



Vulnerability, Dependency, and Trust in the Shadow of Medical Aid in Dying

Cory Andrew Labrecque

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FROM THE NOMENCLATURE to the articulation of the eligibility criteria to its application, debates over the practice of medical assistance in dying (MAID) in Canada are far from settled. It goes without saying that revising provincial and federal law on the matter, at times called for because of challenges to its constitutionality, has come with great division of opinion. Such is the case for the most recent proposal to strike from the Criminal Code the “reasonable foreseeability of natural death” as a requirement for access to MAID, which was put forward in September 2019 by Quebec Superior Court Justice Christine Baudouin and introduced as Bill C-7 in February 2020 by the minister of justice and attorney general of Canada in response to the *Truchon* ruling.¹

The move to modify MAID in this way does not come as a surprise. Constitutional-law experts and other legal scholars saw this coming, primarily because *Carter v. Canada* did not specify that MAID would be restricted only to those whose natural death was reasonably foreseeable. Indeed, as Kim Clarke makes plain in her column “Medically Assisted Death in Canada—Unsettled (and Unsettling?) Law,” the criterion was disputed from the law’s inception, and challenges to the provision were launched on the heels of the MAID Act coming into being in 2016 (Clarke 2016).

Although there is much to say on what is (or should be) meant by “reasonable foreseeability,” the aim of this paper is to explore the impact that changes to the legislation might have on the trust that patients place in their health-care providers (namely, their physicians). To

1. The Superior Court of Quebec also called into question the constitutionality of the “end-of-life” criterion in Quebec’s Act Respecting End-of-Life Care. See Government of Canada 2020.

be sure, concerns about how trust may or may not be compromised when health-care providers (physicians or nurse practitioners) are legally permitted to administer or prescribe a substance to a person, at their request, that causes death were being addressed in the literature long before the advent of MAID. Here, I would like to revisit the notion of trust—what some have called the “keystone of the physician-patient relationship”²—in light of the proposed legislation currently being examined, by grounding it in shared features of the human condition—namely, vulnerability, woundability, and dependency.

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Vulnerability, Woundability, Dependency: Marks of Humanhood

Embodied beings are vulnerable; etymologically speaking, this means that we are all woundable.³ In other words, vulnerability is a shared and constant truth of the human condition (Fineman 2008); the global COVID-19 pandemic has made this rather indisputable. Although this may seem obvious to the reader, scholars in the burgeoning field of vulnerability studies—pioneered by the preeminent feminist legal theorist Martha Albertson Fineman, among others—remind us that ours is a society that champions and idealizes function,⁴ autonomy, and independence while disdaining vulnerability and condemning dependency as a “pathological failure” (Fineman 2012, 86). In spite of this, however difficult it may be to admit and however we might try to convince ourselves otherwise, we are all “vulnerable subjects,” as Fineman explains, “whose embodied vulnerability and social embeddedness creates inevitable dependency on others” (Thomson 2018, 1209).

This understanding is different from the one that is common in medicine and public health, of only discrete “groups of fledgling or stigmatized subjects [being] designated as [vulnerable] ‘populations,’” where vulnerability is “typically associated with victimhood, deprivation, dependency, or pathology” (Fineman 2008, 8) and with assumptions about capacity (Fineman 2012, 85). In her examination of the labelling of the “elderly” as vulnerable, Fineman writes,

The idea of the vulnerable subject is anchored in the fact that we all are born, live, and die within a fragile materiality that renders all of us constantly susceptible to destructive external forces and internal disintegration. What significance should the reality of vulnerability and dependency have politically, socially, culturally, and legally as we construct expectations and aspirations for ourselves as individuals, as members of society, and as institutional

2. See for instance Pellegrini 2017.

3. The word “vulnerable” is derived from the Latin *vulnus* (wound), on which the verbal form *vulnerare* (to wound) is based.

4. See for instance Labrecque 2017; 2015.

actors who both generate and consume the wide range of resources produced within and by society and its institutions? The vulnerability of our embodied beings and the messy dependency that often comes in the wake of physical or psychological needs cannot be ignored throughout any individual life and must be central to our theories about what constitutes a just and responsive state. (Fineman 2012, 89)

In addition, the familiar rendering of vulnerability as “weakness” also overlooks the fact that weakness, too, is a shared feature of the human condition (Fineman 2012, 95–96). “Surely,” Fineman argues, “the need for care from others when one is very young or incapacitated in some way due to advanced age, disability, or illness should not be viewed as a weakness” (Fineman 2012, 96–97). This pairing of vulnerability and weakness, however, has often been an impetus for “othering” and for the perpetuation of an us-versus-them way of thinking that ultimately forms chasms between the (ostensibly) strong and weak, young and old, abled and disabled, as well as between the patient and health-care provider (Fineman 2012, 84–88). It is worth noting that the word “patient” (from the Latin *patior*, “to suffer,” but also “to endure,” “to bear,” “to submit”) in itself exposes an underlying dichotomy; the suggestion here is that a certain passivity is the essential feature of patienthood, and there is a sense that the person-as-patient submits to being acted on by some agent.

Vulnerability is a shared and constant truth of the human condition.

Fineman contends that although we might think of *others* as vulnerable, woundable, weak, or dependent, the labelling or setting up of classes of “vulnerable others,” as it were, as if we ourselves are immune to vulnerability, woundability, weakness, and dependency, has vast implications for individual, communal, institutional, and state responsibility for the care of others. Clearly, this also invites a reassessment of the (power) dynamics of the relationship between the patient and health-care professional as well as serious attention to the increasing disparity in access to health-care resources. For Fineman, vulnerability is not only inherent and universal, it also provides “the impetus for the creation of relationships and institutions and necessitating the formation of families, communities, associations, and even political entities and nation-states” (Fineman 2014, 310). As such, she calls for an appreciation of vulnerability as generative:

Properly understood, vulnerability . . . presents opportunities for innovation and growth, as well as creativity and fulfillment. Human beings are vulnerable because as embodied and vulnerable beings, we experience feelings such as love, respect, curiosity, amusement, and desire that make us reach out to others, form relationships, and build institutions. Both the negative and the positive possibilities inherent in vulnerability recognize the inescapable interrelationship and interdependence that mark human existence. (Fineman 2012, 71)

This is important because the claim that vulnerability is universal, constant, inevitable, and inherent could easily suggest that, in the face of vulnerability, the only response could ever only be apathy or surrender. After all, if vulnerability is an ontological condition of humanhood, how could we possibly get away from it?

Clearly, Fineman does not think that we can, but this need not amount to passivity or the shirking of responsibility on the part of the collective. Here, she speaks of resilience as being

“the essential, but incomplete antidote to our vulnerability” (Fineman 2014, 320). Resilience is that which “provides an individual with the means and ability to recover from harm or setbacks” and, like vulnerability, is also generative, because “when individuals have resilience it allows them to take advantage of opportunities knowing that if they take a risk and something fails, they have the means to recover” (Fineman 2014, 320). Furthermore, a serious recognition of the inevitability of our dependence on societal structures and relationships should configure the social and political culture “to reflect that independence and self-sufficiency are impossible to achieve and it should demand that institutions be shaped to be generally and equitably responsive to our vulnerability” (Fineman 2014, 320) as well as to those conditions, practices, and behaviours that encumber resilience.

It would be negligent of me not to include in this discussion about vulnerability, dependency, and resilience yet another element of the equation that is so very often left untreated (certainly in mainstream bioethics): love. The following passage from C.S. Lewis’s *Four Loves* helps to underscore how love relates to what we have seen thus far:

There is no safe investment. To love at all is to be vulnerable. Love anything, and your heart will certainly be wrung and possibly be broken. If you want to make sure of keeping it intact, you must give your heart to no one, not even to an animal. Wrap it carefully round with hobbies and little luxuries; avoid all entanglements; lock it up safe in the casket or coffin of your selfishness. But in that casket—safe, dark, motionless, airless—it will change. It will not be broken; it will become unbreakable, impenetrable, irredeemable. The alternative to tragedy, or at least to the risk of tragedy, is damnation. (Lewis 1960, 138–39)

Love and vulnerability, as both Lewis and Fineman make plain, are sources of relationship, challenging the socially constructed dichotomies that seek to divide the world between poor and rich, weak and strong, old and young, ill and healthy. Solidarity, in itself a moral virtue, is not a “feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the common good. That is to say to the good of all and of each individual, because we are all really responsible for all” (Pontifical Council 2004, §193). Here, this notion of solidarity takes interdependence and mutual responsibility of one to another as characteristics of, if not prerequisites for, the human community. Indeed, this is very much behind the imperative to love one’s neighbour, an axiom that is not exclusive to the Christian world.

If by common good we mean “the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily” (*Catechism of the Catholic Church* 1992, §1906), then a solidarity that is truly committed to the common good inevitably seeks to contribute to the building up of individuals and communities of resilience in order to best respond to the constancy of vulnerability and to emergent particular vulnerabilities over the course of life that impair human fulfillment. If our society is serious about its commitment to the poor and vulnerable, there is, then, a moral obligation to protect people in their vulnerability as well as to foster and provide social services, practices, and support that would help promote their flourishing.

I lament that discussions of the patient–health-care professional relationship—as well as of many other pressing areas of study in biomedical ethics for that matter—so very rarely consider

love and vulnerability as concepts worthy of serious academic engagement. I suspect that this is the case out of fear that the one who raises such things in public discourse risks calling into question their intellectual rigour. To be sure, talk of vulnerability is ubiquitous in bioethics, especially in reference to vulnerable patient populations in research and health care, but lacking in the literature is the promotion and inclusion of frequently overlooked approaches and theories that have love and vulnerability at their core (I am thinking here of the ethics of vulnerability and vulnerability theory in particular) as new frameworks for bioethical analysis and deliberation.⁵

Love anything,
and your heart will
certainly be wrung
and possibly broken.

—C.S. Lewis

In their article “Why Bioethics Needs a Concept of Vulnerability,” Wendy Rogers, Catriona Mackenzie, and Susan Dodds argue that vulnerability has been under-theorized in bioethics, and the ambiguity around how the concept is understood has “led to problems of paternalism and overprotection of those deemed vulnerable, and neglect of those who are vulnerable in ways not identified by current accounts” (Rogers, Mackenzie, and Dodds 2012, 13; see also ten Have 2015, 395). To say, as Fineman does, that vulnerability is inherent, constant, and shared does not by any means neglect the fact that there are particular vulnerabilities and context-specific harms—and a variety of sources of said vulnerabilities and harms—that require serious attention and intervention (Rogers, Mackenzie, and Dodds 2012, 15–16). Recall that for Fineman we are both embodied and embedded, but our experiences *as bodies* and of a variety of types of relationships means that vulnerability is also person-specific.

Rogers, Mackenzie, and Dodds agree with Fineman’s interpretation, but ask how “universal vulnerability generates obligations, what specific obligations it entails, and why we have particular obligations to persons who are more than ordinarily vulnerable” (Rogers, Mackenzie, and Dodds 2012, 16). In the end, for these authors, shared vulnerability ultimately grounds solidarity as a bioethical value (Rogers, Mackenzie, and Dodds 2012, 32). “Those who experience vulnerabilities of vital need,”⁶ they conclude, “are susceptible to harms that warrant responses from those with the capacity to respond: these include institutional responses aimed at supporting the agency of those who are vulnerable, as well as ensuring access to appropriate support and care” (Rogers, Mackenzie, and Dodds 2012, 32). In this vein, Michael Thomson adds that seriously engaging vulnerability analysis challenges “the privatization of responsibility” as focus shifts from the primacy of autonomy and individual ethics to the different institutions and relationships in which we are embedded (Thomson 2018, 1229). We are reminded again of the inevitability of dependency, which—along with vulnerability—serves as an anchor for trust.

5. There are a handful of scholars who constructively engage love and vulnerability ethics/theory as frameworks for bioethical analysis and discourse. See for instance Macer 1998, wherein he revisions the principlist approach to biomedical ethics, describing autonomy as self-love, justice as love of others, non-maleficence as loving life, and beneficence as loving good. See also Rogers, Mackenzie, and Dodds 2012 and 2014, as well as Thomson 2018, ten Have 2015 and 2016.

6. According to Rogers, Mackenzie, and Dodds, vital needs here are “those that are inescapable and without which the being in question will be seriously harmed or fail to flourish” (2012, 22).

Vulnerability and Trust as Cornerstones of the Relationship Between the Patient and Health-Care Professional:

Important Aspects to Consider

Vulnerability, woundability, and dependency are inexorable features of humanhood. As we have seen, Fineman and others have argued that these shared realities require—or ought to require—a shared moral imperative to respond, to care for, to provide mechanisms to build resilience, and to promote human flourishing.

It would also be remiss of me not to explicitly include suffering among these marks of commonality, although vulnerability, especially as *woundability*, already makes this apparent. Suffering, which possesses as it were its own solidarity (John Paul II 1984, §8), binds—or ought to bind—humans in community. Love of neighbour, a call to action that I think properly encapsulates the relationship between the patient and health-care professional, means that one must not be indifferent to other persons in their suffering, regardless of whether said suffering is caused by illness, disease, poverty, or injustice.

Even though suffering is difficult to define and describe, human beings find common ground in the fact that we all suffer, and this in itself evokes—or ought to evoke—a compassion that actively seeks the alleviation of suffering (however limited our capacity may be to do so) and that is sensitive to the different experiences of suffering, which sufferers often struggle to describe (John Paul II 1984, §4). Virginia Woolf brings this poverty of language to the fore when she laments, “English, which can express the thoughts of Hamlet and the tragedy of Lear, has no words for the shiver or the headache. The merest school girl, when she falls in love, has Shakespeare, Donne, Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry” (Woolf 1926, 34). Carefully listening to the sufferer, then, is not simply a kindness, nor is it an impossibility when words fail, but is a way into the sufferer’s narrative in order to authentically express compassion, the joining of the wounded and the woundable.

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—Virginia Woolf

The medicalization and the technologization of death have moved us from approaching death as an inevitable and shared part of the human narrative to something that ought to be controlled. Indeed, current deliberations in Canada over the bill that proposes a change to the Criminal Code that would allow MAID for eligible persons requesting it, regardless of whether their natural death is reasonably foreseeable, is a perfect example of this desire to harness death through medicalization. Interestingly, we may have to revisit the nomenclature (“medical aid in dying”) for such cases, as they would not be involving people requesting aid in their dying

per se. Instead, this would concern people who are not dying but who are asking the medical system to intervene in order to make it so they are. One might argue—although not without dispute—that since death could be seen as routine (Goold, Williams, and Arnold 2008, 78) by some health-care professionals in the hospital setting, its utter mundanity makes even the medical initiation of dying rather banal. Joseph Ratzinger (now Pope Emeritus Benedict XVI) once remarked that sickness and death have become “technical [problems] technically handled by technical people” (Ratzinger 1988, 70). Yet, however routinized these are, studies show that some health-care professionals nevertheless feel underprepared to discuss dying and death with patients (Hetzler and Dugdale 2018, E767).

This may very well lead to conflicts at the end of life that impede trust in the relationship between the health-care professional and the patient (and patient’s family). As Susan Goold, Brent Williams, and Robert Arnold claim,

The impaired trust profoundly influences the ability of families to believe or understand the prognosis and accept physicians’ recommendations based on the patient’s goals. Physicians, meanwhile, may be angry and frustrated, distrust the family’s motives, worry about litigation, or believe that they are asked to violate their professional ethos . . . conflicts in the context of severe illness involve high stakes, great vulnerability, deep fears, and strongly held beliefs. (Goold, Williams, and Arnold 2008, 78)

On the one hand, some physicians will do everything possible to rescue the dying. On the other, as Peter Hetzler III and Lydia S. Dugdale suggest, while “it is true that sometimes rescuers throw ropes to the drowning . . . it is equally true that . . . an additional way that physicians rescue patients from medicalized dying is by helping them to abandon ship. Physicians do this by intentionally hastening death” (Hetzler and Dugdale 2018, E768–69). Both routes are motivated, at least in part, by the desire to control dying and death.

What we see here is an added conflict between the physician’s duty to save life and the physician’s duty to respect the patient’s autonomy (which is, in this case, to end life). It is important to note that both courses are considered by some to be expressions of care. Hetzler and Dugdale remind us, however, that “it is far easier for physicians to help patients . . . to their deaths than it is to sit with them, listen, and coordinate the help of ancillary staff like social workers and chaplains to address patients’ concerns—existential, spiritual, familial, personal—at the end of life” (Hetzler and Dugdale 2018, E770). This, I think, is a hurried statement that does not account for the experience of many physicians who are torn by the pressures to bend to an eligible patient’s legally supported autonomous decision to end life (even if it is not reasonably foreseeable, as will be the case if the bill is passed). This said, the authors identify a pressing concern here regarding the lack of time committed to serious discussions around end-of-life care.

As policy-makers, MPs, scholars, legislators, health-care providers, patients—that is, Canadians across the board—mull over the recently proposed amendments to the Criminal Code concerning medical aid in dying, let us call to mind a number of pressing questions and concerns that urge our careful consideration. For instance, might the repeal of the provision that requires a person’s natural death be reasonably foreseeable exacerbate the labelling of certain lives as not

worth living?⁷ If so, what pressures might mount against those whose lives these happen to be?

The minister of health asserts that “supporting individual autonomy to choose how one wishes to address intolerable pain and suffering, while ensuring the decision is made freely and not the result of external pressures or a temporary period of despair, underpins MAID legislation in Canada” (Health Canada 2020, 7), but the recent enactment firmly insists that “persons whose sole underlying medical condition is a mental illness are not eligible for medical assistance in dying” (Bill C-7). Regardless of one’s position on this point, what we see in this statement is a selective consideration of the sufferings of some over the sufferings of others in the determination of eligibility, which seems to be an affront to the very autonomy the system claims to be defending. Who decides which kind of sufferings count for access to MAID and which kind do not? Who decides which lives can be terminated and which lives should not? Or will the trend ultimately lead us to forgo more than just the criterion requiring the reasonable foreseeability of death in allowing medical assistance in dying to any and all who request it? For instance, in the name of respect for autonomy, why shouldn’t the ennui of continued living—bereft of any significant medical condition—be considered as grounds for medical aid in dying?⁸ Should health-care professionals be involved in providing MAID in such cases if so permitted by law? If one thinks that this just simply takes things too far, as many might suggest, the perennial query remains: Where, then, should the line be drawn?

These questions are not merely rhetorical; they are being brought to the fore by legislators for serious consideration. Take note that, in Canada, 82.1 percent of patients report a “loss of ability to engage in meaningful life activities” and 78.1 percent report a “loss of ability to perform activities of daily living” as the nature of the suffering that prompted their request for medical aid in dying (Health Canada 2020, 31–32). Feeling tired of life as a motivating factor—combined (for instance, in the case of aged patients requesting MAID) with negative societal attitudes towards ageing, the isolation and marginalization of aged persons, and the often-reported feeling of being a burden on others—should, at the very least, warrant our attention.

Indeed, if “supporting individual autonomy to choose how one wishes to address intolerable pain and suffering underpins MAID legislation in Canada,” and if “it is not the practitioner’s interpretation of the intolerability of an individual’s suffering” (Health Canada 2020, 31)⁹

Might the repeal of the provision that requires a person’s natural death be reasonably foreseeable exacerbate the **labelling of certain lives as not worth living?** If so, what pressures might mount against those whose lives these happen to be?

7. The implications of what this will mean for persons with disabilities cannot be overstated.

8. See for instance Klein 2019 and Cluskey 2019.

9. Interestingly, although the report says that it is not up to the health-care professional’s interpretation whether the patient’s suffering is intolerable, it goes on to say that “practitioners must not provide MAID *if they do not feel* that the patient meets the eligibility criteria” (Health Canada 2020, 31 [emphasis added]).

that ought to determine eligibility, then why limit MAID at all? My contention here is not to advocate for this, but to insist on the following:

1. Clarity in debate, policy, and legislation (especially regarding the use of loaded concepts such as autonomy, suffering, and dignity).
2. Commitment on the part of the medical institution and other powers to assure that health-care professionals are given the proper training and time to talk to patients about the nature of their suffering (which is difficult for patients to describe and for health-care professionals to understand). This ought to include constructive conversations about what the patient might mean by, say, a “loss of ability to engage in meaningful life activities.”
3. Commitment on the part of the medical institution, health-care professionals, and others to provide relationship-centred, culturally sensitive care that assures the patient is given the time, space, and relevant resources needed to talk about the aforementioned. Differences in religious and cultural contexts, for instance, mean that a genuine investment—in time, effort, and patience—is crucial. This cannot be rushed, by any means.
4. Consistency in argumentation. The MAID criteria ostensibly suggest that there ought to be limits in terms of the eligibility for—and in the carrying out of—medical aid in dying, but public, political, medical, and legal discourse about pushing or removing said limits causes confusion.

Who decides which kind of sufferings count for access to MAID and which kind do not? **Who decides which lives can be terminated** and which lives should not?

All of these are desperately needed for constructive public conversation and policy-making. It actually is, as they say, a matter of life and death.

Further, the bill proposes that we permit the provision of medical assistance in dying 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” (Bill C-7 2020). This break from the initial requirement for informed consent at the time of request as well as immediately before medical aid in dying is carried out—allowing for a withdrawal of consent at any time—reveals marked confusion over how to best respect patient autonomy. Health Canada’s “First Annual Report on Medical Assistance in Dying in Canada in 2019” indicates that 263 patients withdrew their requests for MAID last year (Health Canada 2020, 38–39). This should give us pause here. Allowing medical aid in dying for an incapacitated patient, relying solely on their initial consent, suggests that patients either do not or cannot change their minds.

How might these concerns shape patients’ trust in their health-care providers and in the medical institution? If there has been a shift in the relationship between patients and health-care professionals from one of blind trust (“trust me, because I know what is best for you”) to one of

earned trust (“trust me, because I will show that I can be trusted” [Somerville 2000, 5]), then the process of earning said trust must begin with a sincere desire for solidarity that is fuelled by an understanding of shared vulnerability and dependency. If the reasonable-foreseeability criterion is removed, all the more will physicians—especially those who have no qualms with this amendment to the Criminal Code, but also those who might keep their misgivings under wraps or those who feel pressured to conform—have to earn the trust of their patients (both those who reject MAID and those who accept it).

“In some of us,” the great Canadian doctor William Osler described in his *Aequanimitas*, speaking on behalf of health-care providers, “the ceaseless panorama of suffering tends to dull that fine edge of sympathy with which we started. A great corporation cannot have a very fervent charity; the very conditions of its existence limit its exercise. Against this numbing influence, we physicians and nurses, the immediate agents of the Trust, have but one enduring corrective—the practice towards patients of the Golden Rule” (quoted in Nolan 2009, 251). That is, health-care providers must not forfeit their mandate as “agents of the Trust”—an identity that lies at the very heart of the healing arts. This is imperative perhaps now more than ever, considering—as some have pointed out—an erosion of the climate of trust and the loss of “intimate contact between physicians and patients” (Beauchamp and Childress 2009, 41). If trust is, as John Bruhn describes, an “expectation resulting from a cumulative, incremental, interactive process of exchanging mutually valued beliefs and priorities and sharing these in ongoing relationships” (Bruhn 2005, 313), then a certain investment is in order on the part of both the health-care professional and the patient.

I conclude here with the words of Edmund Pellegrino and David Thomasma, who speak to the centrality—indeed, the ineradicability—of trust:

Before we engage this presumably competent physician, we are interested in much more. We expect to open the most private domains of our bodies, minds, and social and family relationships to her probing gaze. Our vices, foibles, and weaknesses will be exposed to a stranger. Even our living and dying will engage her attention and invite her counsel. . . . Ultimately, we must place our trust in the person of the physician. We want someone who knows about us, treats us non-judgmentally, and is concerned with our welfare. We want someone who will use the discretionary latitude our care requires with circumspection—neither intruding nor presuming too much nor undertaking too little. We must be able to trust her to do what she is trusted to do, that is, to serve the healing purposes for which we have given our trust in the first place. (Pellegrino and Thomasma 1993, 68)

The physician’s fidelity to trust, as it is spelled out here, makes the relationship between patient and health-care professional covenantal—rather than simply contractual—in nature. In 1995, sensing a certain threat to this notion, a number of influential physicians (including Edmund Pellegrino, Roger Bulger, George Lundberg, and Lonnie Bristow, among others) published a

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statement in the *Journal of the American Medical Association* declaring that “medicine is, at its center, a moral enterprise grounded in a covenant of trust.”¹⁰ It is what the Faith, Worship, and Ministry Task Force on Physician Assisted Dying of the Anglican Church of Canada has as of late insightfully called “a covenant of presence to the other” that is at once “binding in health and in suffering, in life and in death” (Faith, Worship, and Ministry Task Force 2018, 10 [emphasis added]).

Although one cannot dismiss the implications of the imbalance in power that such a relationship inevitably entails, it is covenantal reciprocity that is being underscored here. This “covenant of presence to the other”—the practical translation of “love of neighbour” into an enduring commitment to be at the side of the other—goes both ways: it is as much a covenant of presence of the health-care professional to the patient as it is a covenant of presence of the patient to the health-care provider.

As an aside, I cannot help but recall a memento mori that I came upon while in Rome some time ago. Fixed to the wall of the Capuchin crypt beneath the church of Santa Maria della Concezione dei Cappuccini is a plaque meant for all passersby. It reads, “What you are now, we used to be; what we are now, you will be.” This is forthright, I admit, and may even come across as an affront to our (comforting) denial of death, but the message not only evokes our shared mortality, it reminds us—starkly—that the human community is one and that the person (health-care professional or other) who accompanies will inevitably become the accompanied in due time. That is, we are all woundable, we are all dependent, and we are all mortal; this shared narrative is an impetus to a solidarity that trusts in mutual support.

This trust—at the heart of the relationship between the patient and health-care professional—must not be undermined, even though it may be tempting to do so in the midst of rising threats (managed care, loss of contact between health-care professionals and patients, growth of impersonal and bureaucratic medical systems, medical error and malpractice, and ongoing changes to legislation around end-of-life care) (Beauchamp and Childress 2009, 41). In the desire to conform to the societal ideal of the functional, autonomous, independent self, shared features of our humanhood—namely, vulnerability, dependency, and suffering—are lamented as weaknesses to overcome (perhaps through medicalization) rather than the foundations of a solidarity built on trust.

The proposed changes to the Criminal Code, if enacted, will give rise to greater access to medical aid in dying, granting patients and health-care professionals the power to choose when to initiate the dying process. Patients (and their families), health-care professionals (as “agents of the Trust”), medical institutions, and the human community writ large are called, with ever more urgency, to (1) counter the de-emphasis on the personhood of the patient (Toombs 1988, 201), who is more than his or her deteriorating body; (2) reassess the ostensibly unbridgeable gap that divides healer and patient by recognizing vulnerability (or, better, woundability), dependency, and suffering as shared features of humanhood; and (3) reaffirm the covenantal nature of the relationship between the patient and health-care professional by carefully, honestly, and openly investing in said relationship so that mutual trust can properly take root and the “covenant of presence to the other” be lived authentically.

10. Crawshaw et al. 1995, 1553. See also May 1983.

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CORY ANDREW LABRECQUE

Dr. Labrecque is associate professor of bioethics and theological ethics, and the inaugural chair of educational leadership in the ethics of life at the faculty of theology and religious studies at the University of Laval in Quebec City, where he is vice-dean and director of graduate programs in theology. He previously served as the Raymond F. Schinazi Scholar in bioethics and religious thought, and the director of graduate programs in bioethics at Emory University in Atlanta. Cory earned a BSc in anatomy and cell biology, an MA

in religious studies with specialization in bioethics, and a PhD in religious ethics at McGill University, where he was a course lecturer in the faculty of religious studies, the Institute of Parasitology, and the department of physiology. Cory's teaching and research examine how the Abrahamic religions—with a focus on the Roman Catholic tradition—approach ethical issues in medicine, biotechnology, and the environment. He is especially interested in ethical issues at the end of life, understandings of personhood, and the impact of emerging/transformational technologies on philosophical and theological perspectives on human nature and the human-nature-God relationship. He is vice-president of the National Committee for Ethics and Ageing (Quebec) and is corresponding member of the Pontifical Academy for Life.

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