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## Assistance in Dying and Its Extensions in Canada

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## Abstract

Medical Assistance in Dying (MAiD) was allowed in 2016 through an amendment of the Criminal Code, prompted by a decision of the Supreme Court of Canada. Initially, MAiD was open for patients with a grievous and irremediable condition and whose death was reasonably foreseeable (now referred to as Track 1). In 2021 another amendment created a second track for MAiD (Track 2), for which the “reasonably foreseeable” requirement was lifted. The 2021 amendment also opened the possibility of MAiD when a mental disorder is the sole underlying medical condition, a decision of which has been postponed to at least 2027. Since the amendment in 2021, Canada has become one of the countries with the least constrained access to MAiD and with the second highest MAiD prevalence as a share of total deaths. The concept of MAiD has been largely supported in the population and the need for safeguards to protect vulnerable individuals was balanced against access to that fundamental right. However, since the implementation of Track 2, criticism of MAiD has come not only from conservative perspectives but also from advocacy groups for persons living with disability.

*L'aide médicale à mourir (AMM) a été autorisée en 2016 grâce à une modification du Code criminel, à la suite d'une décision de la Cour suprême du Canada. Au départ, l'AMM était accessible aux patients atteints d'une condition grave et irrémédiable et dont le décès était « raisonnablement prévisible » (ce que l'on appelle aujourd'hui le premier volet). En 2021, un autre amendement a créé un deuxième volet pour l'AEM (voie 2), pour laquelle l'exigence de « décès raisonnablement prévisible » a été supprimée. La modification de 2021 a également ouvert la possibilité de recourir à l'aide médicale à mourir lorsqu'un trouble mental est la seule affection médicale invoquée, décision qui a été reportée au moins jusqu'en 2027. Depuis la modification de 2021, le Canada est devenu l'un des pays où l'accès à l'AMM est le moins restreint et où la prévalence de l'AMM est la deuxième plus élevée en pourcentage du nombre total de décès. Le concept de l'AMM a été largement soutenu par la population et, si la mise en place de garanties pour protéger les personnes vulnérables a été vue comme nécessaire, elle est aussi conçue comme ne devant pas entraver l'accès à ce droit fondamental. Cependant, depuis la mise en œuvre du deuxième volet, les critiques à l'égard de l'aide médicale à mourir proviennent non seulement des conservateurs, mais aussi des groupes de défense des personnes handicapées.*

### Key Messages

- The concept of MAiD is strongly supported by the Canadian population and most federal institutions, with mixed support among professional groups.
- Although the law's language and its implementation invoke the health care system, the principle of autonomy of the patient is at the core of the decisions of the various Supreme Courts as well as of the Bills on MAiD.
- However, the expansions to Track 2 and, potentially in 2027, to mental disorder as the sole underlying condition have raised concerns over the protection of vulnerable individuals.
- Canada is one of the jurisdictions where access to MAiD is the least constrained, and Canada's proportion of deaths following MAiD is second only to the Netherlands and catching up fast.

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### Messages-clés

- *L'idée d'AMM reçoit un fort soutien de l'opinion au Canada, ainsi que de la plupart des institutions fédérales, et un soutien mitigé des groupes professionnels concernés.*
- *Bien que la loi et sa mise en place concernent le système de soins, le principe d'autonomie du patient est au cœur des décisions des diverses Cours Suprêmes ainsi que des différents textes de loi sur la question.*
- *Cependant, les élargissements au second volet et, potentiellement en 2027, aux cas où un trouble mental est la seule affection médicale invoquée ont soulevé des questions sur la protection des individus les plus vulnérables.*
- *Le Canada est un des pays où l'accès à l'AMM est le moins restreint, et la part de décès suivant une AMM dans le nombre total de décès n'est supérieure qu'aux Pays bas, le Canada rattrapant rapidement.*

## 1 BRIEF DESCRIPTION OF THE POLICY

In Canada, euthanizing someone or assisting someone to die by suicide is a crime. In 2016, the Canadian federal government introduced exceptions through Bill C-14 known as medical assistance in dying (MAiD), under which euthanasia (directly administering lethal medication) or assistance in suicide (providing the medication) are not criminal anymore (Nicol and Tiedemann 2016). The conditions in the 2016 Bill were as follows: Firstly, the person giving assistance in dying must be a physician or a nurse practitioner or anyone helping a physician or nurse practitioner with MAiD. Secondly, the person who is assisted must be at least 18 years of age, eligible for government-funded health services (excludes visitors to the country or temporary residents), and have a “grievous and irremediable medical condition.” Grievous and irremediable means that the four following criteria must be satisfied: (1) the condition is incurable, (2) the state of decline in capability is advanced and irreversible, (3) the individual endures physical or psychological suffering “that is intolerable” and cannot be relieved under conditions that they consider acceptable and (4) natural death is reasonably foreseeable. Furthermore, the person wanting to receive MAiD must write a request “without external pressure” signed by two independent witnesses. The physician or nurse practitioner providing MAiD must seek the independent and positive advice of another physician or nurse practitioner. The original legislation also required a mandatory “reflection period,” a gap of ten days between the request and the provision of MAiD. The person must affirm their consent immediately before the provision of MAiD (except in extenuating circumstances).

Since Bill C-14 was enacted in 2016, the reform has been changing around the eligibility criteria, leading to the creation of two “tracks” of MAiD (two scenarios for which MAiD is legal). In 2021, the federal government passed Bill C-7 that expanded upon the original conditions of Bill C-14 (“Track 1”) to include a track for individuals for whom death is not reasonably foreseeable (“Track 2”).<sup>1</sup> Bill C-7 also eliminated the reflection period for Track 1 and required one independent witness instead of two. For Track 2, a minimum of 90 days for the assessment of eligibility by the health care provider is required and a physician or nurse with expertise in the condition motivating the request must be involved in the decision (either as one of the two assessors or being consulted by one of the assessors). Also for Track 2, the person requesting MAiD has to be informed of available services appropriate to relieve their suffering, be offered consultation with professionals who provide those services, and, in discussion with their practitioner, the requestor must seriously consider the means of alleviating their suffering. It is the responsibility of the health care provider providing MAiD to ensure these last two conditions are met (Government of Canada 2023).

Bill C-7 also excluded persons whose sole underlying condition was a mental disorder (MD-SUMC) but added a sunset clause to that exclusion to give time for a review by an

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<sup>1</sup>It must be noted, though, that the boundary between tracks is somewhat porous as some publicly interpret “foreseeable death” as meaning in a number of years. This aspect is quite unique to the Canadian context.

expert panel led by Health Canada and a joint committee of Parliament to define safeguards, protocols, and guidelines. The original sunset was March 2023 but then pushed back twelve more months in February 2023 (Bill C-39) and, again, in February 2024 for another three years (Bill C-62).

We describe here the ongoing reform of the *Criminal Code of Canada* known as MAiD, from its origin in 2016 to the current discussion of opening Track 2 to MD-SUMC, including the policy process and what is known about the evaluation of the reform. Even though the reform applied mostly to the Criminal Code, it affects the health care system in the sense that health care professionals are the gatekeepers and guidelines must be implemented in each of the fourteen Canadian health care systems to make the law work.

The reform was precipitated by judicial decisions from the Supreme Court of Canada (SCC; *Carter v Canada (AG)*, 2015) and the Cour Supérieure du Québec (CSQ; *Truchon v Canada (AG)*, 2019). It is an important reform of the health care system because it raises ethical and organizational issues and has become a public health concern with swelling utilization numbers.

The goal of the reform was to strike “the most appropriate balance between the autonomy of persons who seek medical assistance in dying. . . and the interests of vulnerable persons in need of protection and those of society” (Preamble Bill C-14).

## 2 HISTORY AND CONTEXT

Suicide was decriminalized in 1972 in Canada. The right of patients to refuse treatment against the recommendation of a physician was discussed in the 1980s and 1990s with the SCC stating around the time of *Rodriguez* (see below) that the Criminal Code did not usually apply to the physician in case of a patient refusing a treatment (Schucklenk et al. 2011). The question of physician-assisted suicide (PAS) became prominent in public discourse in the US around the trials of Dr. Kevorkian and can be traced back in Canada to the landmark case of *Rodriguez v British Columbia (AG) (1993)*. Sue Rodriguez was diagnosed in 1991 with Amyotrophic Lateral Sclerosis (ALS) and wanted to be able to die by suicide before her suffering became intolerable, but she knew that might happen at a time when she would not be physically able to do so. She argued that not allowing her to die by suicide because of her physical inability was a discrimination, Section 15 of the *Canadian Charter of Rights and Freedoms*. She also introduced the notion that the right to a dignified death was part of the right to life guaranteed by Section 7 of the Charter, and that preventing her from getting assistance to die by suicide amounted to cruel and unusual punishment (Collier and Haliburton 2011). In 1993, the SCC ruled against her, five to four, arguing that the disposition in the Criminal Code banning PAS, while impinging on the right to liberty and security, respected the principles of fundamental justice and was not arbitrary, not overbroad and not grossly disproportionate. The SCC considered that the ban on PAS was justified by the state’s interest in the protection of vulnerable persons

and in protecting the sanctity of life.

The issue of PAS remained on the agenda and discussions in Canada, leading to private members' bills in the House of Commons, a Senate study (Canada 1995) and a report of the Royal Society of Canada (Schuklenk et al. 2011).

Two major developments took place in 2014. First, Québec voted an Act “respecting end-of-life care” that allowed MAiD in that province. Second, a new case, known as *Carter v. Canada*, was before the SCC: in a very similar request to Sue Rodriguez’s in 1993, the British Columbia Civil Liberties Association (BCCLA), representing Gloria Taylor (a woman suffering from ALS), the family of Kay Carter (a woman suffering from degenerative spinal sclerosis), and a doctor sued to overturn the prohibition of PAS. They won before the Supreme Court of British Columbia, but the then Conservative federal government appealed the decision and won before the Court of Appeal of British Columbia. The BCCLA brought the case to the SCC, which, this time, ruled unanimously, that the complete ban on PAS was overbroad and grossly disproportionate to its aim of protecting the vulnerable, as harm to individuals suffering from grievous illnesses outweighed the benefit of the law’s aim. The SCC therefore required the *Criminal Code of Canada* to be amended (Nicol and Tiedemann 2016).

Amending the Criminal Code to allow PAS was supported by 77% of Conservative voters (Angus-Reid Institute 2014). However, many in the Conservative caucus were opposed to changing the Criminal Code in the name of the sanctity of life. In October 2015, the Liberal Party of Canada won the election, and the new majority government passed Bill C-14 in less than six months.

Both the Québec Act and Bill C-14 stated explicitly that assistance in dying was legal only for individuals whose death was reasonably foreseeable, but this clause was not mentioned in the decision of the SCC. Bill C-14’s “reasonably foreseeable death” was therefore challenged before the CSQ which, in 2019, decided against the clause on the basis that it discriminated against those with similar suffering but not near death (*Truchon v. Canada and Québec*). Québec dropped it from its Act in 2020, and the federal government chose not to appeal the ruling of the CSQ to the SCC, thus accepted the ruling and introduced Bill C-7.

The initial Bill C-7 had a clause barring MAiD to MD-SUMC, but an amendment in the Senate, which the government did not oppose, replaced the clause with a two-year sunset clause that was set to expire March 2023 and since extended to March 2027, giving time to the government to prepare for its legalization. The amendment and Bill C-7 also mandated a joint Senate-House committee and an expert panel led by Health Canada to provide safeguards for MD-SUMC. In 2020-21, the Liberal party held a minority government but had the Bill and amendment passed with support of either the NDP or Bloc Québécois. Conservatives voiced their opposition to the extension of MAiD to persons with MD-SUMC (Library of Parliament 2024).

In 2021, the Special Joint Committee on Medical Assistance in Dying (Garneau and Martin 2023) and the Health Canada panel (Health Canada 2022) were tasked to discuss the

following three specific concerns in relation to MAiD and mental illness:<sup>2</sup> the uncertainty surrounding possible recovery, which may be more fraught to determine for MD-SUMC than for other conditions; the specific difficulty of informed choice, particularly in the context of structural vulnerabilities, which therefore requires more detailed safeguards; and the use of MAiD to die by suicide when suicidality is one symptom of the disease. Some issues, like whether an individual should be required to try all available treatments before accessing MAiD, even when deemed not acceptable by the patient, before the disease is called “irremediable” pertain to all cases of MAiD. However, the issue is more nuanced for MD-SUMC because reluctance to get treatment can be part of the mental disorder. Countries that allow MAiD for MD (regardless of whether SUMC) tend not to allow it unless all indicated treatments (following standards of practice) have been tried, as the requestor’s preference is not the sole basis for determining medical irremediability (Garneau and Martin 2022). But the issue is still debated and the right for an individual to refuse treatment if its effects would be considered unbearable has to be considered.

### 3 THE POLICY-MAKING PROCESS

In Canada, the judicial branch took an important part in the policy-making process leading to MAiD. As a result, the 3I framework (Ideas, Interests, Institutions) seems more appropriate than the Kingdon (problems, policies, politics) to analyse how MAiD was implemented, how MAiD was extended to persons without foreseeable death, and why the sunset clause for MAiD MD-SUMC has been postponed twice, to a total of six years.

#### 3.1 Ideas

In Canada, as elsewhere, medical progress introduced new ethical questions about patient agency vis-à-vis health care providers, in particular in decisions such as withdrawal and withstanding of life-sustaining treatments (Colier and Haliburton 2011). The non-profit organization, Dying With Dignity, advocated for a change to the Criminal Code and some academics also took up the issue, e.g., Dr. Jocelyn Downie, law professor at Dalhousie University, playing a prominent role pushing for the decriminalization of euthanasia through publications (e.g., Downie 2004), media appearances and support in Carter. The discussion was overwhelmingly in favour of amending the Code, and the few dissenting voices framed their dissension either in terms of opposite principles, for example, the sanctity of life and the right to dignity, or empirical terms based on the experience of countries having allowed some form of assistance in dying, such as the Netherlands, Belgium or Switzerland. The central concern of the latter was the fear of a slippery slope: which safeguards could guarantee that no one would request assistance in suicide under pressure, from family or

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<sup>2</sup>Other questions were discussed by these two groups such as advance requests and MAiD for mature minors. For the sake of space, this HRA focuses on extensions to Track 2 and MD-SUMC only.

society? A feminist critique of assistance in dying had voiced such concerns that women would be vulnerable to such pressure (Wolf 1996) and Indigenous physicians asked that any policy has specific support acknowledging the cultural values of Indigenous communities as well as the high rates of suicide of these communities (Ogilvie and Oliphant 2016).

PAS became widely accepted by public opinion over time (by around two thirds of respondents to polls from 1995 to 2010 (Schuklenk et al. 2011, 23). The already cited 2014 Angus Reid poll found 79% would approve a change to the Criminal Code to make it possible. However, the support was strong for terminally ill patients or those in acute pain, and much less so for other reasons.

With the introduction of Track 2, the discussion changed somewhat. Advocates of the rights of persons living with disability (PLWD) as well as reports from the United Nations and a series of Associated Press reports raised the issue that, by making MAiD available for those who are not at the end of life, Canadian society is in essence telling PLWD that dying might be their best option, given that society was not willing to help them live with dignity (Janz 2023). This argument is more principled than empirical: even if no requests for MAiD were “under pressure,” it would be argued that PLWD would lack a meaningful choice.

### 3.2 Interests

All parties represented in Parliament supported some form of MAiD except the Conservative Party, which was split on Bill C-14, concerned about the SCC leading the political process and strongly opposed to Bill C-7.

By changing the Criminal Code to allow MAiD, the government tasked participating physicians and nurses with actively ending lives, as opposed to withdrawing treatment. Prior to Carter, physicians and nurses were on opposite sides, with the former leaning toward opposing MAiD (with some provincial exceptions, as in Québec) and the latter more supporting it (Schuklenk et al. 2011). The Canadian Nurses Association (CNA) supported Bill C-14 and Bill C-7 wholeheartedly but had second thoughts about MD-SUMC, with an inflexion toward more prudence between 2020 and 2022, and insisted on the possibility of conscientious objection for nurses in cases where the illness is not terminal (CNA 2020). The CNA also insists on adequate funding for mental health care before MD-SUMC is introduced. The Canadian Medical Association (CMA) initially opposed euthanasia or assistance in suicide in ethical code (2007 and 2011) but eventually supported Bill C-14 on the basis that the decision of the SCC made it a constitutional right and after consulting with its members. Because only a minority of physicians were willing to provide MAiD (Warren 2015) the CMA insisted on conscientious objection (balancing the rights of physicians and the rights of patients) and safeguards to protect vulnerable persons. The CMA supported Bill C-7 but raised concerns about MD-SUMC and advance requests for neurological conditions. Palliative care physicians have consistently been wary about MAiD, their concern being that MAiD would become a substitute for palliative care (Coehlo and

Lemmens 2025; Shapiro et al. 2024).

Perhaps the main source of opposition to MAiD came from organizations advocating for PLWD around the time of discussions of Bill C-7. The Disability Filibuster, “a grassroots online protest on a scale never before undertaken in Canadian disability history” (Janz 2023) took place in March 2021 and gave visibility to the major objection to Bill C-7. The group, Living With Dignity, a network of organizations in support of PLWD, had supported Bill C-14 but started a campaign against C-7, insisting that MAiD should be available for patients at the end of life only. Thus, opposition to extensions of MAiD shifted mainly from conservative corners to the progressive side of society that had initially promoted the decision of the SCC in *Carter*.

### 3.3 Institutions

Bill C-14, and, to some extent, C-7 are cases where the judicial branch of government takes the lead and, some argued, shows political activism. The SCC justified its decision in *Carter* in part by saying that the “vast international consensus against MAiD” that had supported the view in *Rodriguez* that the ban in the Criminal Code was not overbroad, did not exist anymore. In some countries (South Africa, UK, US) courts have said the matter involves moral opinions that are better handled by political processes. By affirming MAiD as a Charter right that cannot be denied to any competent adult with a grievous illness the SCC restricted the choice left to the Parliament between de-criminalization and legalization, and invited challenges to the “foreseeable death” condition in Bill C-14.

Most federal institutions supported the initial legalization of MAiD as well as further extensions, to the exception of the Special Joint Committee (Garneau and Martin 2023), which had reservations on MD-SUMC and recommended delaying the final decision. The Health Canada Expert panel (2022) made recommendations in favour of adding guidelines for implementation of MAiD-SUMC without further legislative work to amend the Criminal Code; this refusal to add safeguards to the Criminal Code prompted the resignation of some panel members.

Internationally, two UN Special Rapporteurs and one Independent Human Rights Expert stated that MAiD Track 2 contravened the UN Convention on the Rights of Persons with Disabilities.

## 4 IMPLEMENTATION AND EVALUATION

MAiD grew from 1% of all deaths in 2017 to more than 4.7% in 2023 (based on annual reports from Health Canada), making it the sixth leading cause of death, more so than in Belgium or Switzerland, and the rate of growth of that proportion is much higher than has been in the Netherlands (Raikin 2024) or California (Pullman 2022). Rapidly growing numbers in Canada may signal that MAiD has hampered the growth of palliative care or even substituted for care that could have changed the course of a disease, especially since,

unlike in other jurisdictions, the Canadian law permits MAiD even when such care is refused or is not available to some for financial or rationed supply reasons.

In 2023, two years after Track 2 was opened by Bill C-7, the vast majority of MAiD cases in Canada still pertain to Track 1, and cancer is still by far the main reason for requesting MAiD, at least in Ontario with cardiovascular condition a distant second (Office the Chief Coroner 2024).

An important institutional aspect of the implementation of MAiD and its extension to Track 2 is the federal-provincial-territorial shared responsibility. The federal government can amend the Criminal Code to decriminalize MAiD, including for MD-SUMC, but the protocols and guidelines to make it happen are the responsibility of the provinces and territories. There are significant differences across provinces in the acceptance of MAiD, especially Track 2, and variations in guidelines to administer requests and deliver MAiD might introduce differences in practice across the country. MAiD represents 6.5% of all deaths in Québec but only 1.5% in Newfoundland-Labrador (where nurses are not supposed to mention MAiD in initial encounters to discuss future treatments, Raikin 2024). Furthermore, a small number of physicians are responsible for the majority of MAiD in Canada, suggesting a highly motivated group is driving the implementation of the policy (Lyon et al. 2024).

Evaluation is an important aspect of the reform, and monitoring is required in both Bills. What should be monitored, however, is less clear. For instance, increasing incidence can be seen as a good thing, that access to MAiD is not hampered, but also as a signal that MAiD is used in Canada as a substitute to care or support to live in dignity. One area of emerging consensus is that the introduction of MAiD did not have much effect on suicide rates — neither increasing or decreasing them. In Ontario, women are more represented (60%) than men among Track 2 requesters (MDRC Report 2024 (b)), but, again, Track 2 cases remain relatively few in number. Demographic patterns also indicates that MAiD requests under Track 1 tend to come from higher income individuals (Downar et al. 2020, analyzing Track 1 only). While individual-level data does not show a clear association between MAiD and social vulnerability, data at the regional level suggest that areas with higher marginalization in terms of housing and “age and labour force” are strongly over-represented among MAiD cases (Office of the Chief Coroner 2024). Access to data remains a challenge, with most MAiD data being published in aggregated form in annual reports published by Health Canada, limiting potential for independent health policy research on the topic.

## 5 STRENGTHS, WEAKNESSES, OPPORTUNITIES, THREATS

Table 1: SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• MAiD is supported by a large majority of Canadian public opinion.</li> <li>• Bills C-14 and C-7 responded to challenges to the Charter of Rights.</li> <li>• MAiD and its extensions were supported by most Federal institutions and health care providers' organizations.</li> </ul>	<ul style="list-style-type: none"> <li>• PLWD and other groups raised concerns that Track 2 was making MAiD a substitute to treatments or help to live with dignity.</li> <li>• Extension to MD-SUMC raised strong opposition and is not resolved yet.</li> </ul>
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>• Gives patients more autonomy in their decision to the moment and manner of their death.</li> </ul>	<ul style="list-style-type: none"> <li>• Puts vulnerable individuals at risk (the slippery slope) while, at the same time, preventing eligible individuals to access.</li> <li>• Requires agreement of provincial and territorial health care systems on guidelines for implementation.</li> </ul>

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## 7 DISCLAIMER

The views, information or content, and conclusions presented do not necessarily represent the official position or policy of, nor should any official endorsement be inferred on the part of, the Clinical Center, the National Institutes of Health, or the Department of Health and Human Services.

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