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The Implementation of Assisted Dying in Quebec and Interdisciplinary Support Groups: What Role for Ethics?

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Abstract

The purpose of this text is to tell the story of the implementation of the *Act Respecting End-of-Life Care,* referred to hereafter as *Law 2* (Gouvernement du Québec, 2014) with an emphasis on the ambiguous role of ethics in the Interdisciplinary Support Groups (ISGs), created by Quebec's *Ministère de la santé et des services sociaux* (MSSS). As established, ISGs provide "clinical, administrative and ethical support to health care professionals responding to a request for Medical aid in dying (MAiD)" (Gouvernement du Québec, 2015). It is suggested that their composition includes the participation of a person with an expertise in ethics. These ISGs represent an important innovation for stakeholders involved in MAiD. To date, no scientific research has specifically addressed ISGs and little research has been conducted in other jurisdictions on the roles, operations and practices of MAiD support structures, especially the implication of ethics. Several ISGs have certainly developed promising practices that could benefit all stakeholders in the wider field of ethics and end of life. We will explore the development of ISGs in Quebec as a support structure for MAiD by highlighting the role that ethics has played (and should play) in these morally and humanly challenging situations.

Keywords Interdisciplinary support groups · Medical aid in dying · Ethics

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Introduction

Since changes to the Canadian Criminal Code took effect in March 2021, we are already seeing changes within MAiD practice. Cases are becoming increasingly complex, especially when natural death is not reasonably foreseeable. The frequency of these new complex cases brings the need for ethics and reflection to the forefront of MAiD practice. Will this need impact the ethics structures already in place to support MAiD? It is difficult to say at this time. The purpose of this text is to tell the story of the implementation of the *Act Respecting end-of-life care* (Gouvernement du Québec, 2014), referred to hereafter as *Law 2*, with an emphasis on the ambiguous role of ethics in the Interdisciplinary Support Groups (ISGs), created by Québec's *Ministère de la santé et des services sociaux* (MSSS). We will first discuss the arrival of MAiD in Québec and its implementation through structures such as the ISGs. Then, we will see what place ethics has taken in the implementation of MAiD, and in the ISGs, to bring us to reflect on the place it should take in the face of current and future challenges.

Arrival of MAiD in Québec

The arrival of MAiD in Québec is the culmination of many years of debate, consultation and reflection; this trajectory is unique in Canada and thus deserves its own story (Downie, 2022). In the late 2000s, the *Collège des médecins du Québec*, notably through its working group on clinical ethics, produced guidelines on appropriate end-of-life care (Collège des Médecins du Québec, 2008, 2009). One of the conclusions was that euthanasia, although exceptional, could be considered appropriate end-of-life care within the current continuum of care leading to end-of-life. Thus, on December 4th 2009, following a motion of the Québec National Assembly, the *Special Commission on the Question of Dying with Dignity* was created to undertake the steps that would lead to the adoption of a law to regulate the practice of euthanasia (Commission spéciale, 2012). This resulted in expert hearings, consultations with countries that have legislated on euthanasia (including 21 meetings abroad), but above all, a large citizen consultation: 273 briefs were submitted, 239 individuals and organizations were heard, and 6558 responses to the online questionnaire were received. The report of this *Commission*, tabled on March 22nd 2012, contained 24 recommendations supporting the introduction of MAiD (Gouvernement du Québec, 2011a, 2011b). Following the tabling of this report, a committee of legal experts produced a 408-page supplementary report in January 2013 (Comité de juristes experts, 2013). It should be noted that Québec is the only province in Canada that has taken such a democratic approach to exploring the social, cultural, ethical and legal implications of MAiD, ahead of the Supreme Court of Canada's *Carter* decision of 2015 (Carter v. Canada, 2015).

In *Law 2*, MAiD means "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" (Gouvernement du Québec, 2014). Defining medical assistance in dying as a form of end-of-life care has allowed Québec to stay within its provincial jurisdiction (healthcare is regulated by provincial, not federal, governments in Canada), and to avoid the use of the word "euthanasia," which was not readily accepted by the public. Only doctors can provide this care within Québec's framework.

Bill 52 on end-of-life care was passed on June 10th 2014 and was the culmination of a non-partisan public debate that emerged from the above-mentioned *Commission*. In the context of Bill 52, the Government of Québec launched public consultations on drafts of *Law 2* to take the pulse of the population, users of the health and social services systems, and various groups and associations from civil society and the community. *Law 2* came into force on December 10th 2015, in the absence of any federal legislation on MAiD.[1]

It is important to note that *Law 2* not only covers MAiD, but also clarifies certain practices and rights related to end-of-life care, including the introduction of advanced medical directives that have long been established in the rest of Canada (Table 1).

Recent Changes to MAiD Eligibility Criteria

More recently, on September 11th 2019, the Québec Superior Court rendered the decision in *Jean Truchon and Nicole Gladu v. Attorney General (Canada) and Attorney General (Quebec)* (Truchon c. Procureur général du Canada, 2019), which declared inoperative, effective March 11th 2020, the provisions of *Law 2* requiring that the person be "at the end of life" and the provisions of the Criminal Code requiring that "natural death (of the person) has become reasonably foreseeable" (Government of Canada, 2016) in order for the person to be eligible for MAiD. On March 2, 2020, the Québec Superior Court granted the federal government's request for an extension until July 11th 2020 to amend the law accordingly. The legislative changes resulting from this ruling has resulted in opening the access for MAiD to people with no terminal prognosis who were previously excluded. This is a major change from the original framework, particularly the one that guided Québec's reflections on end-of-life within a continuum of care, and will have an impact on clinical practices and social perceptions from now on.

Implementation of the Act Respecting End-of-Life Care in Québec

In June 2015, when preparing for the implementation of *Law 2*, the MSSS, in collaboration with professional associations and colleges (physicians, nurses, pharmacists who have all worked together) identified several deliverables for health and social services institutions, including:

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[1] Federal MAiD legislation came into effect in Canada on June 15, 2016, 18 months after the Supreme Court of Canada's *Carter* decision.

Table 1 Criteria for Accessing MAiD in Québec and other rights in Law 2

Law 2 not only covers MAiD, but also clarifies certain rights:

- Reaffirms the right to refuse treatment;
- Reaffirms the right to receive end-of-life and palliative care;
- Introduces the concept of advance medical directives
- Confirms and frames the possibility of receiving continuous palliative sedation;
- Affirms the possibility of requesting MAiD;
- Creates the Commission on End-of-Life Care.

According to article 26 of the *Law 2*, the criteria for accessing MAiD are the following:

“Only a patient who meets all of the following criteria may obtain medical aid in dying:

(1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);
(2) be of full age and capable of giving consent[a] to care;
(3) be at the end of life; (this condition no longer applies)
(4) suffer from a serious and incurable illness;
(5) be in an advanced state of irreversible decline in capability; and
(6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.”

Patients who wish to obtain MAiD must make their request themselves. In order to do so, one must:

- Express choice verbally to their doctor, after discussing with their medical situation and the possibilities that remain to relieve their suffering;
- Ask a healthcare professional for the government form and fill it out;
- Sign and date the form in the presence of a healthcare professional. The form must also be signed by the health professional and one independent witness;
- Maintain their desire to get MAiD at each new meeting with their treating physician or other healthcare professional

[a] In June 2021, article 29 of the Québec Act was amended to allow for the waiver of final consent, consistent with the federal Act.

- Development of an end-of-life care program and policy;
- Identification of protocols and trajectories for requests for continuous palliative sedation and MAiD;
- Creation of Interdisciplinary Support Group (ISG) for MAiD. This group is composed of several types of professionals supporting clinicians involved in MAiD;
- Integration of wording related to patients’ rights to end-of-life care within the institutions’ Codes of Ethics;
- Planning for advance medical directives;
- Development and implementation of training programs for all of these elements.

Each institution was required to identify a leader responsible for applying the expected deliverables. Professional colleges worked collegially to produce practice guides on end-of-life care. Under the leadership of the *Collège des médecins du Québec*, three guides were co-produced and co-authored with the help of various associations and professional colleges involved in palliative and end-of-life care (Collège des médecins du Québec, 2015, 2016, 2019). Other guides have followed, notably on the exploration of psychological suffering in the context of a MAiD request (Groupe de recherche sur la souffrance psychique et l'AMM, 2017).

The Creation of the Interdisciplinary Support Groups (ISG) in Québec

In Quebec, ISGs have a mandate to support interdisciplinary teams in the clinical and administrative process of MAiD requests and to provide support to institutional decision-makers with respect to quality assurance and resource availability. They are responsible for:

- Disseminating information to professionals in their organization;
- Supporting the teams in clinical, administrative, legal and ethical issues;
- Transmitting information between professionals and the management of their organization, the Council of Physicians, Dentists and Pharmacists and the professional colleges;
- Writing and promoting clinical practice guidelines;
- Conducting annual reviews of activities;
- Following up on problem cases;
- Contributing to the improvement of practices through their participation in the ISG community of practice (CoP) and consulting with other ISG;
- Participating in the harmonization of practices and supporting the Commission on End-of-Life Care (Gouvernement du Québec, 2015a, 2015b).

Québec has 18 administrative regions and nearly 30 distinct ISGs. At the time of their implementation, the MSSS wished to offer caregivers the necessary space for appropriation of the tools and practices related to MAiD. Québec has promoted a bottom-up approach to knowledge by encouraging the creation of structures adapted to the plurality of local realities. For example, rural and urban characteristics, cultural and religious values, the volumetry of MAiD requests, and the availability of medical and psychosocial resources in each organization were considered in structuring ISG models. Some say this contextualization may have been at the expense of a formal standardization of support structures across the province, and may have impacted the support offered to caregivers and the accessibility of care offered to patients. Maybe, but as personalization of care is a requirement in any healthcare relationship, we suggest a “one-size-fits-all” non flexible approach would have had a more negative impact.

There is no other structure in the world similar to the Québec ISGs. The *Support and Consultation on Euthanasia in the Netherlands* (SCEN) (Jansen-van der Weide et al., 2004, 2007) in the Netherlands or the *Life End Information Forum* (LEIF) (Van Wesemael et al., 2009) in Belgium, offer a centralized platform for patients, families and caregivers. A team coordinates requests and euthanasia-trained physicians assume the role of clinical and ethical support to the requesting physicians. The referral of users to appropriate resources, the enhancement of the skills of the physicians involved and the training of second assessors underlie the constitution of these programs, which distinguishes them from the Québec model.

International support structures for MAiD are generally developed by and for the physicians practicing euthanasia (and pharmacists providing the medication) while ISGs support *all* actors involved in MAiD, regardless of their professional affiliation. An ISG is minimally composed of a coordinator, a physician, a nurse, a pharmacist and a social worker. Ideally, it will include medical specialists, psychologists, lawyers, clinical ethicists, spiritual care workers, patients or family caregivers. In this regard, Fujioka et al.'s literature review supports the Québec model: the incorporation of multidisciplinary teams into support structures contributes to the quality of MAiD services to patients (Fujioka et al., 2019).

In Canada, a variety of structures have been set up to support professionals, caregivers, patients and their families in MAiD. Since health services are under provincial jurisdiction, their deployment and configuration vary widely across the country. Silvius et al. conducted a comparative research on all these structures (Silvius et al., 2019). Some practices, including those of Québec ISGs, stand out for the quality and scope of their services. Interdisciplinarity distinguishes the Québec ISGs, as does the decentralization of structures by local and regional service organization. To date, there is no unique platform in Québec that can inform and guide the general population through the MAiD process. Without claiming to be exhaustive, Table 2 presents the characteristics of the main support structures for MAiD in Canada and internationally.

In Canada and around the world, ethicists may be involved on MAiD compliance review boards (Commissions régionales de contrôle de l'euthanasie, 2019), but they are rarely involved in support structures, close to the caregivers in the field, despite the fact that the stakeholders encounter ethical issues on a daily basis. However, with the recent legislative changes, we observe in Québec a new inclination of teams to turn to ethics services to reflect on and try to resolve the complexities of situations where natural death is not reasonably foreseeable, nor end-of-life present, as they were accustomed to in the recent years.

The Role of Ethics and Ethicists in the Implementation of MAiD in Québec

In order to document our findings about the role of ethics in the development of MAiD implementation in Québec, we consulted available clinical and administrative documents and we have spoken with different individuals responsible for the enactment of *Law 2* to hear their perspectives.

Despite the work of senior ethicists such as Hubert Doucet (2010, 2015) and repeated interventions by various authorities on the ethical issues surrounding the process of dying (CNEV, 2018), the added value of ethics have not yet been recognised in the Québec model of support for MAiD. Several explanations are possible.

First, in the consultations and public hearings on Bill 52, there were discussions about the place of ethical deliberations in the decision-making process for MAiD requests. This idea was supported by the *Association québécoise en éthique clinique* (AQEC) in 2013 when it presented its brief in the context of the

Table 2 Characteristics of the main support structures for MAiD in Canada and internationally

Support structures	Mandate	Constitution	Type	Open information available via website or phone line
ISG (Québec)	Provide clinical, administrative and ethical support to health care professionals responding to a request for MAiD	At least coordinator, physician, nurse, pharmacist, social worker	Local and regional	Not yet
Palliative and End-of-Life Care (Alberta)	Make MAiD and palliative care information accessible to patients, families and caregivers. Emphasize experience sharing, training and learning for stakeholders	Experts, health care providers (physicians, nurses, social workers, spiritual counsellors)	Provincial	For caregivers and the population
MAiD Care Coordination Service (Ontario)	Support patient access to MAiD through caregiver support Make accessible the necessary resources (second assessor, MAiD provider, drug dispenser)	Provincial: Care Coordination Centre allowing the use of MAiD physicians, nurse practitioners or pharmacist evaluators/providers Regional: Variable local services depending on institutions	Provincial and Regional	For caregivers and the population
Support and Consultation on Euthanasia in the Netherlands	Provide consultation, support and advice for physicians	Expert and independent physicians, specially trained to provide support and consultation about MAiD	National	For caregivers and the population
Life End Information Forum (Belgium)	Inform patients and support physicians in the MAiD process (e.g., finding an independent assessor) and in palliative care	Coordinator, social nurse, pharmacist, physicians	National	For caregivers and the population

parliamentary work leading up to the passage of the legislation (AQEC, 2013). Aware that this bill would, among other things, create new clinical procedures, impose new obligations on caregivers and institutions in the health and social services network, create new rights for patients and, in this sense, modify certain relationships between individual, professional and collective values, AQEC wanted clinical ethics to facilitate, as much as possible, the consideration of these values in a process that was respectful of the individuals who hold these values.

The most important recommendation of AQEC was that an ethical deliberation be carried out when applying for MAiD so that all dimensions of the person were taken into account, as well as assuring a clarification of issues and values. If implemented, this process would have had the advantage of facilitating the decisions to ensure adherence not only to what the patient wanted but also what was required by the law. From an ethical point of view, AQEC felt that it is essential that the request for death should not be "for lack of better" options, but should always be "the best option under the circumstances". Thus, AQEC proposed that the current ethics structures in Québec be expanded to contribute to this. For example, at the time the law was drafted in Belgium, the possibility of requiring prior approval by an ethics committee had been studied. This option was rejected because of the burdensome process and the legal risks (Gouvernement du Québec, 2011a, 2011b). Although the requirement of prior approval by an ethics committee has not been upheld in Belgium, some Belgian organizations have included some form of ethical deliberation in the process of requesting euthanasia. The Domus association in Belgium has adopted a procedure of ethical reflection: the *Cellule d'Aide à la Réflexion Éthique* (CARE), in which each participant makes a reflection according to his or her values to better support the request for euthanasia. Nevertheless, this Belgian association has been criticized for adding conditions to the request for euthanasia (2e Congrès international francophone de soins, 2011). Like Belgium, Québec did not endorse this proposal.

Second, at the time the MSSS was preparing to implement *Law 2*, the health and social services sectors of Québec were undergoing an immense transformation. On April 1st 2015, the *Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies* (Bill 10) came into force. Bill 10 imposed a merger of institutions that went from 182 to 34 (Ministère de la Santé et des Services sociaux, 2019), creating the 13 *Centres intégrés de santé et de services sociaux* (CISSS) and the 9 *Centres universitaires intégrés de santé et de services sociaux* (CIUSSS), which now cover entire regions over territories of several hundred kilometres. Ethics then had to find its place in complex organizations that now had thousands of employees working in hundreds of facilities, covering diverse missions and populations (hospital, long-term care, home care, public health, youth protection, physical rehabilitation, addiction, intellectual disability and autism spectrum disorder).

This reform has led to the development of a standardized structure for the newly created institutions. In this organizational chart, the MSSS created the *Direction de la qualité, de l'évaluation, de la performance et de l'éthique* (DQEPE). For the first time, the term "ethics" appeared in the wording of a direction with a transversal mandate. The birth of the DQEPE led institutions to review, at different rates, the organization of clinical and organizational ethics within them. The preliminary results of an ongoing study (Bédard et al., 2020) suggest that there are, currently: (1) few trained ethicists available to support the development of ethics in the entire network, moreover outside urban settings, and (2) that much remains to be done to structure clinical and organizational ethics and evaluate all of its components. Furthermore, the credibility of ethicists has yet to be built in the health and social services network in Québec, as in several regions of Canada outside major urban centres. Unlike other professionals such as doctors, nurses, occupational therapists and other professions, we, ethicists, are not constituted as a professional college and do not possess any accreditation or certification that would allow our skills to be recognized in Québec or Canada. We are still in the era of self-regulation and professionalization. Despite American proposals (ASBH, 2011, 2014; Bruce et al., 2019), which so far had little penetration into Québec, too few ethicists have received graduate training and have had the opportunity to gain field experience under supervision. In this unfavourable context, it became difficult for the various ethicists and ethics programs in Québec to actively participate in the implementation of *Law 2*.

The Role of Clinical Ethics in ISGs in Québec

Based on the documents and testimonials collected in the context of writing this article, it appears that lawyers, administrators and clinicians have been mostly at the forefront of the implementation of *Law 2* and the coordination of ISGs. This implies a different view, one that is more focused on compliance and risk management and less focused on value conflicts and the search for meaning, specific to the practice of ethics.

It should be noted, that in spite of the structural obstacles described above, some individual ethicists were still mandated to participate in certain committees ahead of implementation of the law and ISGs. Already existing clinical ethics support structures (ethics committees or ethics consultation services) were not specifically solicited nor involved as interested stakeholders. In 2016 and 2018, the *Centre d'expertise en santé de Sherbrooke* (CESS) conducted two mixed surveys amongst ISG coordinators (Bazinet, 2018). The objective of the surveys was to draw up a general portrait of the situation and to identify the priorities needed to be investigated.

Following the initial survey in 2016, the ISGs Community of Practice (CoP) for Québec was established. In 2021, there were 553 members, representing 11 functions[2] and over 40 public, community and private institutions, governmental, academic and professional authorities. By 2018, less than half of ISGs had an ethicist (Bazinet, 2018; Dubuc & Bazinet, 2016). Although the number of ethicists in ISGs has not increased significantly in more recent years, many of the concerns raised by CoP members involve ethical considerations, such as complex cases, conscientious objection, mental health and substituted consent (Houle, 2021), thus reaffirming the need for specific ethics expertise in MAiD.

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[2] Physician, nurse, occupational therapist, pharmacist, respiratory therapist, spiritual care provider, clinical ethicist, social worker, psychologist, lawyer, manager.

The CoP provides a virtual space where people involved in the continuous improvement of MAiD practice in Québec can meet. It includes a discussion forum, webinars, consultation and training activities for CoP members. It is a place for learning, interaction, and sharing knowledge and experiences to improve practice.

In Canada, other communities of practice exist for MAiD (CAMAP, 2021; OCFP, 2021), but only the CoP in Québec integrates all the stakeholders involved in practice development, including patient partners and people who are not members of a professional college.

Many ethical issues are raised by CoP members in the forum. For example:

- Can cessation of feeding and hydration be a means to access MAiD?
- How should professionals act when faced with a patient request that MAiD remain a secret from the rest of their family?
- How should professionals respond to threats of suicide by a patient following a denial of access to MAiD?
- How should we approach issues of mental health, competence, conscientious objection and organ donation in the context of MAiD?

In the forum, members are free to participate, to respond or not, but there is no formal process or editorial format. Suffice to say that this constitutes a much needed space for discussion, but perhaps not always the best vehicle for subtle and delicate ethical deliberations. The issues at stake are complex and manifold and could become more acute with the current reflections on the broadening of the criteria (Truchon c. Procureur général du Canada, 2019). There are also ethical issues surrounding the steady increase in demand for MAiD in Québec (Gouvernement du Québec, 2019). In Québec, 682 physicians have practiced MAiD in the last year, many of them more than 10 times (Gouvernement du Québec, 2019). This is burdensome for just a few shoulders. This situation is worrying, hence the importance of accompanying caregivers in this end-of-life care in order to prevent exhaustion and distress. We have to have spaces to reflect: for patients, families, healthcare professionals, teams, organizations as well as society as whole in order to not trivialize it, and make sure it is “the best option under the circumstances”. Ethics encourages reflection in a world where caregivers tend to favor action (Fortin, 2015).

The case of the *Centre intégré de Santé et de Services sociaux de Laval* (*CISSS de Laval*) is notable in that it is the head of the Ethics Centre who was mandated by the CEO to implement *Law 2*. This decision stemmed from the already strong ethical leadership assumed by the organization’s senior management and confidence in the Ethics Centre.

Once the implementation of *Law 2* was completed, and the ISG created by the Ethics Centre, its ethicists were responsible for coordinating each of the MAiD requests on the territory of the *CISSS de Laval*. Among the advantages of this model, let us first mention the mission that has been at the heart of the concerns of the Ethics Centre: that is of attending to the moral well-being of each of the individuals

Table 3 Roles and responsibilities of the ISG in Laval, Québec

(1) Establishment of an ISG composed of psychologists, psychiatrists, physicians, social workers, ethicists, for a total of more than 20 people all chosen for their human qualities and credibility recognized by their peers;

(2) Coordination of each MAiD request and support to the clinical teams by the Ethics Centre as soon as the law came into force;

(3) With the help of the ISG members, implementation of pre- and post-MAiD sessions in order to provide a safe space for everyone to talk about their concerns and conflicts of values and to ensure the benevolence of the protagonists;

(4) Accompaniment of medical evaluators offered by ISG members during MAiD eligibility evaluations;

(5) Delivery of several ethical training sessions, including an e-learning session credited and financed by the Federation of Medical Specialists;

(6) Also for the purpose of assuring better support to physicians and teams, two studies were conducted: 1) on conscientious objection, in which all physicians of the Laval territory were surveyed prior to the adoption of the law and specific qualitative interviews were conducted with physicians who refused to participate in MAiD once the law came into force, in order to better understand the reasons for refusal (Bouthillier & Opatrny, 2019); 2) on the timing of MAiD requests in end-of-life trajectories (Seller et al., 2018);

(7) Ongoing support for complex cases and access to ethics consultations. The coordination of MAiD being under the guidance of the Ethics Centre, this can be done within the normal functioning of the ethics team;

(8) Possibility of raising ethical awareness at all levels of the organization. For example, the person in charge of the Ethics Centre met systematically with the Chief Medical Officer and the President of the Council of Physicians, Dentists and Pharmacists

involved in MAiD. The central idea was and remains to take care of each of the actors involved and to avoid harming the stakeholders in the face of this morally charged gesture, which is likely to leave moral residue. Thanks to this ethical leadership, ethical reflection and moral caring has manifested itself in the work of the ISG in several ways including (Table 3):

Among the disadvantages of this model, we can point out the rapid growth in MAiD requests imposing an unexpected burden on the Ethics Centre, with consequences on its capacity to receive such a volume in the context of all the tasks related to the other mandates of the Ethics Centre in the organization. Furthermore, the ethicists/coordinators responsible for MAiD often felt torn between their reflective and ethics-supporting role and the very operational and clinical role required by the coordination of requests. A tension materialized between the quality of ethical interventions, the intensity to be given and the quantity of requests to be processed. As a result, and to safeguard its capacity to provide ethical support where needed (complex cases in particular), the Ethics Centre team has recently taken steps to develop a more robust informational infrastructure that is both accessible to all healthcare workers concerned by MAiD demands and engages them to respond to informational needs, on the premise that this will free the team from many coordination/administrative tasks.

Conclusion

At the time of writing this article, the MSSS has set up a Task Force to review all palliative and end-of-life care in Québec. Part of this work is supporting research on ISGs. This research aims to explore promising practices in order to implement them at the provincial level (Perron et al., 2022). In addition to providing concrete support to caregivers, the harmonization of practices could have a direct impact on the quality, continuity and accessibility of services for users and their families. In this context, what role will be assigned to ethics? Would it be appropriate to integrate ethics more fully into the ISGs, as is done at the CISSS in Laval?

Although no research can currently support the added value of including ethics in ISGs, the testimonies from ISG stakeholders gathered to write this text suggest that ethics does have a specific place in the general reflection on dying, end-of-life and MAiD. Suffering, death and dying are still taboo. End-of-life planning, discussions surrounding levels of care, and the importance of palliative care consultations all remain primordial ethical issues that have a great influence on the concept of MAiD itself. Challenges in access to essential care options remain, including: adequate care for pain management, rehabilitation after a serious trauma, supports for persons who are disabled or suffering from a terminal illness, and social care supports in the community. Might we face a loss of meaning and ethical coherence in this context, if access to avenues to improve quality of life are not also greatly enhanced and improved alongside access to MAiD? How to better rethink MAiD in this context and use ethics as a bonding element between divergent positions? How can we avoid the trivialization of MAiD? How can we remain careful and mindful to allow us collectively to address uncomfortable issues? Just because MAiD is legal does not necessarily mean it is always ethical. Are we still “doing good in the best of circumstances”? An ethics mediation approach may allow for the reconciliation of diverse views, creating safe spaces in order to address these complex issues and promote interdisciplinarity in the face of the current and future widening of MAiD criteria and increasing moral complexity.

To close this article, we quote a team member involved in MAiD who received support from the ISG:

> *"We are convinced that the contribution of the ISG is essential in this still uncommon ordeal [of MAiD]...It is important to take the time to live this moment, which is not easy for anyone, which requires guidance and constant support."*

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