Of the final thematic categories seen in Table C2 in Appendix C1, many of these categories relate directly back to the legislation and this is seen in 4.2 when looking at the framing of the articles. Not only do the aptly named "Legislation" and "Constitution" categories relate back to MAID legislation, but the very nature of the "Advanced Directives," "Mature Minors" and "Mental Disorders" categories as critiques of MAID also demonstrate their relation to the final category "Eligibility Criteria," which links them all together.

4.1.1. Exploring Critiques of MAID Legislation

Concerns around MAID legislation are tenfold and this is seen in both the number of files that refer to these areas, but also the number of references within these files that outline the areas of focus. Of 227 articles analyzed across this study, 144 articles referred to the thematic category "Legislation," the highest of any other category in the study. Representing 63.4% of files, this is followed only by the thematic category "Contentions" which includes 141 articles, or 62.1% of the files, many of which overlap on account of vocal concerns around MAID legislation running rampant across the three-year study period. These contentions hold a variety of focuses, from personal autonomy, religious disgrace, and condemnation, to conscientious objection and moral and/or ethical discomfort, all of which are further explored in this chapter.

Keeping in mind that many of the other thematic categories are in part directly related to the legislation category, it is of interest to note that the third most referenced thematic category behind legislation and contentions is that of the act's "Eligibility Criteria" which is referenced by 105 files, or by 46.3% of the study's news material. The four other categories that relate to legislation, i.e., "Constitution" (56 files/24.7%), "Advanced Directives" (38 files/16.7%), "Mature Minors" (24 files/10.6%) and "Mental Disorders" (23 files/10.1%), are also frequently referenced and it is no surprise that in the following section, the study's framing also reflects the underlying facets that connect these categories together. Of 15 thematic categories seen in Table C2, six are encapsulated under the larger legislative umbrella that runs throughout this issue, while the remaining categories are combinations of various thematic and framing types that are discussed further throughout the remainder of this chapter.

Apprehension around MAID legislation is certainly justified and regardless of one's personal views, it is impossible to deny the contentiousness that surrounds the very notion of assisting an individual to end their life. While many Canadians understand the desire for ailing Canadians to end their life in what they consider to be a dignified manner, views about how to allow this are by no means black and white. Published June 2, 2016, days before legislation came into effect, one article in *The Globe and Mail* highlighted some of these concerns.

> Did the government unnecessarily rush the legislation? Yes. But one aspect of the bill, its sense that the new right to an assisted death risks being abused to the detriment of the elderly, the disabled and the vulnerable, is not misplaced. The concerns are real. (2016, para. 7)

On that same day, columnist Jeffrey Simpson adds that the debate over MAID is a complicated and emotional subject which must be considered when making legislation.

> Assisted death is something new in Canada. We have only scattered international experience on which to draw. Our physicians and hospitals, where the deaths would likely occur, are not schooled in handling assisted death. Perhaps that explains why the Canadian Medical Association supports the government's bill that is somewhat more restrictive than the Supreme Court Ruling. (2016, para. 16)

However, deciding what truly constitutes an appropriate middle-ground in legislation that both serves and protects is no easy feat and as contentions rise within MAID discourse, this ‘sweet spot’ becomes less and less defined with every passing day.

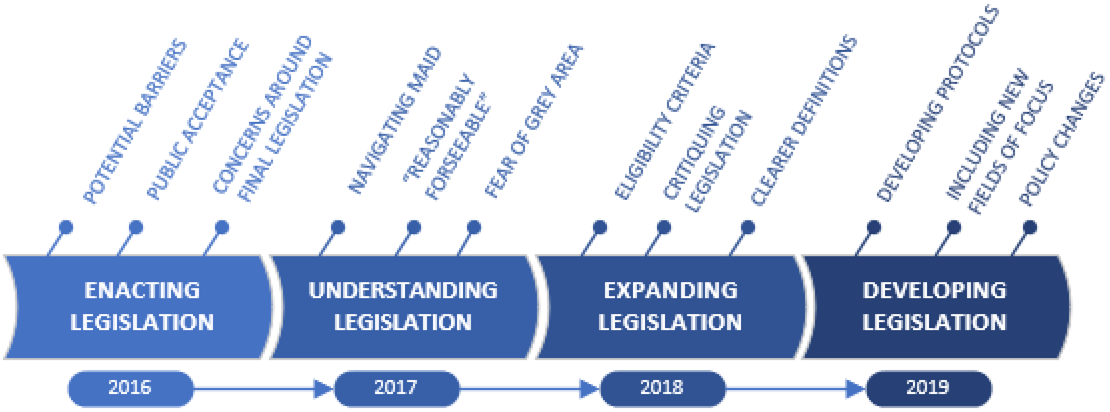

Figure 2. Progress of Legislation Discussion Over Time (2016-2019)[3]

While criticisms of the legislation in the month of June 2016 were frequent, the concerns pointed to very real implications, particularly in light of the Liberal government missing the June 6, 2016 deadline for enacting legislation. As the *National Post* expounds,

> Canada’s increasingly messy attempt to introduce a law on assisted dying can be categorized as seriously democratic. So democratic, in fact, that – four days after a Supreme Court-imposed deadline passed, we have no law at all. Instead we have a mad scramble, as the provinces and territories wrestle with the problem, the Senate muses over possible amendments, and the House of Commons – the one body containing democratically elected members – sits waiting for the smoke to clear, while the clock ticks down on its long summer recess. (2016, p. 2)

Though fiery in its presentation, the point and its follow up remain: “The absence of a law means Canadians have a right to end their lives, but no one wants a free-for all, and no one wants to be held accountable for taking lives in a manner that might be ruled unacceptable somewhere down the road” (*National Post*, 2016, para. 5). But as André Picard counters, no law is better than too much law.

> What is obvious is that the dire warnings that an absence of federal legislation could lead to chaos were ridiculous. What is increasingly clear,

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[3] Figure 2. showcases the changes in discussion around legislation across the course of the study, with keywords representing the main theme and/or issue present in that discussion, per year.

> too, is that having no law – as has been the case with abortion for 28 years – is a legitimate option, and certainly much better than having flawed legislation. And make no mistake, Bill C-14 is a terrible law. Because it is far more restrictive than the criteria set out by the Supreme Court, the legislation is likely unconstitutional. At the very least, it will result in many more years of costly and unnecessary court challenges. (2016a, paras. 3-4)

These concerns are recognized directly by the family of Kay Carter, the woman whose plight prompted the Supreme Court to order changes, Lee Carter, daughter to Kay Carter, questions where the Liberal government went wrong.

> They have not listened to Canadian voices, to their own joint committee or even their own members of Parliament who have serious concerns about this bill. Justin Trudeau says he listens to Canadians, yet he and his team are not listening. (Lee Carter as qtd. in Woo, 2016, para. 4)

Set ten days before legislation came into effect, this comment highlights just one of many concerns surrounding MAID legislation, notably that many of those who 'want' and 'need' the service are ineligible to access it.

> As of this week, Kay Carter would have been able to request a physician-assisted death in British Columbia in accordance with interim standards governed by the top court ruling and the College of Physicians and Surgeons of B.C. However, critics say she would have been rejected under the Liberals' Bill C-14, because she is not terminally ill. The wait for federal legislation has created what federal Health Minister Jane Philpott called a "patchwork approach" to the contentious issue. (Woo, 2016, para. 6)

As many articles from this time acknowledge, the lack of federal legislation could lead to potential barriers to access, a concern noted equally in complaints held with the legislation's eligibility criteria. But while Canadians appeared to have accepted the legislation's arrival, the form in which it arrived in was considered to be unacceptable.

Analyzing the theme of concerns around legislation, the texts examined in this study indicate a shift from the period around June 2016 when legislation was delayed and subsequently coming into effect, to the period of months and years after when provinces and territories were adapting to MAID as a medical service.

> A fundamental problem with Canada's decentralized healthcare system is that 14 jurisdictions – 10 provinces, three territories and a federal government (which is responsible for care delivery for indigenous peoples, the Canadian Forces, veterans, RCMP, prisoners and refugees) – can have differing rules for provision of care. This is glaringly obvious in the

> case of assisted dying, where a real patchwork of inequitable access is arising. (To their credit, however, provinces and territories are trying to co-ordinate their efforts, at least on the data collection part of the puzzle). (Picard, 2016c, para. 12)

Of 166 articles in *The Globe and Mail*, 74 were written in the year 2016, while 56 of those 74 came in the month of June and the first week of July alone. Similarly, in the *National Post*, 32 of 61 articles were written in the year 2016, while 17 of those 32 articles were also written in the month of June. These 56 and 17 articles represent 33.7% and 27.9% of all articles either around the period of time before legislation came into effect or immediately after it was legislated, which is a significant number for each publication. As seen in Figure 2 below, these numbers show a stark contrast between the topic of study for each publication, the meaning of which is explored further in section 4.4. How legislation is represented in subsequent years is explored here, as the coding allowed for the researcher to analyze the way legislation discourse shifted from 2016 to the period of years after legislation was already in effect.

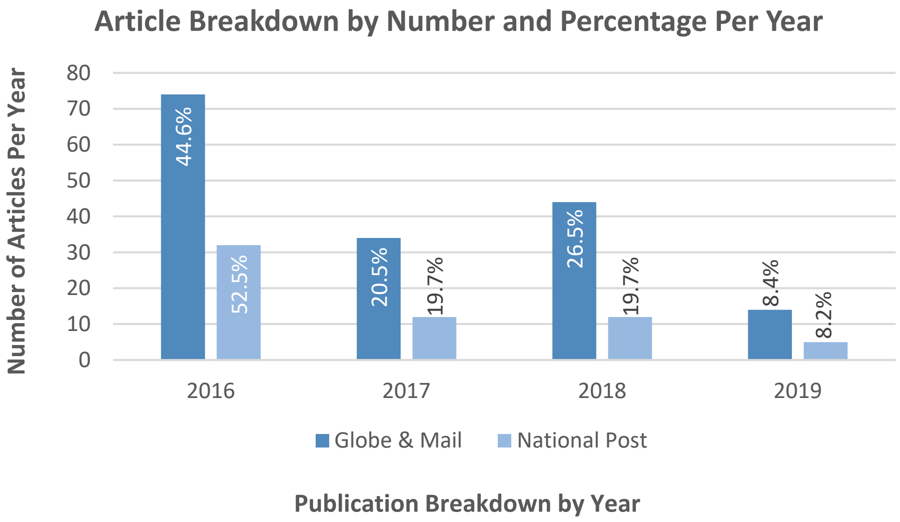

Figure 3. Number and Percentage of Articles Per Publication Per Year[4]

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[4] In Figure 3., the percentage displayed represents the percentage of articles present in that year for each respective publication. This means that 74 articles in *The Globe and Mail* in 2016 represent 44.6% of total articles for that publication, whereas 32 articles in the *National Post* represent 52.5% of total articles for that publication.

Articles written in 2017 showed one such shift that focused on a pertinent issue: even a year later, physicians and organizing bodies still had no idea how to truly navigate medical assistance in dying in response to the new law.

> However, eight months after legalized doctor-assisted suicide took effect in Canada, doctors who have carried out the act say the issue is far less about moral or psychological angst than it is about the legal ambiguities and uneasiness involved. (Kirkey, 2017, para. 6)

This concern comes solely down to the phrase “reasonably foreseeable” in the legislation’s eligibility criteria, a subject which is discussed more in the following section. The ambiguity of this phrase limits physician’s ability or desire to participate in MAID.

> “That confusion causes great anxiety for physicians, and many just pull back,” said Reggler, chairman of Dying with Dignity Canada’s physician advisory council. They see it as too high a risk, he said. “If the doctor doesn’t carry out the medically assisted death according to the law, that doctor is at risk of being prosecuted for murder.” (Kirkey, 2017, para. 12)

What’s more, not only are doctor’s fearful, but medical lawyers feel the same, urging their clients away from participating until legislation is clarified.

> The CMPA’s lawyers [Canadian Medical Protective Association], fearful of exposing their clients to disciplinary action or criminal charges, are advising doctors against proceeding with cases that could open them up to extra scrutiny from coroners’ officers which are reviewing assisted deaths in some provinces to ensure they meet the letter of the federal legislation. With no precedents yet to guide them, the medical lawyers’ group and an untold number of doctors are erring on the side of caution, raising the possibility that patients who might otherwise qualify for medical aid in dying could be denied the procedure. (Grant, 2017a, paras. 9-10)

In addition to these concerns is the question whether physicians who are participating in medical assistance in dying are being paid adequately for their services.

> A year after the passage of Canada’s medical-aid-in-dying law, concerns among doctors over how they are paid to administer assisted deaths – a new medical service that is unlike any other – are not limited to the West Coast. In Nova Scotia, nearly half of the billing claims submitted so far for medical-aid-in-dying are stuck in processing, with some physicians saying that they have yet to be paid for any of their assisted-death cases. In two provinces, Ontario and Newfoundland and Labrador, there are still no specific billing codes for hastening the deaths of the seriously ill. (Grant, 2017b, para. 4)

Though these are just a few examples, the articles from 2017 plainly show that legislation is not at all clear about how to enact the service without physicians and patients personally suffering the consequences if any mistakes in judgement are made.

In 2018 on the other hand, there was a shift in the major themes and issues presented on the topic of legislation that was much more representative of the concerns regarding eligibility and the three Council of Canadian Academies reports that focus on advanced directives, mature minors, and mental disorders as a sole underlying medical condition. Discussed further in the following section, 2018 offered a tonal shift that heavily critiqued these discussions, as well as critiqued institutions, which for religious reasons, were attempting to abstain from participating. As pointed out in *The Globe and Mail*,

> The Department of Justice said in a statement that the government believes the existing legislation achieves a balanced regime for those trying to access the process, while it protects people who are vulnerable and respects the conscience rights of health-care providers. (2018, para. 14)

But as Jessica Leeder and Kelly Grant counter, the law is also defective inasmuch as it might result in the suffering of many ailing Canadians.

> Patients ending their lives are required to give what is known as "late stage consent," meaning they must be lucid enough to agree to their own death immediately before a doctor or nurse practitioner administers the cocktail of life-ending drugs. If patients cannot give late-stage consent, they cannot, under the law, receive an assisted death. Intended as a safeguard, the rule has unintended consequences. Ms. Parker said it seemed to force early death of her before it really feels like her time is up. (2018, para. 7)

This results in a challenging issue for both physicians and patients, as physicians worry about prosecution and patients worry about an untimely death.

> According to Health Canada's most recent interim report on medically assisted dying, 3,714 legal assisted deaths have been carried out in Canada as of the end of last year. An analysis of why requests for the procedure are turned down in six provinces found that loss of capacity was the reason most cited frequently, followed by the patient's death not being deemed "reasonably foreseeable" as the law requires. (Leeder & Grant, 2018, para. 14)

Harvey Schipper from the *National Post* continues this conversation on ethical as well as legislative concerns that critique MAID legislation. Schipper notes,

> In December, the federal government announced it would establish national reporting standards for MAiD. As one prominent journalist put it, "... an idea that was once impossible to imagine is becoming normalized." But in these anecdotes lie hints that the 2015 Supreme Court decision, *Carter*, which opened the legal door to medically assisted suicide, has not settled the matter once and for all, as some might assume. What may be settled from a legal perspective is most emphatically not so in the real world. Setting aside the moral positions at both ends of the spectrum of opinion, there is a fundamental difference between legal reasoning and clinical judgment. What may seem clear to lawyers is not clear to those who have to execute the law. (2018, para. 5)

Patrick Cowan agrees, pointing out that

> legislators of all stripes nowadays have a tendency to substitute legal bafflegab for common-sense language. A good example of this is the text concerning the reasonable foreseeability of natural death that appears in our assisted suicide legislation. Unnatural death generally is unforeseeable while natural death is always foreseeable until threat of an unnatural death intervenes. (2018, para. 3)

Though legislation does not go for review until June 18, 2020, the concerns around eligibility criteria and issues of access are common. Moreover, as will later be discussed, religion and religious concerns also present difficulties where entire institutions opt out of participating in medical assistance in dying by claiming that the right to a physician assisted death is founded on questionable bases. As the critiques in 2018 show, concern is less around MAID being legalized and instead around legislation needing to be clearer in how it defines expectations and processes that contribute to the act.

The biggest shift in thematic discussions of legislation comes in 2019, where the focus shifts away from critiques of MAID legislation and instead turns to examining changes in the policies of other providers and in personal anecdotes that encompass all of the themes and issues found in the years 2016-2018. As Steven E. Rubenzahl retorts in a response to a scathing article by Barbara Kay in the *National Post*,

> If assisted death is part of that recipe for alleviating that suffering, then so be it. Who are we as a society to judge what suffering means to someone? Should all avenues be explored before offering a lethal injection? Absolutely yes. Must there be oversight and strict safeguards in place for physicians and others during this process. One hundred per cent yes, which is what we have now. (2019, para. 3)

Some concern is expressed regarding other procedures that are related to MAID that are often not considered when we think of MAID in a general sense. One such concern has to do with the idea of organ donations from individuals who aim to use assisted dying as a medical service.

> [T]hree years after assisted death became legal in Canada, the medical community is debating a provocative question: should organs be removed from consenting euthanasia patients while they're still alive? [S]ome say changing the rules would allow people choosing an assisted death to donate as many organs as possible – in the most optimal condition possible – because blood and oxygen would continue to flow through vital organs until the moment of retrieval. [U]nder this scenario, people granted an assisted death would, with their full knowledge and consent, be transported to an operating room, put to sleep under general anesthesia and their organs removed, including the heart and lungs. (Kirkey, 2019, para. 1)

Another has to do with the lack of direction around whether it is permissible and acceptable for bodies of individuals who undergo MAID to be donated for the sake of research.

> The law opens up an important new source of good-quality cadavers, but it also raises delicate questions about how anatomy programs should deal with grievously ill patients and families who contact them about body donation while they are exploring the option of a physician-assisted death. (Grant, 2019, para. 6)

Collectively, though only a few samples of the small number of articles written between the two publications in the first six months of 2019 are shown here, an evident shift has occurred. Seen in Figure 2, in 2016, themes and issues around legislation focused on *how* to enact legislation, with concerns rising around the final product that was passed. In 2017, a thematic shift was seen that focused on *understanding* legislation, with concerns around language choices and ambiguity. In 2018, a shift in legislation was seen that focused on *expanding* legislation, with critiques around eligibility and provider capabilities, while 2019 showed a *development* in legislation that shifted to include and invoke better protocols for other providers and encouraged the discussions from previous years. Though legislation is only one of the 15 thematic categories studied overall, the changes across the three-year study period are evident and as seen in later sections, contribute to an acceptance of MAID in Canada as a medical service that subsequently aims to enhance legislation, as opposed to restrict it.

4.1.2. Demanding More from MAID Eligibility Criteria

As shown in Table C2 in Appendix C1, the number of references (an NVivo term relating to the number of instances) present in every category was another indicator of the importance of the themes and issues found in the study, with the legislation category containing 374 references across all 227 articles. This category is followed only by “Contentions” with 297 references, “Eligibility Criteria” with 239 and “Ethics” with 234. This is of note largely because of the interconnectedness between these categories. While eligibility criteria focuses on what many consider to be the unconstitutional and restrictive nature of the final legislation, many of the contentions and ethical grievances that are found across this study focus on the same areas of concern, particularly that MAID legislation is not giving many individuals who want to use the service the ability to do so.

Explored in detail in Section 1.3, the final legislation for MAID and its adjustments to the Criminal Code state that “Eligibility for medical assistance in dying” means

> a person may receive medical assistance in dying only if they meet all of the following criteria:
>
> (a) they are eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada;
>
> (b) they are at least 18 years of age and capable of making decisions with respect to their health;
>
> (c) they have a grievous and irremediable medical condition;
>
> (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
>
> (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (Government of Canada, 2016, pp. 5-6)

But of these changes to the Criminal Code, one particular component that has been the source of considerable contention is the fourth point under Section 241.2 (2), “Grievous and irremediable medical condition” which states that for a person to be considered as having an incurable condition then

> (d) 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. (Government of Canada, 2016, p. 6)

While this may seem like a straightforward criterion to many unfamiliar with the legal system, for physicians and their governing organizations, this language is ambiguous without further definition. To put it simply, what exactly can be constituted as "reasonably foreseeable?"

On one hand, the phrase "reasonably foreseeable" is well intentioned, despite the muddy nature of the definition. As *The Globe and Mail* notes, "The Trudeau government put it into the law to prevent someone who is grievously ill or injured, but not terminally ill, from taking an irrevocable step in his or her darkest hour" (2017, para. 6). But on the other hand, as a result:

> What we know, anecdotally, is that, as many feared, the law's controversial wording, that death must be "reasonably foreseeable" for a patient to be eligible for assisted death is proving problematic. Practically, because the term "reasonably foreseeable" has no legal definition and no medical meaning, physicians tend to be interpreting it in a highly restrictive manner and, as a result, many are being denied an assisted death. (Picard, 2016b, para. 10)

In addition to this are concerns as to *who* gets to decide what suffering constitutes using the term "intolerable" to define it. This problem has prompted the following explanation from Jeff Blackmer, the Canadian Medical Association's vice-president for medical professionalism (at the time of writing):

> "What providers are telling us is a number of them have seen patients who will come and they'll say, 'I want an assisted death, but I want it in two months,'" Dr. Blackmer said. "So the physician will say, 'If you can wait a month or two months, it's very hard to say that your pain and suffering is currently intolerable.'" Right now, nobody is tracking these issues at a national level. (Blackmer as qtd. in Grant, 2016, para. 10)

Yet from another perspective, in a case in which a medical regulator was asked to rule on whether doctors should be able to grant assisted deaths to patients who only satisfy criteria after stopping eating and drinking (based on a real case):

> "It was determined that Ms. S met the requisite criteria and was indeed eligible for medical assistance in dying, despite the fact that her refusal of medical treatment, food, and water, undoubtedly hastened her death and

> contributed to its 'reasonable foreseeability,'" the college's inquiry committee wrote in a Feb. 13 report. The report notes that all competent patients, including those seeking an assisted death, have a "right of refusal," that includes declining treatment, food and water. (Grant, 2018b, paras. 3-4)

One of the most difficult thoughts to wrap one's head around, however, lies with decisions regarding the notion of reasonably foreseeable and how individual influences impact the enactment of MAID. "The Supreme Court decision, issued in the particular format reserved for decisions emphasizing the unanimity of opinion, stated that assisted death was legal: "… for a *competent adult* person who (1) *clearly consents* …and (2) has a *grievous and irremediable medical illness, disease or disability* that causes *enduring suffering* that is *intolerable to the individual*" (Schipper, 2018, para. 6). As Schipper further highlights,

> To a lawyer, that probably seems clear. However, clinicians will tell you that each of the words I have italicized is ambiguous, subjective, context-dependent and likely constantly changing. How do we define competence? Ought we to expect different degrees of competence depending on the consequence of the decision? What is consent, and how do we determine that someone has capacity to give consent? The fact is there is little data, and no consensus on how to assess capacity in the face of intolerable suffering. (Consider your ability to make a complex important decision moments after you've broken your leg, or discovered the sudden death of a loved one.) What is grievous, and in these days of medical advance, how sure are we that something is irremediable? What makes an illness, or disease or disability more than a variant of normal? How do we characterize suffering? Is it pain? Lack of care? Loneliness? Poverty? Ennui? Loss of function, and if so what function? What do we mean by intolerable? What do we mean by individual? Is it the person sequestered by the anatomic limits of their skin, or in another view of autonomy, as part of an interconnected world? Each and every one of these questions needs an answer in every instance where the law is applied. That is the clinical reality. (Schipper, 2018, para. 7)

These examples themselves are indicative of just some of the problems concerning the MAID legislation's eligibility criteria. The thematic category by the same name is replete with examples similar to what is seen above that highlight anecdotal retellings of painful stories in which individuals who themselves deem to be living in unbearable suffering are ineligible for assistance. But it is not just the term "reasonably foreseeable" that is contentious in respect of this issue, but rather the areas of focus in which people are *not* eligible that also merits discussion.

Advanced directives, discussed in detail in section 1.4.1, is one such area that is not yet permissible under MAID legislation. As André Picard says:

> Canada's law requires express consent immediately prior to a patient receiving a lethal injection. Practically, that means people cannot give advance consent to MAiD. For example, a person cannot say that once their dementia becomes advanced and they are bedridden, they want an assisted death, because they will lack the capacity for that final consent. (2018b, para. 7)

Yet as Picard adds, there are many pieces to consider with advanced directives. Picard thus asks the following questions, "is written prior consent sufficient? Do you allow substitute decision-makers to make that call, the way they do with ending life support or discontinuing eating and drinking?" (2018, para. 18). One piece of this puzzle relates to the idea of consent, while another piece focuses on how far in advance said consent could allowably be given. One respondent, when asked to address this, notes that they personally would be willing to honour a will that encompassed an advanced directive 15 to 20 years in advance, because "if you're asking for something like that, you've thought about it long and hard and you've made that choice for your reasons, you've had those conversations with those people who are going to honour your will" (RI4). This is certainly one component of the conversation and leads back to the notion of the language of a "fully competent adult" as is found in the legislation. "To be honest, I really struggle with the advanced directives issue. To me that's the most difficult one by far, having had two parents with dementia, who I know would have wanted this – I think this notion of being able to have the final say, I think it's really important for patients" (RI1). Ultimately, this theme of personal autonomy is consistent with the idea of advanced directives, as is the issue of dementia. While advanced directives would certainly include a variety of situations, were it to become legalized, the focus remains primarily on relieving those suffering from dementia from any pain as their conditions begin to worsen up to the point that they no longer value their choice in living.

The second area yet to be permissible under MAID legislation is that of mature minors. Explored in detail in section 1.4.2, mature minors are individuals under the age of 18 who are of sound mind in recognizing the condition that they are in. Yet thematically, the general consensus with mature minors is with the need to expand MAID legislation to suffering teenagers, though the discussions around doing so are oddly unaccounted for. For the most part, of 55 references across 24 files, the majority of articles simply refer to the three Council of Canadian Academies reports, but almost no articles go into depth on the topic. This alone is indicative of the highly controversial, contentious, and ethical concerns that arise when we consider allowing individuals under the age of 18 to consider taking their lives. "'A young person experiencing grievous and irremediable suffering is unimaginably tragic" (Shaul as qtd. in Kirkey, 2018, para. 12). But as Shanaaz Gokool is quoted as saying, "how can we look away and say you have to be 18 before you can access MAID? … That's the real question that we need to grapple with in these coming months … It's their body, and it should be their right [to choose MAID] if they have capacity" (as qtd. in Blaze Baum, 2017, para. 13). In a survey released by the Canadian Paediatric Surveillance Program, results show the frequency with which pediatricians are having exploratory conversations about, or fielding, requests for MAID from minors.

> Of the 1,050 pediatricians who participated in the survey, 118 said that over the course of a year, they had MAID-related discussions with a total of 419 parents; most of the minors in question were children under the age of 13. When it came to explicit MAID requests, 45 doctors said they dealt with a total of 91 parents. Nearly half of the requests related to infants less than one month old. The survey also found that 35 doctors had exploratory conversations with a total of 60 minors, and nine pediatricians reported getting explicit MAID requests from a total of 17 minors. The vast majority of the minors in both scenarios were aged 14 or older. (Blaze Baum, 2017, paras. 4-5)

Only seven of 24 articles that reference mature minors are actually written with a focus on children and medical assistance in dying and in most cases, these stories are written about children in other jurisdictions. This indicates that even though there is an awareness that we should expand the law to include competent minors here in Canada, actually starting those conversations makes us deeply uncomfortable and is likely why this topic has currently gone unaddressed.

Similarly, of 48 references across 23 articles, only 5 articles are actually written with a focus on mental disorders as a sole underlying condition. Discussed in detail in section 1.4.3, the concept of mental illness as being a grievous and irremediable condition, and more notably one that meets the reasonably foreseeable criteria, is a subject which, like mature minors, makes people deeply uncomfortable. As one respondent puts it:

> Now MAID, it has been passed based on the Canadian Charter of Right's and Freedoms in Section 1, Section 7, and Section 15, and I think its section 15 is the one that says you cannot discriminate. So, if we open up in 2021 and we say, okay, we are going to make MAID available where mental illness or mental disorders are the sole underlying condition and Section 15 of the charter says we cannot discriminate based on the nature of the illness, we can't discriminate and say that only people with ALS can have MAID, but not people who have cancer, you can't do that because of our charter. So, if we opened it up to mental illness, are we going to make all 125 of those disorders eligible? (RI3)

This number of disorders is discussed by Working Group members from the CCA who collectively rely on the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to determine which conditions should be considered under the umbrella "mental disorders" (Council of Canadian Academies, 2018c). But as this respondent goes on to add:

> Under the Charter of Rights and Freedoms, how are you going to discriminate and say no, no, you're eating disorder doesn't count? If you use the ICD, the International Classification of Disorders, there is pedophilia, there is sexual dysfunctions, they are all in there and people go through all kinds of emotional trauma and pain, but are we going to let them die? Are we not only going to let them die, are we going to provide that death for them? (RI3)

As Gokool is quoted as saying, "We can't arbitrarily discriminate against people because we are uncomfortable. We have to find a way to understand what are the parameters [through which] people with severe mental illness may be included in medical assistance in dying" (Chiose, 2017, para. 6). Yet despite this, "some mental-health advocates have argued that treatment of mental health is not yet extensive enough to show that a patient has exhausted all options. In addition, the tensions within the medical profession around assisted dying are likely to sharpen if the legislation is extended to those who are mentally ill. That could make every such request on mental-health grounds a battle" (Chiose, 2017, para. 10). This is consistent with the other two areas that are not yet permissible under MAID, as thematic categories and issues indicate an understanding of the need to move towards each of the three areas, but the actual conversations aiming to do as such are missing. Though the three CCA reports are readily available for discussion, it might still be too early for the general public to engage in these conversations, or to see these issues discussed in the media. At some point in the future, however, it is imperative that the public begin talking about the way that MAID and mental illness should be dealt with from a legislative point of view.

4.1.3. Contextualizing the Differences Between Patient and Physician Rights

For many years, the debate around medical assistance in dying has centered on one key question: Should the patient's right to an assisted death outweigh the right of the physician who objects to participating in MAID? Since medical professionals potentially involved in MAID have expanded to include medical professionals in a broader sense, such as nurse practitioners, pharmacists, therapists and on the provider front, whole institutions, this debate is one that to this day acts as a central focus within MAID discourse. The very notion of "Conscientious Objection," "Patient Rights," and "Providers" as three thematic categories are spread across 53, 83 and 50 individual articles from the study, respectively. While taking into consideration the high proportion of anecdotal stories as told through editorials, opinion pieces, and letters to the editor, even a cursory glance at the numbers showcase a greater focus on the patient as compared to the physician, which, considering the emotions that pain and suffering evoke in humans, is unsurprising. But as one respondent notes, we need to move past the either/or discussion.

> It is important to recognize that physicians are moral agents. With that said, what I think is important is to move beyond the 'either/or' dichotomy that we are seeing, framing it as either a patient right, patient interest, patient autonomy or physician conscience or conscientious objection. I think we need to transcend that dichotomy. I think we can achieve both and what we need to do as a society is to be able to set up mechanisms and put in place resources where you can both allow a physician not to provide or to participate in an intervention that they deem to be morally abhorrent, while having other mechanisms or resources in place for patients to access these. (RI2)

Considering the numerical breakdown between thematic categories and the experience of the researcher who ended up separating the "Practitioner vs. Patient" category as a result of the two unique focuses that presented themselves during the coding process, this belief is evidently one that we haven't fully achieved yet. "This is very much a responsibility of our society, it's a responsibility for our communities, it's a responsibility of our health system, so that this is no longer an individual responsibility, it's no longer just up to that one physician to provide it, it's up to our health system to provide it" (RI2). But navigating that path is still contentious in every regard.

One component of this contention relates back to the fundamental discussion about patients versus physicians. Since the MAID Act went into legislation, it is now the constitutional right of patients to be able to seek a medically assisted death if they so choose if they meet the eligibility criteria. But very real concerns of access arise when considering that many physicians for personal, ethical, or religious reasons, conscientiously object to participating in the service, which is their own personal right. Yet navigating the space between the right of the patient to access the service and the right of the physician to not participate in the service is a complex issue. “A patient’s power to compel a doctor to do what the doctor believes to be harmful is as destructive as a doctor’s power to compel a patient to do what the patient believes to be harmful” (Carpay, 2018, para. 11). Ultimately, it is widely understood that there must be physicians who provide medical assistance in dying as a medical service in the same way that it is understood that patients must be allowed to access MAID as a medical service. Yet it is also abundantly clear that opinion is divided on how exactly to go about navigating this conundrum.

John Carpay, writing for the *National Post*, makes a compelling analogy. “If I told you that I wanted to rob a home or store, would you sell me a gun? Presumably not. But what about giving me the name and contact info of another person who is willing to sell me a gun? If you wanted to avoid any participation in the planned robbery, you would refuse to provide a referral” (2018, para. 1). This analogy encapsulates one key component that further clouds the already troubled waters of this debate: the requirement that physicians who opt out must provide an effective referral. In essence, this means that for physicians who do not want to participate or provide MAID must instead send their patient to someone who will. Yet for even more physicians, this is the same as providing the service themselves.

> Steven Bodley, president of the College of Physicians and Surgeons of Ontario, said in a statement that the goal of the referral policy is "to protect the public, prevent harm to patients and facilitate access to care for patients in our multicultural, multifaith society, by guiding all physicians on how to uphold their professional and ethical obligations of non-abandonment and of patient-centred care within the context of Ontario's public health-care system." (Fine, 2018, para. 11)

But as Dr. Ramona Coelho, a family practitioner in London, Ontario is quoted as saying, the ruling puts her in a bad position. “I couldn’t bring myself in good conscience to do it [refer a patient]. I’m not saying patients shouldn’t have access, but when we live in a pluralistic society, can’t we do it in a way that we don’t make people feel compromised?” (Fine, 2018, paras. 7-8). This very question is one that thematically, remains consistent across the period of study.

A ground level analysis of this very issue examines the way that MAID functions from the operational front when taking into consideration both perspectives of patient and physician rights. As a Director of Operations explained, “we have no reason as a public sector, nonfaith-based organization that we can say ‘we won’t respect your legal right.’ … it didn’t really matter what my opinion was or what have you, but at the end of the day it was our responsibility to allow those people to have what they were legally entitled to” (RI5). During this initial period of MAID initiation, understanding and respecting the perspectives of staff was paramount.

> We did our survey, so we could find out from our staff where they lied as far as, were they comfortable with it [MAID]? Not comfortable with it? Where were they? Would they support it more directly or not? And then we really had to make it clear to staff that regardless, because it is a really slippery slope, right? Regardless of what you think of these clients, until the point of the MAID procedure, they are a client like anybody else. And you may not morally, ethically agree with the decisions they make, but you will treat them as your client with the respect that they deserve. You have a duty to provide that care until the point of when the MAID procedure, when it starts. Then you can opt out, we give them the right to be out of the building, some of them choose to be out of the building when it happens. And we did that because we just, we thought that was our compromise, was you provide care up to this point and that at the point when it happens, we will give you choice. (RI5)

This choice is thematically a central focus within MAID discourse, whether it be the choice of the patient to request a medically assisted death, the choice of the physician to participate, the choice of an institution to abstain for religious reasons, and so forth. Throughout the articles coded under each of the three thematic categories, this discussion of choice is constant, and the solutions offer a workaround that has yet to solve any issues. Some governments, like the Ontario and Nova Scotia provincial governments, require that doctors must effectively refer. Other provinces, like Alberta, have created a registry to which patients may go to find a physician willing to help them. Yet access remains an issue when people don’t know how to get the process started. “It appears that much work still needs to be done to resolve these issues. ‘Somehow we need to find a balance between being patient-centred in our approach and honouring those who are conscientious objectors'" (Newbery as qtd. in Taylor, 2016, para. 32). As Picard expounds, "we need a law that respects the desire of people – all people – to maintain control over their lives and their wish to a dignified death, all the while safeguarding them from potential abuse" (2018b, para. 20). These qualms are expressed across the various articles found in this study and the themes and issues of access, personal autonomy, decision-making and conscience are all widely referenced. Though no clear answer exists, it is obvious that collectively, discussions are moving these issues to the forefront and as time passes, the hope is that we can surpass the 'either/or' dichotomy and move into a period in which MAID is accessible to all, without the legal ramifications for objecting individuals.

4.1.4. Debating Religion in the Context of MAID

The notion of religion and the thematic category by the same name is referenced 165 times across 56 articles in this study and contains many ethical and legal contentions that provide a surprising focus. While many would believe that a religious focus would examine the personal religious beliefs of patients or physicians, as a whole, the discussion around religion across the three-year study period focuses much more on religious institutions and governing bodies than it does on individuals.

> Religious freedom sometimes has to yield to laws that prevent religious people from harming others. The Supreme Court of Canada has emphasized this in limiting religious freedom on a wide range of topics, including denials of blood transfusions, witnesses wearing niqabs in criminal trials, child custody disputes, accountability for unaccredited church schools and bans on Sunday shopping. When the Supreme Court struck down the former ban on assisted dying in 2015, it emphasized that religious freedom must be reconciled with the Charter right of patients who want to access MAID. (Smith, 2017, para. 4)

Yet some people argue that religion has no place in medicine. "There is no such thing as 'faith based' medical care. Medicine is based on science. Faith is based on religious beliefs. Why should we allow publicly funded hospitals to impose their religious views on tax-paying citizens and refuse to provide health care such as assisted dying?" (Smith, 2018, para. 1). As Smith says, we should respect the religious beliefs and autonomy of individuals, but not those imposed by institutions.

This notion of religion in medicine is not the opinion of Christian doctors when it comes to medical assistance in dying, most of whom have an issue with the “effective referral” requirement that mandates they pass patients on to other physicians.

> The doctors say that the college has limited their religious freedom under the Charter of Rights and Freedoms unjustifiably. They argue that a referral endorses the procedure and helps kill, breaking God's commandment. In their view, patients should have to find willing doctors themselves and "self-refer," sparing religious objectors from sin and a guilty conscience. (Smith, 2017, para. 2)

While this brings up previously mentioned issues of access that result from a lack of effective referrals, the larger institutional resistance prevalent on this issue stands as a prominent barrier to MAID as Catholic Hospitals take the position that as institutions, they have the religious right to object under the Charter of Rights and Freedoms. As a result of the Loyola High School v. Quebec Supreme Court ruling,

> Three judges concluded that a religious institution, as a collective, could claim a right to freedom of religion under Section 2(a) of the Charter. However, the three judges added a key caveat to this conclusion: "... an organization meets the requirements for s. 2(a) protection if (1) it is constituted primarily for religious purposes, and (2) its operation accords with these religious purposes." Publicly funded hospitals do not satisfy this test and therefore have no claim to freedom of religion. (Gilbert, 2016, para. 2)

As the author adds: “While an individual physician may have a Charter-protected religious right to ask another doctor to take over the role of ending a life, a hospital has no constitutional right to prohibit all its physicians from doing so. Hospitals have no conscience, only the people who work in them do” (Gilbert, 2016, para. 7). This is further explored by one respondent who describes controversial aspects of this issue as it relates to religious institutions.

> In Alberta they have Covenant Health and Covenant Health is a Catholic organization that runs a lot of healthcare sites. I don’t understand how they, and they’ve been working on that to their credit … on trying to figure out how this works in their organization, but it doesn’t make sense to me that when the public has a right legally to something and the public is funding their system, how they can opt out and send it to somewhere, send that task somewhere else. So, I think there is still work to be done. In some of the faith-based organizations I think there should be a better balance. It’s putting a lot of the onus and the workload for MAID and a lot of the emotion that comes with that and how that impacts staff, it’s putting that on certain providers that are doing more than their fair share. (RI5)

This is especially apparent when considering that religious facilities – be they Jewish, Baptist, Catholic or otherwise – are refusing to allow the practice on their grounds, forcing patients within these institutions to be transferred elsewhere which is often a traumatic, painful and difficult experience.

As Christopher De Bono, vice-president of mission, ethics, spirituality and Indigenous wellness at Providence Health Care notes, "the core issue … is that Catholic and faith-based organizations are committed to the inherent dignity of every human life and would never intentionally hasten the end of a life" (as qtd. in Grant, 2018, para. 18). Yet it is widely understood across the 227 articles that religiously informed opposition to MAID is not focused on religious individuals, but on religious institutions.

> That is not to say a Catholic doctor must be required to assist someone's death - except perhaps in unusual circumstances. But an institution, per se, has no religion. It just happens to be under the control of those who wish to use it as a platform for advancing their beliefs. As such, every Catholic hospital should have at least one non-Catholic doctor with unimpeded access to terminal patients who is free to assist patients with their deaths. These rights must apply to patients of all creeds - including Catholics themselves. (Owens & Wiebe, 2016, para. 7)

Across the various categories it is clear that as a whole, most people understand the concept of conscientious objection and begrudgingly understand the need to allow conscientious objection in a free and just society. But as a large majority of articles coded under religion demonstrate, as soon as this conscientious objection is provided to an entire institution or governing body, then barriers to access and personal autonomy result in significant push back to the very idea. Sandra Martin believes that faith-based hospitals, despite their opposition to the practice, should participate. "I think publicly funded hospitals are supplying health care. They're not supplying religious care. They're supplying health care – a right we won many, many years ago" (as qtd. in Lederman, 2017, para. 18).

It is interesting that the analysis of the 165 references found under the religion category reveals that an overwhelming number of articles focus on critiques of religious opposition to MAID, but very little material is written to provide a truly religious or faith-based perspective on the matter. While letters to the editor and opinions pieces are filled with personal opinions regarding the topic, most news articles do not amplify religious voices. This may be an editorial choice of the publication, or representative of the larger societal acceptance of medical assistance in dying as a medical service overall. This societal acceptance is seen also in the periods in which religiously focused articles are based, as an overwhelming majority of articles were written in 2016 and almost all of them were written in September or October of 2016, as opposed to the month when legislation came into effect. Amongst articles written in the period after legislation came into effect and in years following 2016, most had to do with anecdotal stories that largely critiqued religious institutions for denying access to or for participating in the transfer of patients who suffered as a result of their transfer. In one sense this may suggest an acceptance of religious institutions opting out of MAID, but from interview discussions, all of which were held in 2019, the religious issues outlined here are still prevalent. What that says for the future of religious institutions and MAID is unclear, but as the thematic category suggests, religion in medicine is still as contentious as ever.

4.1.5. Navigating MAID in an Ethical Context

The discourse around MAID is convoluted and the various issues, themes and contentious arguments that make up this conversation are complex. While it is clear that there is no one correct opinion on the matter, and that there are a variety of perspectives that make up a spectrum of ideologies regarding the service, it goes without saying that a large ethical barrier persists, both for those with active interest in the topic and for those without. Seen in the previous subsections, which analyze the various thematic categories and the issues present in them across the study period, ethical concerns weave a narrative throughout each and every category, with critiques that stem from personal, moral, and religious backgrounds, summarized here through respondent interviews.

> I think in mainstream society, I think it's – people have just become more accepting of this, much like abortion. You know before these laws or the absences of laws happen, I think the fears are much greater, that people worry much more than they should. I think like after the abortion debate, Canada hasn't had an abortion law for twenty years. And there were all these dire predictions, "there's going to be slaughter, no one will have babies anymore," and nothing's changed. We have as many abortions now as before when there was a law and I think it's the same thing with MAID. People said it's going to be this slippery slope, we're going to be killing off all our old people and the numbers are as we expected, actually a little lower because there's all sorts of bureaucratic hurdles, so I think people are like "hm." (RI1)

The decriminalization of medical assistance in dying, creating it as a right to patients, it touches on fundamental ethical questions of medicine, questions such as what are the goals of medicine? Is it to alleviate suffering, and if it is to alleviate suffering, how do we alleviate suffering? What does it mean to alleviate suffering? What is the role of physicians in alleviating suffering? What does it mean to respect patient autonomy? Those are fundamental ethical questions. (RI2)

There are languages and images that really polarize people. So, if we were sort of, maybe wanting to hear the other side and at least hear the person out, hear the position out even if we're not going to change, I sometimes find that language will be put out there or images that kind of silence that kind of ability to have a dialogue. Have you ever noticed the images that have been used when you look at an article in a magazine or a newspaper? Whenever you are talking about MAID, it is these hands on each other and [it's shown] that it's great care and compassion and love and just, how do you respond to this? … It's evoking an emotional response and it directs one, so it's not neutral. (RI3)

[There's a] power struggle. Who has the right to make that call for a person? Should it be the government? Should it be a doctor? Is the person really sound of mind? Or are they just having a moment of clarity? I think those are the new kinds of themes because ultimately by having to submit the form to the government, you are asking the government, "hey, can I actually kill myself? Can this doctor actually help me? Do I still have that right as a human?" (RI4)

Access is an issue for sure, especially in smaller centres. We have a shortage of practitioners in Canada, so that's a definitive issue and not an easy one to get around, especially when you're making these decisions, you're making them at a really difficult time in your life and you're obviously not young and spry and healthy, so it makes it all the more complicated and to me, that's why it has to be easy and it has to be fast. If you have a three month wait time for this, it's pointless, it's like not having access. (RI1)

Today we don't really talk about patient autonomy, we talk about patient empowerment, patient engagement, shared decision making, those are the things now integral to the practice of medicine … We've seen the role of patient autonomy become more and more central, we see that respect for patient autonomy is today the paramount ethical consideration that underlies assistance in dying, it can be said that choosing the manner and time of one's death and the very act of granting that choice as a right as it was by the Supreme Court is the total affirmation of autonomy, it's the last definitive step in gaining whole self-determination. (RI2)

So, it's one of those ones where you kind of say, I understand that it's a contentious issue, but there are some positives. When people die spontaneously, these sorts of [positive] things don't happen and there are sometimes these things that are really important to people and so, when I talk to people that don't support it, all I can say is, we're a public sector, we're non-faith based, we have a duty to support the rights of people, but

> on the flip side of that, I want you to understand that there are some things that this allows, that there are some really positive stories that come out of these situations, too. (RI5)

It's true that news articles only ever show one part of an issue. Moreover, as the above interview quotations demonstrate, the perception of MAID is often times drastically different from the actuality of the service, as seen by those who work with – or are directly influenced by – medical assistance in dying. Ethical concerns around this topic are both important and varied and isolating these concerns into a singular category proved challenging as the crossover between various other thematic areas was evident as seen in multiple instances of double or triple coding. Using Table C4 to define the term "ethics," it was clear that every category contained ethical concerns, though the phrasing of these concerns was what justified their inclusion in the related category. But as seen above in the interview excerpts, these concerns also tell a story, both in how we view MAID today, as well as how MAID is perceived on an operational level, as opposed to a theoretical one. Explored here, these excerpts bring to light and make note of several issues that are not discussed in depth in other sections, but which are worthy of note for the reasons listed above. These interviews also helped to contextualize many of the issues and contentions as they were discovered in the text and allowed for the researcher to investigate many key areas of MAID discourse that may not have been discovered if it were not for the time and meaningful insights of the five interviewees.

4.2. Analyzing Media Frames

The previous sections provided an in-depth analysis of the thematic categories present in news articles and interviews on the topic of medical assistance in dying since legislation came into effect. They also highlight the numerous shifts in the way MAID is presented to the public across the three-year study period. However, though the themes and issues in this study encompass 15 individual categories, the overall frames of the articles only encompass five, largely in part due to the crossover of various categories. On account of the main point of study being the examination of news articles, all 227 articles are, by their very nature, media frames. However, the individual topical frames for each article differ and are discussed in full below.

As seen in sections 4.1.1 and 4.1.2, as well as in the table in Appendix C3, multiple categories are connected on account of their base purpose, which in these sections was desired changes or contentions having to do with MAID legislation. Even simply focusing on the issues of advanced directives, mature minors, and mental disorders, all three categories relate back to the notion of changing or adapting current MAID legislation. Mentioned in passing earlier and seen in full in Table C2 found in Appendix C, the number of references for each thematic category were indicative in part of the overarching frame of the article. For instance, the thematic category “Legislation” was referenced 374 times across 144 articles, while “Eligibility Criteria” followed at 239 references across 105 articles. The other categories that were associated with legislation, namely “Constitution,” “Advanced Directives,” “Mature Minors,” and “Mental Disorders” were referenced 117 times across 56 articles, 64 times across 38 articles, 55 times across 24 articles, and 48 times across 23 articles, respectively. Collectively, articles that primarily referenced these six categories held an overall “Legislative Frame,” that while many may consider to be a political frame, focused specifically on facets of the ambiguous wording found within MAID legislation.

The second frame of focus was that of “Ethical Frames” which was developed as a result of both the “Ethics” and “Contentions” categories. The contentions category contained 297 references across 141 articles, while the ethics category was referenced 234 times across 90 articles. These numbers indicate the moral, ethical, and contentious concerns that surround medical assistance in dying to this day, as these two categories were the second and fourth most referenced categories across the study. Even though there is some crossover from other categories for references that were double or triple coded to show up in multiple categories, the primary focus on the notion of “ethics” and “contentions” (defined in Table C4) make no mistake of the overall focus of the articles.

The next most common frame that presented itself was that of a frame labeled “Logistics of MAID.” This frame, as defined in Table C5, encompasses articles that focus on statistics, information sharing, costs of MAID as well as other considerations such as organ donations and other processes related to MAID. While many of these articles had individual focuses that did not result in references being coded solely in the “Logistics of MAID” thematic category, these articles were often times neutral and were specific to fact sharing and statistics updates that kept them from being presented under a legislative frame or an ethical one. Of the thematic category by the same name, this category was referenced 106 times across 46 articles. Even though there was some crossover from other thematic categories such as “Providers” or “Death with Dignity

(Groups),” the latter of which was referenced 43 times across 27 articles, these information-based articles followed similar trajectories that brought them together under a common frame.

The second-to-last frame was a “Personal Rights” frame, which encompassed the categories of “Conscientious Objection,” “Dignified Dying,” “Patient Rights,” and “Providers.” These thematic categories were referenced 105 times across 53 articles, 82 times across 47 articles, 141 times across 83 articles, and 110 times across 50 articles, respectively. Even though some of these references were focused on other areas and were double or triple coded amongst the themes, the primary focus was on the rights of the patient, the rights of the physician, or in some cases, the rights of the institution (i.e., provider) to participate or refuse participation in medical assistance in dying. These articles also included personal experience stories where appropriate, as it was found in the sections above that anecdotal stories carried a particular weight to them.

The final frame to be developed as a result of this study was a “Religious” frame, made up of the thematic category by the same name. Referenced 165 times across 56 articles, these articles focused heavily on the notion of religion in medicine either for or against, and the overall theme of these articles were reflective of such. While 56 articles referenced religion and yet only 22 held a religious frame, this distinction is due to the morally ambiguous grey area that religion encompasses in modern day medicine. For this reason, some religious references held overtly ethical frames, while many were to the point and focused simply on religion and its role in denying or restricting MAID and were therefore coded as such. Many of these religious articles were focused less on conscientious objection and more on institutions and providers that were faith-based, along with religious teachings that view ‘suicide’ as a sin.

As seen in Table 2 below, the breakdown of articles by frames varied across categories for each publication. However, of these frames, stark differences could be seen between the number of articles found in certain categories which are worthy of note. In both publications, the logistics of MAID frame made up 16.3% of *The Globe and Mail* articles and 16.4% of *National Post* articles, and the legislative frame also held similar percentages at 39.7% of articles for *The Globe and Mail* and 34.4% of articles for the *National Post*. For the ethical frame, the *National Post* had a higher percentage at 27.9% of articles, while 20.5% of *The Globe and Mail* articles were labeled the same.

Interestingly, 16.3% of articles in *The Globe and Mail* had a personal rights frame, while only 4.9% had the same in the *National Post*. On the flipside, 16.4% of articles had a religious frame from the *National Post*, while only 7.2% of articles had the same from *The Globe and Mail*. As discussed in Section 4.4, these frames contribute to how readers interact and grow to understand medical assistance in dying and the higher proportion of anecdotal stories in *The Globe and Mail* is reflective of the difference in these personal right frame numbers. Though it goes without saying that the ways in which media frames and thematic frames portray a subject influences the way it is received, as seen in the numbers above, these frames may also influence the thematic categories and sentiments, the latter of which is discussed further in the following section.

Table 2. Framing Category Breakdown by Publication

Category Name	*Globe and Mail (n)*	Percentage of Files (%)	*National Post (n)*	Percentage of Files (%)	Total (n)	Percentage of Files (%)
Ethical Frame	34	20.5	17	27.9	51	22.5
Legislative Frame	66	39.7	21	34.4	87	38.3
Logistics of MAID Frame	27	16.3	10	16.4	37	16.3
Personal Rights Frame	27	16.3	3	4.9	30	13.2
Religious Frame	12	7.2	10	16.4	22	9.7

4.3. Understanding MAID Sentiment

The attitudinal and tonal devices that created the sentiment behind each news article told a story of its own, a phenomenon that was rather surprising at the conclusion of the study. As mentioned in an earlier section, it had not been the intent of the researcher to analyze the sentiment behind each of the 227 articles, however, these sentiments made themselves known and wove a narrative that was worthy of analysis. This is in part due to the nature of articles as being for or against medical assistance in dying which is a meaningful area of study on its own, but after breaking many of the thematic categories down to look at shifts in themes and issues across the various years of study, examining how sentiments also changed was therefore relevant in supporting the analyses made in earlier sections.

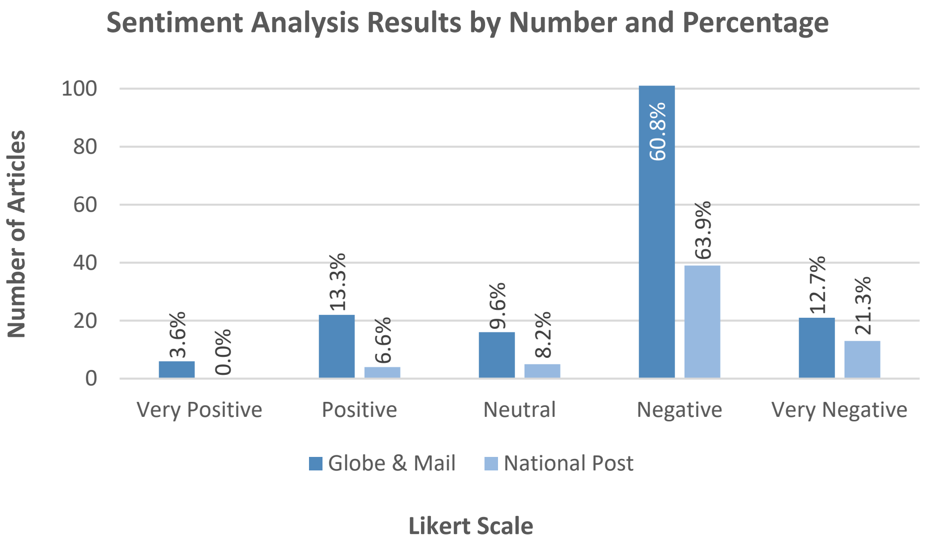

Figure 4. Sentiment Analysis Results For Each Publication[5]

Examining the placements of articles across the sentiment Likert scale as seen in Figure 4 above, 6 articles were coded as ‘Very Positive,’ 26 articles were coded as ‘Positive,’ 21 articles were coded as ‘Neural,’ 140 articles were coded as ‘Negative’ and 34 articles were coded as ‘Very Negative’ across the two publications. Some of these categories, such as neutral and negative, represented similar proportions of articles in each publication, as neutral articles made up 9.6% of *The Globe and Mail* articles and 8.2% of *National Post* articles, while articles with a negative sentiment made up 60.8% of *The Globe and Mail* articles and 63.9% of *National Post* articles. The other three categories, however, were quite distinct and as seen in Section 4.4, reflective of the publication themselves and their overall attitudes towards medical assistance in dying.

Of 26 articles that were coded as positive, 22 came from *The Globe and Mail* and 4 came from the *National Post*, representing 13.3% and 6.6% of articles, respectively. Of the 34 articles that carried a negative sentiment, 21 were from *The Globe and Mail* and 13 from the *National Post*, representing 12.7% of *The Globe and Mail* articles, but 21.3%

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[5] In Figure 4., the percentage displayed represents the percentage of articles present for that sentiment for each respective publication. This means that 22 articles in *The Globe and Mail* in the Positive sentiment category represent 13.3% of total articles, whereas 4 Positive articles in the *National Post* represent only 6.6% of total articles for that publication.

of *National Post* articles, the second highest of the five sentiment categories. The final category, of articles with a positive sentiment, was made up of 6 articles, all of which came from *The Globe and Mail*. These six articles, while only representing 3.6% of total articles for said publication, are also indicative of the ways in which MAID is presented in Canada on account of the fact that the second publication had no articles at all listed as having a very positive sentiment.

Notes on the reasoning behind a 'very positive' designation vary, but of these six articles, 3 were news articles while 3 were letters to the editor. In the reasoning column in the working Excel document, four of the six articles were listed as being very positive because "MAID allowed a dignified death," while one article was very positive on account of giving medical professionals options when providing end of life care and the last was coded as such due to an award winning book receiving recognition and the discussions that resulted from this achievement. On the other end of the spectrum, of 34 articles that were designed as 'very negative,' only 7 of these 34 articles were found in the actual 'News' section of either publication and the remaining 27 articles were all letters to the editor or opinion pieces. This is not overtly surprising since language choices differ based on the various media. News pieces, which rely primarily on fact, are more likely to focus on a singular feature of the topic, while opinion pieces are heavily influenced by the emotions and personal experiences of the writer. As well, since the authors of letters to the editor are usually everyday people or experts on the subject who are writing in, it is unsurprising that articles would be written in a way that would evoke emotions, especially considering the limited and condensed format.

Examining the spread of sentiments over the years, the first sentiment 'very positive' is made up of two articles from 2017 and 4 articles from 2018. These numbers are consistent with the thematic breakdown of categories around legislation which note that the years after legislation came into effect allowed for an uptick in personal anecdotal stories. Of articles categorized with a positive sentiment, 15 articles were published in 2016, two were published in 2017, six were published in 2018 and three in 2019. Of these 26 articles, 12 were framed around Logistics of MAID, which makes sense considering the positive nature of information sharing and presenting changes in protocol that allow MAID legislation to expand into new, unchartered territory.

Neutral articles focused on providing statistical updates to readers and of 21 articles found within this sentiment, 14 of the 21 are coded neutrally specifically due to the nature of the article focusing on data and statistics. Eight neutral articles were published in 2016, four were published in 2017, eight published in 2018 and only one was published in 2019. Considering the ‘update’ component of neutral articles, this spread of sentiments is rather par for the course. Of 140 articles coded with a negative sentiment, 66 articles were published in 2016, 33 were published in 2017, 28 were published in 2018 and 13 were published in 2019. Considering the overwhelming amount of critique that has surrounded MAID legislation since the act came into effect in 2016, as demonstrated in previous sections, it makes sense that the highest proportion of articles coded with a negative sentiment were from the same year, especially when being reminded that 73 of 227 articles were published in the month of June 2016 alone. Since this was the period in which the Liberal government missed the original deadline of June 6, as well as the period in which heavy debate occurred around the final form of legislation, the increased focus during this time is consistent to the thematic breakdowns discussed in Section 4.1.

The final sentiment category of ‘very negative’ is similar to the negative sentiment, with 17 articles being published in 2016, five articles being published in 2017, 10 articles published in 2018 and two published in 2019. In both cases, the higher proportion of negative opinions line up with the actual enactment of the MAID act itself and was a result of the heavy debates that occurred during this period as senators made numerous amendments before legislation was passed on June 17. Of 17 articles that were published in 2016, 10 articles coded as very negative were published in the month of June alone, which is consistent with prior data. Within the notes captured in the reasons for coding for this category, multiple articles are described as having “strong emotions around MAID,” of the authors feeling anger, the articles possessing extreme criticism on a topic or because the articles outline a personal experience that is inherently negative due to the nature of the experience. Of these 34 very negative articles, 17 articles are framed as having an ethical focus, which is consistent with both the definitions of the category, as well as the criteria for the framing category which remains in line with prior analyses.

Collectively, these sentiments paint a picture across the study period that depict an attitudinal shift throughout the years. This is seen in the disproportionately high number of articles containing negative sentiments found in 2016, versus later years in which other sentiments across the spectrum are more pronounced. If it is considered that 106 of 227 articles were published in 2016 and that 66 articles are coded with a negative sentiment and 17 articles with a very negative sentiment from that same year, then of 106 articles, 83 articles are presented negatively which represents a startling 78.3% of total articles from 2016. In comparison, of 46 articles published in 2017 from both publications, 25 negative and 3 very negative articles were published in *The Globe and Mail*, whereas 8 negative articles and 2 very negative articles were published in the *National Post*. These 38 articles made up 82.6% of total articles, indicating that the overall sentiment in 2017 was much the same as 2016 as Canada tried to come to terms and navigate MAID legislation. Of 56 articles published in 2018, however, 38 articles were listed as carrying a negative or very negative sentiment which represented 67.9% of articles. This was followed in 2019 by 15 of 19 articles published in this year having listed a negative or very negative sentiment, representing 78.9% of overall articles.

Table 3. Sentiment Analysis by Publication Per Year

Sentiment	**Publication**	**2016**		**2017**		**2018**		**2019**		**Row Total**	
		n	%	n	%	n	%	n	%	n	%
Very Positive	*The Globe and Mail*	0	0	2	4.3	4	7.1	0	0	6	2.6
	National Post	0	0	0	0	0	0	0	0	0	0
Positive	*The Globe and Mail*	12	11.3	2	4.3	5	8.9	3	15.7	22	9.7
	National Post	3	2.8	0	0	1	1.8	0	0	4	1.8
Neutral	*The Globe and Mail*	7	6.6	2	4.3	6	10.7	1	5.3	16	7.0
	National Post	1	0.9	2	4.3	2	3.6	0	0	5	2.2
Negative	*The Globe and Mail*	45	42.5	25	54.4	22	39.3	9	47.4	101	44.5
	National Post	21	19.8	8	17.5	6	10.7	4	21.0	39	17.2
Very Negative	*The Globe and Mail*	10	9.5	3	6.6	7	12.5	1	5.3	21	9.3
	National Post	7	6.6	2	4.3	3	5.4	1	5.3	13	5.7
	Column Total	106	100	46	100	56	100	19	100	227	100

These shifts in attitudes are consistent with other analyses found in this study, most notably the level of critiques and the focus of contention. If we consider a point made earlier in this study around the shift in discussion of legislation across the years, than these changing negative sentiments align with what was said in Section 4.1.1.

Specifically, this section made note in Figure 2 of how 2016 focused on *how* to enact legislation, 2017 focused on *understanding* legislation, 2018 focused on *expanding* legislation and 2019 focused on *developing* legislation, all of which aligns with the changes in sentiment as the level of critiques and their focuses shifted across the years. As well, since articles from 2019 only go up to the end of June, there is no data on the other half of the year, which could easily have included a higher proportion of neutral and/or positive articles. Overall, however, it is clear that the various thematic categories and framing schema heavily influenced the overall sentiments of each article and the way these are presented in the media subsequently influence readers who come to either publication seeking a reliable source of information.

4.4. Comparing Publications

Prior to legislation coming into effect in 2016, Crumley et al. (2019) note that while disability advocates received more attention from journalists during this period, their arguments weren't as compelling as the stories of people suffering horrible deaths by being denied MAID.

> Since it seemed that Canadians wanted to determine their own death, journalists began to portray MAiD as a national debate that needed to occur. They highlighted calls of discrimination against ill patients who were physically unable to take their life or travel to receive MAiD. Newspapers also explored the various interpretations of quality of life and the process of dying, and featured frameworks and processes that could be used for MAiD in Canada. Although the terms 'euthanasia/euthanasie' and 'suicide' had long been used by the press to describe MAiD, journalists began to use phrases such as 'dying with dignity' and 'mort douce et sans souffrance.' Reports about Quebec's legislative debate fuelled the idea that MAiD could become legal in Canada and many newspapers took notice." (p. 17)

Yet seen in *The Globe and Mail* and the *National Post*, the ways in which these stories are told differ greatly. For example, of 227 articles, 53 articles from *The Globe and Mail* were letters to the editor that encompassed personal opinions and significant sentiment variants, almost all 'very positive' and 'very negative' sentiments falling within these sections. This was the same for the *National Post*, in which 12 articles were letters to the editor and these same sentiment variations were found throughout. This is relevant because publications exercise editorial control over what they publish in their papers and by choosing pieces with strong language and sentiments that are situated on either end of the spectrum, these articles play a part in influencing the general public whose only interaction with the topic of MAID may be through these inflammatory, visceral or contentious opinion pieces.

Another instance of this is seen in the discrepancy between the number of articles included from both publications. If we consider that *The Globe and Mail* has just short of three times as many articles included in this study as compared to the *National Post*, it is obvious that there would, in turn, be a greater number of anecdotal stories presented. However, this does not change the fact that even beyond that, the *National post* has a disproportionately small percentage of articles that include personal anecdotes and whether good or bad, *The Globe and Mail* provides many such accounts. This demonstrates a choice that was made between the two publications on how to present the topic to the public and the amount of coverage and proportion of specific articles from each publication is representative of that choice. For one publication, the notion of assisted dying is seemingly important, relevant to the employees, reflective of the paper's values, and mindful of stories that need to be told to enact change. For the other publication, the notion of assisted dying is one to be scorned, unworthy of coverage, and which is best represented with articles that lean heavily on religious and ethical concerns, as opposed to neutral facts or uplifting tales.

Table 4. *The Globe and Mail* Author Breakdown

Author Types	Total (Unique Authors)	Total (Double Authors)	Total (Overall)
Unique Authors	136	10	146
Partnered Authors	14	0	14
Authors with 1 Article	109	9	118
Authors with 2+ Articles	27	1	28

In part this may be due to the breakdown of authors. Of 285 articles initially pulled for the sake of this study from *The Globe and Mail*, 136 of these authors were unique authors, with 10 additional unique authors who had co-written an article bringing the total up to 146 unique authors as seen above in Table 4. From these 285 articles, 109 authors were responsible for one article, while 27 authors had written 2+ articles, most notably, *The Globe and Mail* staff writers with 32 articles, Kelly Grant with 21, Sean Fine with 16, Laura Grant with 15 and André Picard with 13. These five authors alone were responsible for the publication of 97 of 285 articles, or 35% of total articles. Of 126 articles initially pulled from the *National Post*, 66 of these authors were unique authors, with two unique authors who had co-written an article bringing the total to 68 unique authors as seen in Table 5 below. Of these authors, 46 were responsible for only one article, while 20 were responsible for 2+ articles, most notably, *National Post* staff writers with 11 articles, Andrew Coyne with 10, Sharon Kirkey with 9, John Ivison with 6 and Ian Macleod with 5. These five authors were responsible for 41 articles overall, or 32.5% of total articles. This suggests a lack of diversity on the topic of MAID in Canada, as there are multiple instances of repeat authors who control their own narrative who have the ability to influence the way the average Canadian views the topic of MAID.

Table 5. *National Post* Author Breakdown

Author Types	Total (Unique Authors)	Total (Double Authors)	Total (Overall)
Unique Authors	66	2	68
Partnered Authors	0	2	2
Authors with 1 Article	46	2	48
Authors with 2+ Articles	20	0	20

Having a heavy presence of repeat authors allows for consistent perspectives on any given topic and this is seen even in this study which has frequently quoted the same authors, despite having pulled quotations from category nodes in NVivo and not from the authors' articles themselves. But this may also contribute to an interesting phenomenon that this study's researcher discovered around the number of files that use specific terms and the way that this influences how the general public interacts with and views a topic. Looking at the terms to describe assisted dying as outlined in Section 3.3, in the end, all results were pulled for both *The Globe and Mail* and the *National Post* that used the terms "assisted death," "assisted dying," "assisted suicide" and "medical assistance in dying" at any point within the documents. But looking at the breakdown of terms used, a clear discrepancy presents itself on how exactly each publication prepares the topic to be presented to its readers.

Table 6. Number of Files That Use Specific Assisted Dying Type Terms

Publication	Assisted Death (n)	Assisted Dying (n)	Assisted Suicide (n)	Euthanasia (n)	MAID (n)
Globe and Mail	128	112	48	15	67
National Post	39	26	32	27	23
TOTAL	167	138	80	42	90

As seen in Table 5 above, of 227 included articles between the two publications, there is quite the variety of terms used to describe assisted dying activities. But of note is the fact that this study period is specific to the three years *after* MAID legislation came into effect and yet, the MAID category which is representative of both 'MAID' or the phrase 'medical assistance in dying,' is not remotely the most used term. This is interesting in the sense that prior to June 17, 2016 before legislation was officially called medical assistance in dying, many interest groups were still fighting to either create legislation or to ban legislation, so contentious descriptive choices are less surprising. One thing to note is that the phrase "MAID" was announced in 2016, and since the entirety of this study focuses on the period after medical assistance in dying became legal, it is more surprising then that the variations of 'MAID' are the most common terms, considering MAID is the actual official name of the service. Even considering that MAID encompasses the phrase "assistance in dying," the assisted dying category above is a complete standalone to this phrase and is used independently of MAID as a whole.

Table 7. Percentage of Files That Use Specific Assisted Dying Type Terms

Publication	Assisted Death (%)	Assisted Dying (%)	Assisted Suicide (%)	Euthanasia (%)	MAID (%)
Globe and Mail	77.1	67.5	28.9	9.0	40.4
National Post	63.9	42.6	52.5	44.3	37.7
TOTAL	73.6	60.8	35.2	18.5	39.6

More interesting than just the overall number of uses for each specific assisted dying type term, is the percentage of uses from each respective publication. Seen in Table 7 above, the term "assisted dying" is found in 67.5% of *The Globe and Mail* articles, in 42.6% of *National Post* articles and 60.8% of the total 227 articles. Considering the aforementioned inclusion of the phrase 'assistance in dying' in the overall term MAID, this makes sense for why the assisted dying category carries the second highest number of files that use the term. The term 'assisted death' (which spoken aloud is slightly harsher than that of assisted dying) is the most used term across the files overall and in part is higher due of the heavy inclusion of the term from the *National Post*, despite having almost a third the size of included articles. This is followed by the MAID category which is almost even between the two papers. But collectively, this lack of unity indicates a perception difference in how medical assistance in dying is viewed, first by the publication themselves and then followed by the perception of the readers whose first encounter may be with a harsher description of the service and may lead to confusion as the official medical term is often overlooked.

Looking back at the assisted dying category, a large gap is noticeable in the percentage of articles, a difference that is 25% higher for *The Globe and Mail* than it is for the *National Post* which some may attribute to the large difference in overall articles between the two papers. However, a stark contrast is seen in the remaining two categories that indicates that this is likely not the case. The ‘assisted suicide’ category is one example of this as 35.2% of overall articles use the term, which is not overly surprising due to the fact that prior to February 6, 2015 the notion of assisted dying was then known as ‘physician assisted suicide.’ However, since legislation came into effect, the Canadian government has shifted away from using the term ‘suicide’ and instead uses softer descriptors like ‘aid in dying’ to make the concept easier to digest. As the respondent working for one of the two publications mentions, “we’re careful, we never use ‘assisted suicide’ because suicide means something else, suicide is associated with killing yourself … because of mental illness where … this is a procedure like any other, it’s the same as giving someone their diabetes medicine, you’re giving them this medicine to stop their pain” (RI1). But what is important to note in this category is the discrepancy between the two papers. For the first time out of all the categories, *The Globe and Mail* used the term ‘assisted suicide’ in only 28.9% of articles, while the *National Post* uses it in 52.5% of articles making it the second most used term behind ‘assisted death’ for that publication. Since most articles use multiple terms throughout their reporting and since other categories like the MAID category show numbers that are equally reflected, having such a large gap is noticeable. This is even more noticeable in the final category ‘euthanasia’ which is only used in 9% of *The Globe and Mail* articles, but 44.3% of *National Post* articles, making up 18.5% of overall articles. This discrepancy without a doubt contributes to the differences in the way MAID is presented between each paper and is a stylistic choice that contributes to the way readers interact with the topic while reflecting the publication’s personal views on the matter.

This point is further driven home by doing a simple word frequency of each ‘includes’ folder, setting the query to the 100 most frequent words, three characters or longer, and selecting the ‘with stemmed words’ option which groups together variations of words (such as talk, talks, talking) before adding words to the stop words that detract from the analysis. For the *National Post*, ‘euthanasia’ was the 17th most used word. For *The Globe and Mail*, it’s not even on the list. This in itself shows the stark contrast between the way MAID is presented in Canada, as general public perception is moving away from the terms euthanasia and suicide, whereas the *National Post* shows no intentions of veering away from these terms. While both publications use MAID relatively consistently (the 32nd most used word for *The Globe and Mail* and the 34th most used word for the *National Post*), the terms 'assisted,' 'dying' and 'death' are used 1,171, 1,089 and 964 times, respectively, across 166 articles in *The Globe and Mail*, versus 334, 197 and 267 times, respectively, across 61 articles in the *National Post*. Yet for the other categories, 'suicide' is the 14th most used word in the *National Post* with 113 occurrences, while in *The Globe and Mail* it is the 81st most used word with 126 occurrences. This further drives home an earlier discussion in which the differences in the way that MAID is presented to the public can influence the audiences perception of the service, as for *National Post* readers they may see the act as being cruel (due to their high use of the term euthanasia), versus *The Globe and Mail* readers who are exposed to the phrase 'assisted dying' which sounds more agreeable.

This information is relevant when considering the mediums in which the average Canadian receives their news and the way that information is presented influencing the audience's perception on a topic. For if a reader only ever came across MAID presented in the context of 'euthanasia' by a writer who consistently writes on the topic, versus a reader who comes across MAID expressed in the context of assisted death or assisted dying, their perceptions of the topic would surely differ. Though this study does not have the capability to do a deep dive analysis of the connotations that are associated with the various descriptive terms, even looking back at Section 1.6 and seeing the different ways that the terms are defined should be enough to paint a preliminary picture on how these terms have the ability to influence readers.

Examining the media bias of the two publications, both publications are listed as having a 'right-center' bias, though on a spectrum of perspectives, the *National Post* is considered to be significantly 'more right' than that of *The Globe and Mail*. As Media Bias/Fact Check indicates, "Overall, we rate *The Globe and Mail* slightly Right-Center biased due to editorial positions and High for factual reporting based on proper sourcing" (2018, para. 2) whereas for the second publication, "overall, we rate the *National Post* Right-Center Biased based on story selection that favors the right and High for factual reporting due to proper sourcing and a clean fact check record (2019, para. 2). In response to each publications' 'analysis/bias,' the analyses of these biases are shown in the following comparison. For *The Globe and Mail*,

> *The Globe and Mail* reports local news through the use of field journalists, while World news is primarily syndicated via the Associated Press and Reuters. News headlines and articles contain minimal loaded words and are well sourced. However, editorials do utilize sensational headlines … Editorially, *The Globe and Mail* has a history of endorsing slightly more conservative candidates than liberal. (Media Bias Fact Check, 2018, para. 7)

For the *National Post* on the other hand,

> The *National Post* publishes news about Canada and the World. Most Canadian news is from The Canadian Press and world news from the Associated Press. Toronto news comes from local journalists and politics comes from a variety of sources that lean right. Editorially, Post Media mostly supports the consensus of science with climate change but does present doubts. In general, *National Post* has a slight right lean through the support of President Trump. (Media Bias Fact Check, 2019, para. 7)

As indicated here, this right leaning nature of the *National Post* may reflect why harsher terms are selected to represent MAID, as opposed to *The Globe and Mail* which is only slightly right leaning. As the Bias website indicates, “these media sources are slightly to moderately conservative in bias. They often publish factual information that utilizes loaded words (wording that attempts to influence an audience by using appeal to emotion or stereotypes) to favor conservative causes. These sources are generally trustworthy for information, but may require further investigation” (2018, para. 1). Though it is hard to confirm the assumptions that have been made around the information presented in this section, one fact is still clear: the way the general audience views the topic of medical assistance in dying is most likely influenced by the publication they get their information from, as evidenced here in this chapter.

4.5. Summary

The practice of assisting another person to die is a complex one, whether that be on a physical, emotional, or psychological front as we try and navigate challenged associated with the best way to aid suffering individuals, without risking those from vulnerable demographics. It is no easy feat managing the ethical, moral, religious, and personal beliefs of individuals and organizations on a topic as contentious as this and as seen through the analyses found in this chapter, one that continues to shift over time. The standard belief that MAID legislation is not sufficient runs through all sections and analyses in this chapter, whether that be through examining critiques around legislation, a look at legislative frames or analyzing how sentiment contributes to the way that an article is received. These legislative frames, heavily influenced by ethical frames, lead the way regarding MAID discourse as almost all sub-categories directly relate back to it, whether it’s through the notion of assisting mature minors and adding a subsection to legislation or providers trying to abstain from participating due to religious means. Regardless, the continuity of legislative concerns is seen throughout the study and may be an area of continued interest for future researchers.

Taking into account the various methodologies used and the two different data sources (seen through the content analysis of newspaper articles and interviews), data collected in this chapter used a variety of analytic approaches to present results in a way that was easier to visualize and contextualize. With the aid of the five interviews, analyzing the study data was a straightforward and efficient process, bolstered by a systematic approach that allowed for an objective analysis that aimed to present the findings in a way that would demonstrate the key areas of MAID discourse, as well as the shifts in opinions over time. Comparisons between the two publications allowed for the development of a hypothesis around the way publications influence their audience based on the terminology presented, and the different proportion of included articles contribute to this based on frequency and type of articles written. Various frames highlighted throughout this thesis showcase the major themes, issues and contentions present throughout and a conducted sentiment analysis demonstrated the to-this-day negative sentiment that is still widely associated with medical assistance in dying. Changes in the way MAID discourse was presented across the time period of study include struggling with understanding and enacting legislation, discussions around conscientious objection, expanding eligibility criteria to be more inclusive and more, which demonstrated the key areas of focus as time progressed. As MAID legislation moves into its period of review following June 18, 2020, many issues and themes found throughout this study indicate areas that should be of focus over the next 12-month period and bring to light some of the considerations around MAID that still need to be examined if we want to better improve MAID as a medical service in Canada.

Chapter 5.

Conclusion

While the methodological process encapsulated a variety of means to examine the media discourse on the topic of medical assistance in dying in Canada, the number of findings that resulted from this process far exceed what can be discussed here in the context of a master's thesis. Though these findings are highlighted in Chapter 4, information found within specific categories are further expanded upon in the initial data documents, many of which may provide an interesting study point as a foundation for future research. In addition to this, though some limitations were evident in the study, namely that of the work being completed by a single researcher and not a research team, this study may one day act as a stepping stone to further research as it aims to fill a gap in academic MAID literature by looking specifically at a more recent period in time. This is especially relevant when considering the mandatory review period for MAID legislation falling on June 18, 2020, which dictates "[A]t the start of the fifth year after the day on which this Act receives royal assent, the provisions enacted by this Act are to be referred to the committee of the Senate, of the House of Commons or of both Houses of Parliament that may be designated or established for the purpose of reviewing the provisions" (Government of Canada, 2016, para. 10.1). Though this study may only be published during this fifth year, it will hopefully help to contextualize the key issues, themes, and contentions that have continued to exist since the law came into effect on June 17, 2016, which may be of use to some interest groups for future changes.

5.1. Bill C-7

In addition to this mandatory review period come the fifth year of legislation, on February 24, 2020, Bill C-7 "An Act to amend the Criminal Code (medical assistance in dying)" was introduced in the House of Commons by the Minister of Justice and received it's first reading that same day (Nicol & Tiedemann, 2020, para. 1). The enactment amends the *Criminal Code* to, among other things,

> (a) repeal the provision that requires a person's natural death be reasonably foreseeable in order for them to be eligible for medical assistance in dying;

> (b) specify that persons whose sole underlying medical condition is a mental illness are not eligible for medical assistance in dying;
>
> (c) create two sets of safeguards that must be respected before medical assistance in dying may be provided to a person, the application of which depends on whether the person's natural death is reasonably foreseeable;
>
> (d) permit medical assistance in dying to be provided to a person who has been found eligible to receive it, whose natural death is reasonably foreseeable and who has lost the capacity to consent before medical assistance in dying is provided, on the basis of a prior agreement they entered into with the medical practitioner or nurse practitioner; and
>
> (e) permit medical assistance in dying to be provided to a person who has lost the capacity to consent to it as a result of the self-administration of a substance that was provided to them under the provisions governing medical assistance in dying in order to cause their own death. (House of Commons, 2020, p. ii)

Though parliament was prorogated due to the onset of COVID-19 and the associated safety measures put in place in response, Bill C-7 will push forward discussions around many of the key issues identified in the making of this thesis and is an important site of study for MAID discussion and implementation. More pertinently, any current MAID studies being published in late 2020/early 2021, including this one, may be able to offer support for the convoluted discussions surrounding this subject matter and should be leveraged in full to enhance the government's understanding of current and developing MAID issues.

5.2. Suggestions for Future Research

MAID research in recent years has begun to pick up in intensity, though there is still an obvious disconnect between studying MAID from a communication studies perspective, versus other disciplinary approaches such as policy studies or psychology. This in itself presents an interesting site of study, as future researchers in the communication field might choose to look specifically at how information is communicated to various interest groups and the ways in which this is done. There are many opportunities within MAID research to follow a top-down approach and see how the government communicated information to representative bodies, like the Canadian Medical Association, and how the Canadian Medical Association then communicated with their members. Alternatively, it would also be of interest to look at how health care professionals communicated their concerns around MAID to their organizing bodies and how these representative organizations then communicated back to the legislators. As it appears this is not something that has been studied up to this point, gaining a better understanding of the ways in which MAID has been communicated thus far should make researchers consider a media effects study as a future site of research.

One suggestion for future research that came around as a result of the interviews was how MAID is being communicated in the workplace. As seen in Chapter 4, one individual who tried to request bereavement in advance for a grandparent using the MAID service the following week was denied the right as their manager informed them they could not request bereavement until after the individual had died. This presents an incredibly interesting site of study, as looking at the ways in which companies are or are not incorporating MAID into their bereavement policies will indicate how MAID is being accepted in Canada in the bigger picture. As well, this will also demonstrate to legislative bodies an area within MAID legislation that may need to be expanded on or clarified to reduce the stress on the everyday person who is encountering MAID for the first time on a deeply personal level. While this type of study would likely be a mix of policy and communications work, the relevance to Canadian businesses as MAID becomes more commonplace within our country could prove to have an impact such that bereavement policies could be adjusted to be more inclusive and therefore enable anyone who knows someone using the service to provide their bereavement notice in advance to better prepare their workplaces for their pending absence.

Another area of interest that emerged due to the nature of coding in this study is that of the average person's opinion of medical assistance in dying. Both the researcher's personal experiences and the mix of voices found within the news articles and interviews made it clear that many of the voices relevant in MAID are those of individuals or organizations with a direct involvement in MAID. Thinking of the range of perspectives as being on a spectrum, in the findings that are discussed in Chapter 4, many of the discussions within the news articles are from individuals who are adamantly opposed to MAID on one end, to individuals who support MAID but want it to be more inclusive towards the other. In between are policy groups or interest groups who either want to see legislation expanded or restricted based on their own beliefs and ethics. However, on this spectrum of perspectives, the average person who has no involvement in MAID, but may eventually need it in the future or know someone who will come to use it is not included, so studying the average person's perception of MAID to get a sense of people’s understanding of the service may better help policy makers and health organizations better prepare to assess this issue. This lack of knowledge and understanding around the issue was especially evident in the case of the researcher who, on multiple occasions across their three years of study, was asked whether their thesis topic was legal in Canada or whether they hoped to help make it legal through their contributions. These comments made it abundantly clear that unless you had a direct involvement in MAID either through your work, through your beliefs, or through knowing someone who has or plans to use the service, the average individual has little to no understanding or awareness of medical assistance in dying in Canada. Though likely not an easy study as finding participants may be challenging since assisted dying is still to this day quite a contentious subject, doing so would open doors on how interest groups can and should communicate the topic to a wider audience to make people more aware of MAID legislation and its challenges, or to provide resources for individuals for when they become aware through any of the aforementioned means. Though there are of course many more variations for future research in this area, it is the hope of the researcher that MAID academic literature continues to grow in the future and that fellow communication researchers continue to take interest in this important and timely area of study.

5.3. Study Limitations

Though obvious attempts were made to ensure the study at hand was systematic in its approach and well thought out to reduce errors and oversights, some limitations remained on account of only having a single researcher and in relation to perspectives provided. While all efforts were expended to try and invite multiple perspectives, especially in relation to the interviews, this was not the case in the end which must be acknowledged for the sake of transparency in the research. Furthermore, though the researcher has no direct relationship to medical assistance in dying, nor do they receive any personal benefits from the completion of this study outside of acquiring a master’s degree, it may be worth noting that the personal opinion of the researcher is in favour of medical assistance in dying. While not necessarily a limitation based on the systematic nature of the study, as well as the objective presentation of the facts using quantitative and qualitative facts, it is still important to mention this for the continued sake of transparency.

Along with these facts were some study design limitations, such as the fact that this study only looked at English articles, though Canada as a country is bilingual. As the researcher is not fluent in French, the scope of the study could possibly have been expanded if this were not the case, but as it stands the study chose to focus on English articles, as French was not an option. As well, since this study chose to focus on Canada, there are many different discourses surrounding the topic of assisted dying that could have been included by comparing and contrasting discursive representations in various jurisdictions. However, this type of study was too grand a scope for a master's thesis and for the work of a solitary researcher. Due to the focus of this work on academic sources with the aim of contributing to academic literature and debates concerning MAID, it has not explored grey literature or legislative sources such as Hansard records. Additional work undertaken on this topic could make a meaningful contribution by going into greater depth with these sources, as well as by expanding the coverage of analysis to social media sources also. If other researchers were to complete a similar study in the future, these limitations should be taken into consideration so that they can be removed or reduced to better strengthen the validity of results moving forward.

5.4. Summary

Across the course of this research study, an examination of the themes, issues and debates surrounding the topic of medical assistance in dying in Canada since 2016 were examined for the sake of better understanding the way MAID discourse is presented in the media. Using a variety of quantitative and qualitative methods, an examination of the types of topics being presented within MAID discourse allowed for insights to be gained on the still rather negative perception of MAID legislation and the contentions that go along with those complaints. While MAID has been legal within Canada for four years at the time of writing, it is clear over the course of the findings and ensuing discussion from Chapter 4 that there are many facets of MAID legislation that still need work and as conversation shifts to the three key areas of advanced directives, mature minors, and mental disorders moving forward, it is obvious that this contentiousness will continue unless we can find a better way to discuss the material.

Though in recent years there has been an increase in the number of research studies within MAID academic literature, there are still numerous gaps that need to be filled as researchers from different areas look to examine MAID content from different angles and perspectives. Multiple suggestions were provided over the course of this study on areas of research that may prove interesting for future academics and with time and more changes to MAID legislation, hopefully some of these aforementioned gaps in the literature begin to be filled.

While it is clear that we as a society still have a long way to go in navigating assisted dying within Canada, it is also clear that the foundations that have been placed are leading the way forward and that with time and enough pressure, many more Canadians will be able to access the service without putting another individuals' morals and beliefs at risk. Though currently this topic is still up for debate in Canada, assisted dying is here to stay and because of this we should collectively aim to prepare ourselves to address and communicate our ever-growing needs on the matter and work to better serve the needs of ailing Canadians.

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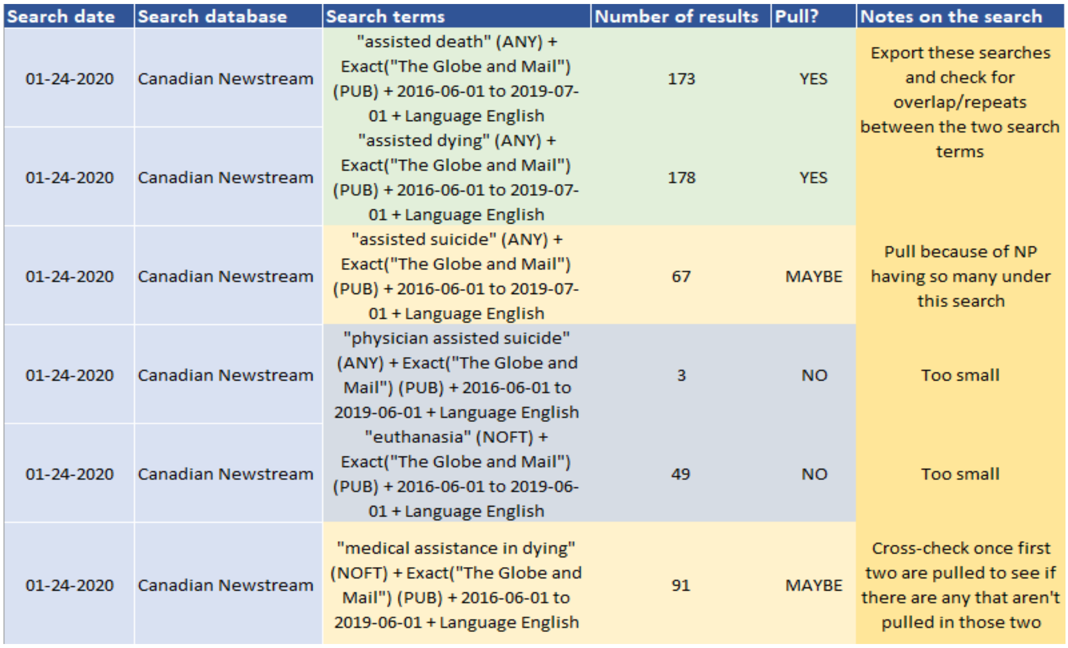
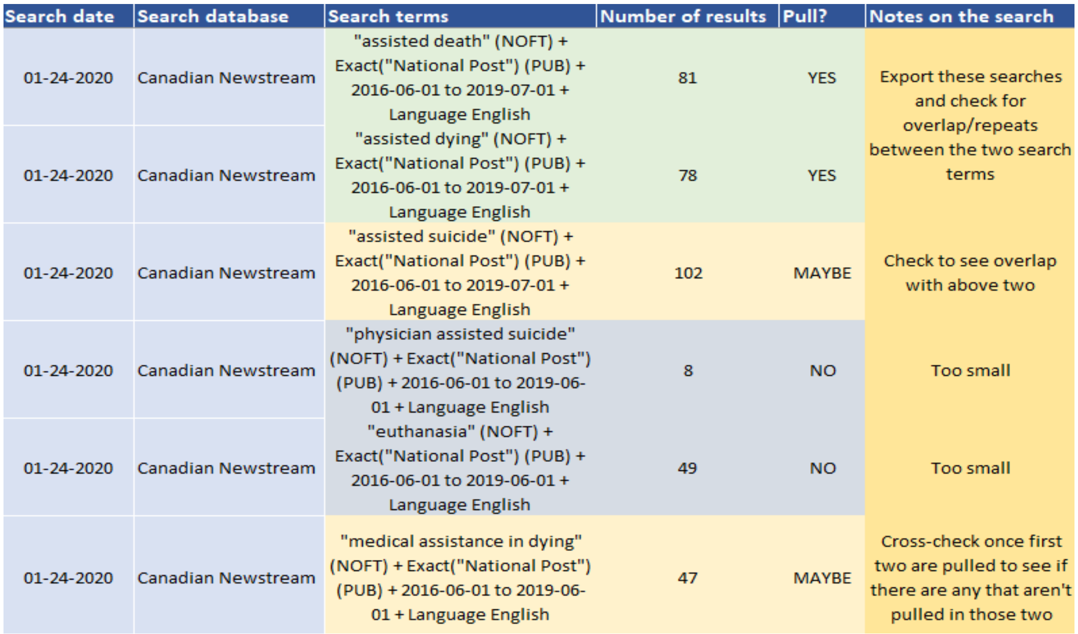
Appendix A.

Search Logs



Search date	Search database	Search terms	Number of results	Pull?	Notes on the search
01-24-2020	Canadian Newstream	"assisted death" (ANY) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-07-01 + Language English	173	YES	Export these searches and check for overlap/repeats between the two search terms
01-24-2020	Canadian Newstream	"assisted dying" (ANY) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-07-01 + Language English	178	YES	
01-24-2020	Canadian Newstream	"assisted suicide" (ANY) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-07-01 + Language English	67	MAYBE	Pull because of NP having so many under this search
01-24-2020	Canadian Newstream	"physician assisted suicide" (ANY) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-06-01 + Language English	3	NO	Too small
01-24-2020	Canadian Newstream	"euthanasia" (NOFT) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-06-01 + Language English	49	NO	Too small
01-24-2020	Canadian Newstream	"medical assistance in dying" (NOFT) + Exact("The Globe and Mail") (PUB) + 2016-06-01 to 2019-06-01 + Language English	91	MAYBE	Cross-check once first two are pulled to see if there are any that aren't pulled in those two

Figure A1. Search Logs for *The Globe and Mail* Articles



Search date	Search database	Search terms	Number of results	Pull?	Notes on the search
01-24-2020	Canadian Newstream	"assisted death" (NOFT) + Exact("National Post") (PUB) + 2016-06-01 to 2019-07-01 + Language English	81	YES	Export these searches and check for overlap/repeats between the two search terms
01-24-2020	Canadian Newstream	"assisted dying" (NOFT) + Exact("National Post") (PUB) + 2016-06-01 to 2019-07-01 + Language English	78	YES	
01-24-2020	Canadian Newstream	"assisted suicide" (NOFT) + Exact("National Post") (PUB) + 2016-06-01 to 2019-07-01 + Language English	102	MAYBE	Check to see overlap with above two
01-24-2020	Canadian Newstream	"physician assisted suicide" (NOFT) + Exact("National Post") (PUB) + 2016-06-01 to 2019-06-01 + Language English	8	NO	Too small
01-24-2020	Canadian Newstream	"euthanasia" (NOFT) + Exact("National Post") (PUB) + 2016-06-01 to 2019-06-01 + Language English	49	NO	Too small
01-24-2020	Canadian Newstream	"medical assistance in dying" (NOFT) + Exact("National Post") (PUB) + 2016-06-01 to 2019-06-01 + Language English	47	MAYBE	Cross-check once first two are pulled to see if there are any that aren't pulled in those two

Figure A2. Search Logs for *National Post* Articles

Appendix B.

Ethnographic Interviewing Process

B1. Recruitment Email Invitation

SUBJECT: Interview Request for Master's Thesis: Medical Assistance in Dying

BODY TITLE: Communicating Contentious Issues in Canada:
Analyzing Media Discourse of Medical Assistance in Dying (MAID)

BODY: Dear [Personalized Name Address],

My name is Jess Taylor and I am a Master’s student in the School of Communication at Simon Fraser University. Presently, I am working towards obtaining a Master of Arts in Communication, with a research focus on medical assistance in dying. My research looks at examining the period from February 6, 2015 when the Supreme Court of Canada struck down the ban against physician assisted suicide (PAS), to June 17, 2016 when the Medical Assistance in Dying (MAID) Act came into being. My specific focus is on the discoursal changes within the PAS/MAID discussion during the selected period, to be examined using a quantitative approach of thematic content analysis which will identify key phrases and discourse found within the text. These same data sets will then be examined using a qualitative approach of critical discourse analysis with a specific focus on the language and framing of speakers.

I am writing to you today to make use of your knowledge and involvement within the legislation of medical assistance in dying practices, whether for or against, and to request an interview with you so I can discuss what you view as the key themes, debates and considerations within MAID debate. In previous work conducted at the undergraduate level, I coded material using categories I had self-developed and upon reflection, felt like this type of methodology was not sufficient in ensuring a systematic and robust review. Therefore, I am reaching out to you today to utilize the expertise of individuals involved within the

PAS/MAID debate for assistance in developing stringent coding measures with which to apply to my selected material.

If this is of interest to you, please reply to the above email so that I may fill you in on the details of your involvement, including an outline of the study in full, a discussion of meeting requirements, data collection, the dissemination of results and of course, a consent form to be signed before any of the above is to be completed.

I look forward to hearing from you and thank you for your consideration. I realize that while you have publicly spoken on the topic before, you may not feel as comfortable doing so now, so for your consideration in

replying I thank you and I hope that I have sparked your interest in contributing to the academic literature surrounding the topic of medical assistance in dying.

Sincerest thanks,

Jess Taylor

B2. Consent Form

Communicating Contentious Issues in Canada: Analyzing Media Discourse of Medical Assistance in Dying (MAID)

The purpose of this study is to understand changes in discourse surrounding the topics of physician assisted suicide (PAS) and medical assistance in dying (MAID) in Canada. Research will be conducted on news stories from *The Globe and Mail* and the *National Post*, examining for shifts in discourse over time. Ethnographic interviews will take place with 8 to 10 key individuals within the fight for or against PAS/MAID prior to this analysis which will result in transcriptions that will be used to develop a coding schema to be applied to the selected data sets. This information will then be used towards completing a Master of Arts in Communication thesis at Simon Fraser University, resulting in a 100-page thesis to be submitted to the SFU Library Database and select academic journals for publishing.

To participate in this study, you will be asked to take part in a 90-minute audio recorded interview with the principal investigator (PI) at a location of your choosing at your earliest convenience. During this interview, the principal investigator will ask you to identify what you consider as the key themes and discussions within PAS/MAID debate. This data will then be used in developing coding schema to be applied to secondary data at the conclusion of the interview period. Alternatively, written responses are also deemed acceptable under the same parameters of consent and confidentiality.

Confidentiality of information will not be offered to participants during this stage as the principal investigator has specifically chosen individuals who have publicly spoken on the topic of PAS or MAID previously. The PI is not looking for new opinions on the subject matter, but rather, is looking for a succinct summary of your involvement within PAS/MAID legislation prior and what you self-identify as the most important factors to examine. However, while confidentiality will not be maintained, the only personal information that will be used (if any) within the research thesis itself will be that of the participant’s name and title, as additional information which will be collected for contact purposes only, is not relevant to the research.

This consent form and collected contact information will be kept in a locked drawer in the personal home of the PI, the only person who has access to the drawer being the PI them self. The audio recording of the interview will be destroyed at the completion of the transcription period and the transcription will be stored on a one-terabyte hard drive with encryption coding. Once the study is completed, the transcription (audio or written response) will be stripped of personally identifying information and uploaded to an online data repository for open access which is a requirement of many academic journals.

The transcription of the interview will be stored for six years or until the PI completes a PhD on the same topic. If for any reason the PI takes slightly longer to complete their PhD, the transcriptions will be destroyed at the completion of their doctoral degree. The PI’s supervisor will have access to the study data if requested, which will be removed from the locked drawer at that time and taken to an agreed upon location within Simon Fraser University.

Participation in this study in voluntary and if you agree to participate, you will be free to withdraw your participation at any time before, during or after the interview stage, up to the point of the PI submitting their paper for defense at the university. Data relating to your person will be deleted as soon as possible after the stage the request was made, and proof provided that data was destroyed.

You may request access to the completed version of the thesis before publication if you would like to ensure that information was presented accurately. If you would like to see the thesis, the PI will note this down when collecting your information and will contact you after the thesis has been vetted by faculty supervisor Dr. Gary McCarron. This version of the thesis will be sent to you in PDF format with a watermark overlaid across the text, so its contents may not be shared. The PI and the supervisor will both be receptive to any changes requested at this stage, though it is up to the PI whether changes are to be made unless it relates to personal information.

While there are no expected physical, psychological or reputational risks associated with this research, it is understood that some people may find it difficult to discuss a topic in which individuals suffering from irremediable or incurable diseases have or are in the process of trying to end their lives by their own choosing. If this subject matter becomes too much for you and you start to experience mental or emotional pain from participation in this study, you are encouraged to seek counselling services within your community to address your concerns. However, the study design is structured in such a way so as to minimize harm to participants and it is the belief of those involved that these services are being offered as a worst-case scenario only and will not need to be utilized.

It is important to note that the purpose of this interview is to provide an overview of one’s involvement with this topic, as well as a summary of the key themes, issues and areas needing improvement regarding medical assistance in dying. As confidentiality will not be provided and your name and title will be used within the completed thesis, please ensure to only provide information you are comfortable with making public if you think there may be any reputational risks associated with your involvement in this study. Furthermore, if you are representing an organization, organizational approval must be granted by a senior official within your organization such as a Director or President who must also sign the consent form indicating that they have read and understood the purpose of the study.

To thank you for your participation, the PI will cover the costs of transit, parking, food and beverages should any of the interviews take place in a location deeming travel or if you and the PI stop to get something to eat before completing the interview. While there are no immediate benefits to participating in this study beyond helping the PI complete their master's thesis and reflecting on your role within PAS/MAID debate, the PI and their faculty supervisor are both grateful for your time and for your comments and insight on the chosen subject matter.

If you have any concerns about the way you've been treated as a participant or concerns with the research project itself, please contact Dr. Jeff Toward, Director at the Office of Research Ethics at Simon Fraser University. He may be contacted via email at […] or via phone at […].

By signing this form, you agree that you have read its contents and have had the research study explained to you in full.

I ___________________, hereby acknowledge that I have read the consent form in full and understand its contents, including my participation in the study, use of my data and right to request access to the completed thesis before publication.

Signature: ____________________________________ Date: __________________

Jess Taylor	Gary McCarron
Principal Investigator	Faculty Supervisor
School of Communication	School of Communication
[…]	[…]

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B3. Interview Guide

In-Depth Ethnographic Interviews: Individuals and Organizations

Summary:

The following interview guide is a representation of questions to be asked to a range of eight to ten individuals or representatives of organizations involved in physician assisted suicide (PAS)/medical assistance in dying (MAID) debate. While many of these questions are applicable to both parties, some questions may be asked exclusively to one or the other given the context of their respective role and involvement within said debate. Furthermore, while this guide provides a systematic overview of questions that will act as the main driving force of any interview, additional questions may be added in on a case-by-case basis to request that the interviewee expand on a topic of interest, to ask for further detail or clarification on an answer, or simply due to the nature of the conversation that would allow for the addition of questions to fill the allotted 90-minute interview period. For written responses, follow-up questions may need to be sent.

To indicate questions that may be asked to only one demographic group, a legend has been created below.

(IE*) Individual Exclusive
(OE*) Organization Exclusive

Interview Guide: Individuals and Organizations

1) During my research on the topic at hand I became aware of [your name/your organization’s name] and the role that you played within PAS/MAID debate. Can you self-describe what that involvement was and how that came to be?

  a) (If not immediately clear) What would you say prompted you to get involved in PAS to the extent that you did?

2) Would you say it was a conscious decision to become a public figure in some form or another within the discussion around this topic, or a by-product of your involvement? **(IE*)**

   a) In addendum, would you even consider yourself a public figure head on the topic, though people like me may find you only because of that?

3) What would you say went into the decision making for [your organization name] to get involved in some form or another within the discussion around this topic and would you say that was a conscious decision by your organization? **(OE*)**

   a) Who makes that decision in this case within your organization to approve/allow some level of involvement within a discussion that at one time was so contentious?

4) There are several nuances for either side of the argument, for or against the notion of developing legislation for physician assisted suicide. Which one do you identify with most and what was the primary motivation for doing so?

   a) On a topic such as this that at one time was so contentious, do you see your feelings on the topic being on more of a spectrum, or on a fixed point?

   b) (Depending on their answer to 4a) To someone who does see this topic from the opposing side (a spectrum of emotions versus a fixed-point stance), how do you communicate with them to make the discussion meaningful?

5) Staying on the theme of contentious topics, what was it in your own view, that caused so many people (and still causes them) to see PAS/MAID as such a contentious and challenging issue to discuss?

   a) Since the MAID act came into legislation in June of 2016, do you think the way that people see the topic of physician assisted suicide has changed?

   b) Further to what we are discussing here, in trying to change opinions one direction or the other, who would you say was the most important demographic to sway towards your point of view or your stance on the subject matter?

6) I’m not sure your knowledge regarding my next question, but if you can answer it please do, what would you say was the reason it took us so long to get from 1991 with Sue Rodriguez starting the fight to now, where legislation on the topic is in effect?

   - **a)** Going back to an earlier involvement, would it have been possible to do something differently to have gotten this done sooner?

7) This subject is obviously incredibly convoluted, but in [your eyes/your organization's eyes] what are or were the key issues of debate that were present across all those years?

   - **a)** Additionally, do those issues look different looking back at 1991 versus 2015 and if yes, how so?
   - **b)** How many, if any, would you say are still unresolved today that we need to still be working on?

8) Who would you say are the primary people of interest in this debate or the people you view as the most important in enacting change?

   - **a)** Similarly, how different does that look in 1991 versus where we are now?

9) Moving forward with this idea, what are some other key themes or considerations that we haven't discussed here that you think are important to address within the discussion on this topic?

   - **a)** How much of that is personal interest versus functional interest in ensuring that subject matter on this topic is systematic and robust?
   - **b)** Like the previous question group, did those themes change over time and what do you think we need to be focusing on moving forward with adapting and streamlining legislation?

10) During the 24 years that it took for legislation to come into effect, what was the one moment that stood out to you during that time? That one moment that you can remember clear as day, regardless of your or your organization's direct involvement in that moment.

   - **a)** Going back, would you have done anything differently than how it played out?
   - **b)** If so, what wasn't working at that time that you wanted to have changed?

11) Two final questions as we wrap up here, how long do you think it's going to take for other jurisdictions to enact legislation similar to the other eight countries that already have it and who do you think are going to be the next leaders in making that change?

12) Finally, from 1991 to 2016 the fight for legislation on physician assisted suicide took place with hundreds of thousands of people involved. Now that legislation is in place, where do we go from here and what do you see a future in Canada with working legislation looking like?

***Note:** Some questions, especially those regarding feelings or sentiments, may need to be adjusted in the moment if a respondent gives a surprising answer so as not to offend said respondent and to avoid leading the conversation in any one specific direction.

Appendix C.

Coding Categories

C1. Creation of Coding Categories

As a result of the organic coding process that allowed for changes and adaptions to be made when it was discovered that certain content was better suited to a different category, many of the categories throughout the thematic content analysis shifted to incorporate these changes. The following tables are representative of these changes as the first table showcases the initial coding categories, as well as the number of files found within those categories, while the second table showcases the final coding categories at the conclusion of the thematic content analysis, framing and sentiment analyses.

Table C1. Initial Coding Breakdown by Category

Coding Category Name	Number of Files Included (out of 227)	Percentage of Files (%)	References (1853)	Percentage of References (%)
Advanced Directives	37	16.3	61	3.3
Constitution	57	25.1	118	6.4
Contentions	130	57.3	257	13.9
Death With Dignity	48	21.1	91	4.9
Eligibility Criteria	96	42.3	228	12.3
Ethics	80	35.2	216	11.7
Legislation	147	64.8	378	20.4
Mature Minors	23	10.1	51	2.8
Mental Disorders	26	11.5	51	2.8
Patient vs. Practitioners	62	27.3	145	7.8
Personal Rights	67	29.5	107	5.8
Religion	51	22.5	150	8.1

Table C2. Final Coding Breakdown by Category

Coding Category Name	Number of Files Included (out of 227)	Percentage of Files (%)	References (2180)	Percentage of References (%)
Advanced Directives	38	16.7%	64	2.9%
Conscientious Objection	53	23.3%	105	4.8%
Constitution	56	24.7%	117	5.4%
Contentions	141	62.1%	297	13.6%
Death With Dignity (Groups)	27	11.9%	43	2.0%
Dignified Dying	47	20.7%	82	3.8%
Eligibility Criteria	105	46.3%	239	11.0%
Ethics	90	39.6%	234	10.7%
Legislation	144	63.4%	374	17.2%
Logistics of MAID	46	20.3%	106	4.9%
Mature Minors	24	10.6%	55	2.5%
Mental Disorders	23	10.1%	48	2.2%
Patient Rights	83	36.6%	141	6.5%
Providers	50	22.0%	110	5.0%
Religion	56	24.7%	165	7.6%

C2. Defining Coding Categories

To be able to better understand the criteria used to assign text to different nodes/coding categories within NVivo, the following tables depict a breakdown of definitions that were used as a guideline during the coding process. Of note, the ethnographic interviews were coded separate to the media articles with their own specific categories based around the interview guide with the annotation “Interview – Category” to indicate as such. As noted in the body of the thesis, these categories were an organic development, that grew, expanded, and adapted based on how the data presented itself. It is also important to note that these guidelines (particularly the interview categories) are not strictly limited to the question they were created for from the interview guide. While categories for the interview coding may have been originally created in relation to questions from said guide, there was a much broader range of material that met the guideline criteria in the end and were therefore included within. The following are the final categorical breakdowns and their definitions.

Table C3. Interview Coding Criteria Breakdown

Category Name	**Definition and/or Criteria**
Interviews – Contentions	*Relating to Questions 4/5 from the Interview Guide (See Appendix A4).* Contentious: “Likely to cause disagreement or argument; exhibiting an often perverse and wearisome tendency to quarrels and disputes” (Merriam-Webster, n.d.b.). Synonyms: contended, controversial, disputable, debatable
Interviews – Issues	*Relating to Questions 4/7 from the Interview Guide (See Appendix A4).* Issue: “A vital or unsettled matter, a matter that is in dispute between two or more parties; concern” (Merriam-Webster, n.d.d.). Synonyms: concern, difficulty, hurdle, complication, problem
Interviews – Key Considerations	*Relating to Question 9 from the Interview Guide (See Appendix A4).* Consideration: “A matter weighed or taken into account when formulating an opinion or plan; a continuous and careful thought” (Merriam-Webster, n.d.a.). Synonyms: account, debate, deliberation, reflection, thoughts
Interviews – Personal Experience	*Relating to personal asides of the interviewee that do not represent the organization or position/status they are speaking on behalf of.* Personal: “Of, relating to, or affecting a particular person; private; individual; relating to an individual or an individual’s character, conduct, or private [opinions]” (Merriam-Webster, n.d.g.). Synonyms: first-hand experience, individual experience, particular
Interviews – Themes	*Relating to Question 9 from the Interview Guide (See Appendix A4).* Theme: “A subject or topic of discourse or of artistic representation; a specific and distinctive quality, characteristic, or concern” (Merriam-Webster, n.d.i.). Synonyms: concept, concern, idea, matter, message, subject, topic

Table C4. News Article Coding Criteria Breakdown

Category Name	**Definition and/or Criteria**
Advanced Directives	In the report, *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, the Panel defines an "advance request (AR)" for MAID as a request for MAID, created in advance of a loss of decision-making capacity, intended to be acted upon under the circumstances outlined in the request after the person has lost decisional capability. ARs for MAID should be distinguished from provincially and territorially regulated advanced directives, which are documents that "allow a decisionally-capable individual either to designate someone to make decisions about health care on his or her behalf, or to specify types of treatment to be accepted or rejected, should the need arise, or both," (Gilmour as qtd. in Council of Canadian Academies, 2018a, p. 5) in the event the individual loses decision-making capacity (2018a, p. 5). **Note: This category includes both Advanced Directives and Advanced Requests as many news articles use the two terms interchangeably, despite the government's distinction between the two.*
Conscientious Objection	*Specific to nurses, nurses' aides, physicians and all other medical professionals in relation to MAID, abortion and like contentious issues and their feelings on such. Focus on medical professionals.* The Canadian Medical Association's position on conscientious participation and conscientious objection aims to harmonize two legitimate considerations: (1) effective patient access to a legally permissible medical service and (2) protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience. The CMA believes that physicians are not obligated to fulfill a patient's request for assistance in dying but that all physicians are obligated to respond to a patient's request. … There should be no discrimination against a physician who chooses not to provide or otherwise participate in assistance in dying. The CMA believes that physicians are obligated to respond to a patient's request for assistance in dying in a timely fashion. Physicians are expected to make available relevant medical records (i.e., diagnosis, pathology, treatment and consults) to the physician accepting care of the patient when authorized by the patient to do so. Physicians are expected to act in good faith. They are expected to never abandon or discriminate against a patient requesting assistance in dying and to not impede or block access to a request for assistance in dying. Physicians should inform their patients of the fact and implications of their conscientious objection. No physician may require a patient to make a commitment not to seek assistance in dying as a condition of acceptance or retention of the patient (Canadian Medical Association, 2017, pp. 4-5).

Constitution	In relation to the Canadian Criminal Code (s. #), Canadian Constitution, Charter of Rights and Freedoms and the words constitution/unconstitutional as found in news articles. Criminal Code, "a federal statute enacted by Parliament pursuant to s91(27) of the CONSTITUTION ACT 1867, which provides the federal government exclusive jurisdiction to legislate criminal offences in Canada" (Pringle, 2014, para. 1).
Contentions	Contentious: "Likely to cause disagreement or argument; exhibiting an often perverse and wearisome tendency to quarrels and disputes" (Merriam-Webster, n.d.b.). Synonyms: contended, controversial, disputable, debatable
Death With Dignity (Groups)	Dying With Dignity Canada and Death With Dignity (US Group), specific to comments from the organization/representatives and work/statements from the various groups.
Dignified Dying	Dying with dignity: "In the conception of death with dignity outlined, the term "death" has been taken to apply to the process of dying, and the term "dignity" has been taken to apply roughly to someone who lives well (in the Aristotelian sense of living in accordance with reason). It follows from this that dignity is a function of someone's personal qualities and that a death with dignity is a personal achievement; it is not something that can be conferred by others, such as health care professionals. By contrast, indignities are affronts to personal dignity. They are things that prevent or impede someone from living with dignity, mainly because they prevent him from taking an active, reasoned part in his own life" (Allmark, 2002, p. 257).
Eligibility Criteria	Section 241.2 (1) of the Criminal Code "Eligibility for medical assistance in dying," reads a person may receive medical assistance in dying only if they meet all of the following criteria: (a) they are eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada; (b) they are at least 18 years of age and capable of making decisions with respect to their health; (c) they have a grievous and irremediable medical condition; (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (Government of Canada, 2016, pp. 5-6)
Ethics	Ethics: "The discipline dealing with what is good and bad and with moral duty and obligation; a set of moral principles: a theory or system of moral values; the principles of conduct governing an individual or a group; a guiding philosophy; a consciousness of moral importance" (Merriam-Webster, n.d.c.). Specific to medical ethics, personal ethics, and professional ethics in particular, but broad stroke ethics from the definitions above apply also.

Legislation	In relation to Bill C-14, the Medical Assistance in Dying Act (MAID), federal, provincial, and local legislations, as well as policies and procedures within organizations and medical establishments. Legislation: "The exercise of the power and function of making rules (such as laws) that have the force of authority by virtue of their promulgation by an official organ of a state or other organization; the enactments of a legislator or a legislative body" (Merriam-Webster, n.d.e.).
Logistics of Maid	Includes the costs associated with MAID, the 'how to' for administering drugs, the referral process and like logistical merits surrounding MAID. Logistics: "The handling of the details of an operation. Logic, used strictly in the singular, is a science that deals with the formal principles of reason. If a visitor walks in the house with wet hair, it is logical for one to assume that it is raining outside. Logistics, which involves such concerns as the delivery of personnel or supplies in an efficient manner, can often employ logic, such as by reasoning out the path least likely to interrupt the flow of a delivery" (Merriam-Webster, n.d.f.)
Mature Minors	In the report titled The State of Knowledge on Medical Assistance in Dying for Mature Minors, adults are defined as "people who have reached the age of majority" while minors are defined as "people under the age of majority, which is 18 or 19 depending on the province or territory" (MacIntosh as qtd. in Council of Canadian Academies, 2018b, p. 36). Mature minors, however, are not defined by their age, but rather by their ability to make informed decision-making. To have such capacity, a person must be able to "understand and appreciate the information relevant to a particular decision or type of decision, and the consequences of making that decision (or of not making a decision)" (Council of Canadian Academies, 2018b, p. 36). While there is no universally accepted definition of the term "mature minor," Canadian courts, common law and health law and policy generally view a mature minor as "a person under the age of majority with the capacity to make an informed healthcare decision and the ability to act voluntarily with respect to that decision" (Gilmour as qtd. in Council of Canadian Academies, 2018b, p. 36).
Mental Disorders	In the final report, The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition, the phrase "sole underlying medical condition" is used to differentiate between cases in which a person with a mental disorder already meets eligibility criteria for MAID (e.g., death is reasonably foreseeable) from those cases in which a mental disorder is the only illness, disease or disability that motivates the request (Council of Canadian Academies, 2018c). Mental disorders can be defined as "health problems that disturb or impair a person's thoughts, experiences, emotions, behaviour, and/or ability to relate to others" (Council of Canadian Academies, 2018c, p. 37), a broad definition that includes hundreds of conditions across a diverse clinical profile. Mental disorders may be characterized as being of a relapsing and remitting course, a stable course, a course of progressive decline or an unpredictable course (Course of Canadian Academies, 2018c).

Patient Rights	Patients in Canada have the right to the following: To receive appropriate and timely care; to be treated with dignity and respect; to receive health services without discrimination; to have their personal and health information protected from disclosure; to have access to their health information unless, in the opinion of a relevant health professional, the disclosure could result in immediate and grave harm to the patient's health or safety; to refuse consent to any proposed treatment; to receive information relating to any proposed treatment and options; to the recognition of your Representative Substitute Decision-maker; to the recognition of your Advanced Directive; to a second opinion; to pain and symptom management " (Canadian Health Advocates Inc., 2020). *Important to note, each province has its own unique documented 'Patient Rights.' The above rights are a general standard.*
Providers	There are many non-physician examples of health care providers which include: the home health care company that provides your visiting nurse, the durable medical equipment company that provides your home oxygen or wheelchair, your pharmacy, the laboratory that draws and processes your blood tests, the imaging facility that does your mammograms, x-rays and MRI scans, the specialty laboratory that does your DNA test, the urgent care center or walk-in clinic in your neighborhood shopping center, and the hospital where you receive inpatient (or in some cases, outpatient) care (Davis, 2020, para. 5). In the context of MAID, "provider" mostly references hospitals.
Religion	Focuses on the practices and beliefs of various world religions specifically in relation to their viewpoints on medical assistance in dying and like contentious issues and how this could have an impact on individuals. Religion: "A person set or institutionalized system of religious attitudes, beliefs, and practices; a cause, principle or system of beliefs held to with ardor and faith" (Merriam-Webster, n.d.h.).

C3. Developing Framing Categories

Understanding that framing categories are a result of the themes and issues present within the text, the following framing schema highlight the specific ways in which news articles are presented to the public on the topic of medical assistance in dying. These categories encompass the many themes and issues present in the initial coding process, as well as the headlines and ledes that provide the central focus of each article. Though there are only five framing categories in comparison to the 15 thematic categories, these upper-level frames include many of the individual themes as well as general notions and ideas, the culmination of which resulted in the following table.

Table C5. Framing Category Breakdown

Category Name	Definition and/or Criteria
Ethics Frame	Encompasses ethical and moral issues, themes, and contentions surrounding the topic of MAID.
Legislation Frame	Encompasses all articles that focus on legislation and constitution themes and issues, as well as articles that discuss eligibility criteria, advanced directives, mature minors, and mental disorders as these are all directly related back to current legislation or suggested changes to legislation.
Logistics Frame	Encompasses articles that focus on statistics, information sharing, costs of MAID as well as other considerations such as organ donations and other processes related to MAID.
Personal Rights Frame	Encompasses both patient rights and physician rights, as well as personal experiences that stem from either focus.
Religion Frame	Encompasses articles whose discussion is on religion in medicine, as well as providers (i.e., hospitals) who try to conscientiously object to MAID for religious purposes.

Appendix D.

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