Olivia Gale-Wagner
PHL440

# The Ethical Case for Extending Medical Assistance in Dying Eligibility to Terminally Ill Minors with Decision-making Capacity

In Canada, Medical Assistance in Dying (MAID) refers to the process of a physician or nurse practitioner prescribing or administering a lethal substance to a patient who has made the choice to have a medically-assisted death (Government of Canada, 2024-a). Terminally ill adults in Canada have had the right to a medically-assisted death since June 2016 (Government of Canada, 2024-a). MAID has allowed these patients to die painlessly and quickly. In 2021, MAID was expanded to include non-terminally ill adults who are suffering due to an untreatable medical condition (Government of Canada, 2024-a). Despite having a relatively permissive MAID framework in Canada, we still have automatic age restrictions in place, which I'll be arguing against in this paper.

Currently, anyone under the age of 18 is automatically ineligible for MAID (Government of Canada, 2024-a). This is true even if the person is suffering greatly and is in the final stages of a terminal illness. MAID legislation requires that anyone receiving MAID has decision-making capacity to be able to make the choice to have an assisted death (Government of Canada, 2024-a). However, terminally ill minors are excluded from MAID, even if they have been deemed capable to make treatment decisions.

In this paper, I will argue for the moral permissibility and imperative of expanding Medical Assistance in Dying (MAID) eligibility to terminally ill minors with decision-making capacity. I will take the position that age, on its own, is not a valid exclusion criterion. I will first lay out my argument in standard form. I will then elaborate on the pertinent components of my argument, and will finally defend my argument against objections.

To begin, I will state my argument in standard form. It is as follows:

**Premise 1:** Decision-making capacity is defined by being able to understand the information relevant to making a treatment decision *and* by being able to appreciate the reasonably foreseeable consequences of a decision or lack thereof.

**Premise 2:** There are minors who are able to understand the information relevant to making a treatment decision *and* are able to appreciate the reasonably foreseeable consequences of a decision or lack thereof.

**Intermediate conclusion:** Minors can have decision-making capacity.

**Premise 3:** Minors can be terminally ill.

**Premise 4:** Terminally ill persons with decision-making capacity ought to be included in MAID eligibility.

**Main conclusion:** Terminally ill minors with decision-making capacity ought to be included in MAID eligibility.

My intermediate conclusion states that minors can have decision-making capacity and my main conclusion rests on this being true. The definition I used for decision-making capacity is from the College of Physicians and Surgeons of Ontario (CPSO, 2025). In their Guide to the Health Care Consent Act, the CPSO states that minors can have decision-making capacity. The college also states that minors who have been deemed capable are able to make their own medical decisions, even if they are accompanied by a parent or guardian (CPSO, 2025). The Canadian Paediatric Society uses the same definition for decision-making capacity as the CPSO (Coughlin, 2018). In their position statement, the Canadian Paediatric Society says that, "the participation of children and adolescents in medical decision-making should always be sought, and their involvement should be proportionate with their capacity" (Coughlin, 2018, p. 139). In Ontario and every province other than Quebec, there is no minimum age to presume capacity (Coughlin, 2018). In Quebec, the age to presume capacity for medical decision-making is 14 (Coughlin, 2018).

With the exception of Quebec, age cannot override a capacity determination in respect to a patient's right (or lack thereof) to medical decision-making (Coughlin, 2018). In Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island, Saskatchewan, the Northwest Territories, Nunavut, and Yukon, age cannot be used as a stand-alone proxy for decision-making capacity. In these provinces and territories, a physician's determination of capacity, on an individual basis, will always supersede the most common capacity determination associated with a specific age group (Coughlin, 2018). For instance, a majority of 12-year-olds may be deemed incapable, but a physician making a determination that their 12-year-old patient has decision-making capacity will supersede an age generalization. Thus, it is widely recognized in our laws and established precedent that age and decision-making capacity are separate and independent from each other. I am making the additional claim that when we consider both age and capacity, only capacity is morally relevant in determining the patient's ability to engage in medical decision-making related to their care. There are strong ethical reasons for this separation of age and capacity in healthcare, namely that it

affords people the rights that they are owed, including bodily autonomy and self-determination. It is logically inconsistent to fail to apply these same rules to MAID legislation. The age restriction for MAID is arbitrary, considering that a capacity determination from multiple physicians cannot override it, leaving nothing of substance for these age restrictions to fall back on.

It's also relevant to recognize that people who are deemed capable can refuse treatment, including life-saving or life-sustaining treatment, even if it results in their death (Campbell et al., 2022). Any minor who has been deemed capable is included among people who have this right. In Quebec, a minor has to be 14 years old to be able to legally be deemed capable (Coughlin, 2018). Our laws are thus set up so that a minor who could otherwise live and make a full recovery is allowed to die through refusal of life-saving treatment (e.g. refusing a blood transfusion), but a terminally ill minor who is actively dying and suffering is forced to stay alive until their natural death (Campbell et al., 2022). There are a number of historical reasons why this may be the case, including the fact that some people have traditionally seen a distinction between allowing someone to die versus facilitating their death. However, this distinction and debate about the permissibility of passive versus active euthanasia is not relevant in this context, considering that MAID (active euthanasia) *is* legal for terminally ill or incurably suffering adults in Canada, but is not allowed for minors. The question then comes back to age and why terminally ill minors are excluded on the basis of age alone. Being 18 is an arbitrary metric to allow access to MAID, and age itself should not be used as a proxy for decision-making capacity; I am arguing that determinations of capacity should be used directly instead.

Premise four of my argument states that terminally ill persons with *decision-making capacity* ought to be included in MAID eligibility. The reason ultimately comes down to the importance of autonomy and choice in end-of-life care to reduce suffering. Gibson (2018) discusses how suffering has many different dimensions and goes beyond physical pain. Suffering is a state that encompasses physical pain, but also includes psychosocial and relational dimensions of discomfort or distress (Gibson, 2018). Cassel (as cited in Gibson, 2018) proposed that suffering is a "specific state of distress that occurs when the intactness or integrity of the person is threatened or disrupted" (p. 532). The most recent report on MAID in Canada, titled *Fifth Annual Report on Medical Assistance in Dying in Canada, 2023* has a section on the reported nature of suffering for MAID recipients. The top three sources of suffering reported were loss of ability to engage in meaningful activities, loss of ability to perform activities of daily living, and loss of dignity.

Inadequate pain control was in fourth place as a reason (Government of Canada, 2024-b). These sources of suffering align with the definition provided by Cassel and Gibson (2018), and demonstrate that suffering can consist of multiple different components that disrupt the "intactness" of the person.

It is a logical extension of these observations to conclude that when a person is already dying, and no longer has control over most aspects of their life, retaining autonomy in end-of-life care can reduce suffering. MAID offers a unique opportunity to regain control over one's life, as the patient is able to decide when they're going to die. This allows them to have family and friends with them at the time of their death. It also means that they do not have to endure further loss of their capacities, which for some people, would mean that they would be unable to say goodbye to loved ones before their natural death. Additionally, over 54% of MAID recipients in 2023 cited inadequate pain control as a reason for choosing MAID (Government of Canada, 2024-b). Evidently, on a collective level, MAID reduces suffering, and on an individual level, it ends a person's suffering entirely. This is why my fourth premise is that terminally ill persons with decision-making capacity ought to be included in MAID eligibility.

My third premise is that minors can be terminally ill. This may seem like an obvious fact, but there are important reasons to discuss it. Firstly, when we think of children and teenagers, we think of young people who have their whole lives ahead of them. Campbell et al. (2022) points out that there is a cultural tendency to focus on treatment and cure, even when ultimately futile. This tendency may be even stronger for sick children, because it is our natural desire to protect, save and cure children; to give them a chance to grow up (Campbell et al., 2022). The cultural narrative of "continuing to fight" through severe, incurable or terminal illness is often visible in the media. While these are personal choices that ought to be respected, it is also crucial to recognize that for some people, death from their illness is inevitable. Understandably, our culture wants to believe that there is always hope and that there is a chance for these children.

It's likely that for many people, the "terminally ill" label may not fully register for children for the above reasons. As a result, giving minors the ability to choose MAID is still seen as "allowing them to die" or "giving up." Of course, this is not the case because these children are already dying. However, these children may not be seen as terminally ill in the psyche of the lay public until the child actually dies. I believe that this lack of acknowledgement in our cultural psyche of the existence of terminally ill minors likely contributed to the total exclusion of minors

from MAID legislation. In reality, there *are* terminally ill minors and some minors have decision-making capacity, thus minors should not be excluded from MAID legislation.

In this section of the paper, I will move on to discussing possible objections to my argument and responding to them. One possible objection is that this expansion could normalize suicide as an option for youth. Some people might view the expansion of MAID to minors as "allowing kids to kill themselves," and those people might worry that this could influence other minors to die by suicide. My response is that permitting the deliberate ending of life in one context for minors (terminal illness) does not normalize it in completely separate contexts, such as emotional distress. I think the general public has the ability to differentiate between a terminally ill minor choosing MAID and a minor dying by suicide due to mental health challenges. Additionally, when we compare suicide rates in the adult population pre-2016 and post-2016, suicide rates have remained stable (Centre for Suicide Prevention, 2025). MAID was legalized in Canada for terminally ill adults in 2016, thus there is no evidence to suggest that allowing MAID for adults has normalized or increased suicide rates in the adult population. There is no reason why this would be different for minors.

Another common objection is that children are uniquely vulnerable persons and we have a special responsibility to protect them. The objection, more specifically, is that by allowing minors to access MAID, we are failing in our duty to protect children. My response is that vulnerable populations deserve the same rights as other demographics. Elderly people and children are both especially vulnerable, compared to other age groups. However, if individuals in these demographics have decision-making capacity, then they should not be excluded from accessing MAID. Within MAID discourse, I've never encountered an argument that elderly people should be excluded from MAID eligibility due to their age. This is likely because most people recognize that elderly people can be terminally ill. In contrast, and as discussed earlier in the paper, people tend to ignore the reality that children can also be terminally ill, which leads to more concern surrounding the proposal of expanding MAID to minors. Unfortunately, however, this reality is real, and part of protecting minors is protecting their rights. This means that minors ought to have the same right to end-of-life care options as adult Canadians, if they have the capacity to make those decisions. Fighting against these rights ultimately leads to the prolongation of suffering for capable, dying minors who want a medically-assisted death. It is what I would consider to be the opposite of

"protection." In fact, I view the withholding of equal options for end-of-life care as actively harmful.

I do want to acknowledge the slippery slope objection. Some people might say that allowing terminally ill minors access to MAID is permissible, but doing so would open the door to non-terminally ill minors being allowed access to MAID, which they argue would be wrong. Thus, to prevent the latter, we must also prevent the former. In my response to this objection, I am going to make a few points. Firstly, I understand why this could be a concern, since adults with non-terminal but untreatable medical conditions that cause intolerable suffering *can* access MAID. In Canada, expansions to MAID eligibility have so far occurred through the courts deciding that a restriction contravenes the Canadian Charter of Rights and Freedoms (Government of Canada, 2024-a). Thus, extending MAID to terminally ill minors does not result in non-terminally ill minors also having access, since whether or not each restriction contravenes the Charter is decided on its own merits. Secondly, the slippery slope objection is not an objection to my *argument* itself but an objection to my *conclusion,* for reasons that do not have to do with how I arrived at it. Regardless, discussion on the moral permissibility of non-terminally ill minors accessing MAID is not within the scope of this paper.

These objections often come from a place of fear of the unknown and imagining worst case scenarios. Ultimately, people may have strong feelings of unease around this type of proposed expansion of MAID. Our feelings can be a guide to let us know which aspects of a moral issue we should contemplate further. However, having uneasy feelings about a subject does not mean it is intrinsically wrong. If we wish to make strong arguments for a moral cause, it's important that our arguments are grounded in consistent moral reasoning.

In this paper, I have laid out an argument for the moral permissibility and imperative of expanding Medical Assistance in Dying (MAID) to terminally ill minors. My argument rests on the premise that terminally ill people with decision-making capacity ought to be included in MAID eligibility. Minors can be both terminally ill and have decision-making capacity, thus they ought to be allowed access to MAID. I discussed how the requirement of being 18 to access MAID is arbitrary, and as such, has no strong moral reasoning or arguments underpinning it. Age should not be used as a proxy for decision-making capacity and doing so is in stark contrast to the current Canadian laws in healthcare that allow capable minors to consent to or refuse treatment, even when those refusals would result in death. I also discussed how minors can be terminally ill, but this fact

is often met with resistance in the cultural psyche, which may be a contributing factor to the current total exclusion of minors from MAID eligibility. Ultimately, my position is about protecting the rights of minors to the same end-of-life care options as adults. A terminally ill person should never be excluded from MAID eligibility on the basis of age. Instead, they ought to have the same rights as everyone else to have a capacity assessment to see if they have decision-making capacity in the context of this medical decision. The suffering of children and youth matters, and if they are terminally ill and capable, they ought to have the right to end their suffering through MAID. Thus, expanding Medical Assistance in Dying to minors is not only morally permissible, but also a moral imperative.

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