Open Access Library Journal
2025, Volume 12, e13246
ISSN Online: 2333-9721
ISSN Print: 2333-9705

An Analysis of Public Attitudes toward Medical Assistance in Dying (MAID) and the Associated Safeguards in Canada: A Systematic Review

Ifeoluwa Claudius Daramola[1*], Olabode Aleshinloye[2], Farah Mudhafar Fattah Algitag[3], John Charles Chidozie Ifemeje[1], Kenechi Unachukwu[4], Sekinat Ashiru[5], Joy Adewale Felix[6]

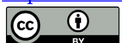
[1]Department of General Medicine, Windsor University School of Medicine, Basseterre, St Kitts and Nevis
[2]Department of General Internal Medicine, College of Medicine, University of Saskatchewan, Saskatoon, Canada
[3]College of Medicine, The Hashemite University, Zarqa, Jordan
[4]School of Medicine, Grodno State Medical University, Hrodna, Republic of Belarus
[5]College of Medicine, Olabisi Onabanjo University, Ago-Iwoye, Nigeria
[6]College of Medicine, Obafemi Awolowo University, Osun, Nigeria

Email: *claudiusdaramola@yahoo.com, gaf926@mail.usask.ca, farah_alchetachi95@yahoo.com, ifemejecharles@yahoo.com, radneyunachukwu@yahoo.com, sekinatt.a@gmail.com, joyadewale1000@gmail.com

How to cite this paper: Daramola, I.C., Aleshinloye, O., Algitag, F.M.F., Ifemeje, J.C.C., Unachukwu, K., Ashiru, S. and Felix, J.A. (2025) An Analysis of Public Attitudes toward Medical Assistance in Dying (MAID) and the Associated Safeguards in Canada: A Systematic Review. *Open Access Library Journal*, **12**: e13246.
https://doi.org/10.4236/oalib.1113246

Received: March 11, 2025
Accepted: April 22, 2025
Published: April 25, 2025

Copyright © 2025 by author(s) and Open Access Library Inc.
This work is licensed under the Creative Commons Attribution International License (CC BY 4.0).
http://creativecommons.org/licenses/by/4.0/



Open Access

Abstract

Medical Assistance in Dying (MAID) has become a significant topic of public and ethical discourse in Canada since its legalization in 2015 following the Carter v. Canada Supreme Court decision. This systematic review examines public attitudes toward MAID, focusing on the influence of demographic, cultural, and socio-economic factors, as well as perceptions of the safeguards designed to protect vulnerable populations. The review, adhering to PRISMA guidelines, analyzed 13 studies published between 2015 and 2025, including public opinion polls, policy analyses, and qualitative research. Findings indicate strong public support for MAID, driven by principles of autonomy and dignity, with higher approval among younger, secular, and more educated individuals. However, opposition persists, particularly among older, religious, and conservative groups, who cite concerns about the sanctity of life and potential coercion of vulnerable populations. Safeguards, such as independent assessments and waiting periods, are generally viewed positively, though recent legislative changes, including the expansion of eligibility to individuals with mental illness and the removal of the 10-day reflection period, have raised concerns about their adequacy. The review highlights the need for ongoing public engagement, equitable access to healthcare, and transparent policymaking to address ethical dilemmas and ensure MAID aligns with societal values while protecting vulnerable individuals such as the older population, Individuals considering MAID,

Religious or conservative individuals and persons lacking equitable access to healthcare. Recommendations include further research on public concerns, improved safeguards, and greater involvement of healthcare providers in policy development.

Subject Areas

Internal Medicine

Keywords

Autonomy, Public Attitudes, Ethical Principles, Vulnerable Populations, Mental Illness, End-of-Life Care, Healthcare Providers, Beneficence, Non-Maleficence, Religious Beliefs, Cultural Factors, Socioeconomic Status, Legislation, Policy, Equity, Terminal Illness, Neurodegenerative Diseases, Informed Consent, Indigenous Perspectives

1. Introduction

Medical Assistance in Dying (MAID) refers to the practice in which a healthcare professional assists a patient in ending their life. This assistance may involve either prescribing medication for self-administration (physician-assisted suicide) or administering medication directly (voluntary euthanasia). MAID is typically employed in cases of severe, incurable medical conditions or terminal illnesses that cause significant suffering. Recent legislation in Canada, along with similar developments in other countries, has made MAID a subject of ongoing public discourse, particularly following the 2015 Supreme Court of Canada decision in Carter v. Canada, which legalized the practice [1].

Since the Carter ruling, the number of MAID cases in Canada has increased annually. The eligibility criteria have also evolved; under Bill C-14 (2016), individuals with non-terminal conditions and mental illnesses were not eligible. However, Bill C-7 (2021) expanded eligibility to include these individuals, raising ethical concerns about autonomy, dignity, the right to die, potential coercion of vulnerable individuals, and ensuring the mental competency of participants [2] [3]. The primary objective of MAID is to offer a compassionate option for relieving suffering when other treatments prove inadequate.

Prior to the 1990s, MAID was prohibited under the Criminal Code of Canada, which classified physician-assisted suicide and euthanasia as criminal offenses. The law was first challenged in the 1993 Rodriguez v. British Columbia case, in which the Supreme Court upheld the prohibition in a narrow 5 - 4 decision, ruling that while the law engaged Charter rights, it was a reasonable limitation in a free and democratic society [4]. The 2015 Carter decision overturned this precedent, recognizing that prohibiting MAID violated an individual's right to life, liberty, and security under Section 7 of the Canadian Charter of Rights and Freedoms [5] [6]. This ruling was based on the principle that individuals suffering from griev-

ous, irremediable medical conditions should have the autonomy to decide whether to end their lives. Initially, strict eligibility criteria required that a person's natural death be reasonably foreseeable.

Eligibility criteria for MAID vary by jurisdiction but generally require individuals to be mentally competent and to have a grievous and irremediable medical condition causing enduring and intolerable suffering. Conditions that may qualify for MAID include:

- **Terminal Illnesses**: Advanced metastatic cancer, amyotrophic lateral sclerosis (ALS), end-stage organ failure (heart, liver, kidney), advanced chronic obstructive pulmonary disease (COPD), and late-stage neurodegenerative diseases such as Parkinson's disease and multiple sclerosis (MS).
- **Neurodegenerative Diseases**: Alzheimer's disease, Huntington's disease, and spinal muscular atrophy.
- **Other Conditions**: Severe paralysis with complications (e.g., quadriplegia with intractable pain), persistent vegetative state, or locked-in syndrome.
- **Mental Illness**: In Canada, eligibility for individuals whose sole underlying medical condition is a mental illness has been deferred until March 17, 2027.

Determining terminal illness in clinical practice involves assessing the confirmed diagnosis, the progression of the disease despite treatment, and the estimated prognosis. Functional status and symptom burden are key factors in evaluating eligibility, often measured using tools such as the Eastern Cooperative Oncology Group (ECOG) performance status or the Karnofsky Performance Scale.

MAID in Canada is governed by safeguards designed to ensure ethical and responsible conduct. These safeguards depend on whether a person's natural death is reasonably foreseeable [7]. In 2019, the Superior Court of Quebec ruled in Truchon v. Canada that the "reasonable foreseeability of natural death" (RFND) and "end-of-life" criteria were unconstitutional, as they violated Sections 7 and 15 of the Canadian Charter of Rights and Freedoms [8] [9]. In response, the Canadian government engaged the public and stakeholders to refine MAID legislation. Concerns raised included barriers to access, such as the requirement for two independent witnesses and the mandatory 10-day waiting period, which prolonged patient suffering [10] [11].

Bill C-7 (2021) introduced significant amendments, including the removal of the 10-day reflection period to streamline the process and reduce delays. The requirement for two independent witnesses was replaced with one, and healthcare or personal care professionals were permitted to serve as independent witnesses. The RFND criterion was also eliminated, and new safeguards were established for individuals whose death is not reasonably foreseeable. These include a minimum 90-day assessment period, which may be shortened if practitioners determine that loss of capacity is imminent [10].

If all criteria and safeguards are met, the individual and healthcare provider schedule the procedure. Immediately before administering MAID, the practitioner must confirm the individual's consent and provide an opportunity to withdraw

the request. MAID can then be clinician-administered or self-administered.

Public support for MAID in Canada has been consistently high. A public opinion poll conducted before legalization found that 63% of respondents supported the measure [12]. Studies indicate that public approval has grown over time. Crumley *et al.* (2019) documented increasing support from 1968 to 1990, while Bozinoff (2015) observed similar trends between 2011 and 2015 [13] [14]. The ethical principles most commonly cited in support of MAID include autonomy—the right to determine the manner and timing of one's death—as well as beneficence and non-maleficence [15]-[18].

Public attitudes toward MAID are influenced by factors such as age, religion, geography, education, and socioeconomic status. Studies show that younger individuals tend to be more supportive, whereas older and more religious individuals are more likely to oppose it. Bozinoff (2015) also found higher support among non-religious individuals [19] [20]. Regional differences have been reported, with support levels varying between provinces such as Quebec and Alberta. Additionally, individuals with higher education and socioeconomic status tend to favor MAID. While public perception of MAID safeguards is generally positive, concerns persist regarding accessibility and the potential for coercion among vulnerable populations [21]. The inclusion of mental illness as a sole eligibility criterion remains a contentious issue [18].

Understanding public attitudes toward MAID is crucial for shaping policies and safeguards. Public opinion influences political decisions and healthcare practices and affects the perception and ethical acceptability of MAID laws [20]. In Canada, public acceptance has driven legislative changes and shaped societal discourse on death and dying [22]. Public engagement has played a pivotal role in developing safeguards. Societal attitudes toward MAID can also influence regulatory frameworks, with stronger support potentially leading to broader eligibility and fewer procedural barriers, while opposition may result in stricter controls and increased restrictions [16]. Media coverage also plays a significant role in framing MAID debates, often highlighting ethical considerations and policy implications.

The purpose of this systematic review is to analyze public attitudes toward MAID and its associated safeguards. This review aims to:

1) Identify prevailing public attitudes toward MAID and the ethical, legal, and social factors that influence them.

2) Evaluate perceptions of the adequacy of safeguards in preventing misuse and protecting vulnerable individuals.

3) Assess the impact of cultural, religious, and socioeconomic factors on attitudes toward MAID and its safeguards.

4) Provide recommendations for future policy and safeguard improvements to align MAID laws with ethical principles while addressing public concerns regarding fairness and access.

This study will explore public attitudes across demographic groups and time periods, examining how these perspectives influence policy and healthcare provider engagement. Additionally, it will assess the alignment of MAID practices with

ethical principles in Canadian healthcare and offer recommendations for policy refinement and communication strategies.

2. Methodology

This systematic review was conducted in accordance with the PRISMA guidelines to ensure transparency and methodological rigor. The PICO framework was employed to formulate the research question and guide the selection of relevant studies [23] [24]. The P (Population) comprised Canadian citizens who are aware of or have opinions on Medical Assistance in Dying (MAID). The I (Intervention) was MAID, while the C (Comparison) referred to the absence of medical assistance in dying. The O (Outcome) focused on public attitudes toward MAID, particularly how these attitudes are shaped by the presence or absence of legal safeguards. The research question was developed based on these parameters: How do public attitudes toward Medical Assistance in Dying in Canada vary across different demographic groups, and what role do legal safeguards play in shaping these attitudes?

2.1. Inclusion and Exclusion Criteria

Eligible studies included original peer-reviewed research articles (qualitative, quantitative, or mixed methods), systematic reviews, and reports that examine public opinion, attitudes, or legal protections related to MAID. Research focusing on either the general Canadian public or specific subgroups—classified by province, age, education level, or profession—was also considered.

The inclusion criteria were based on publication type, timeframe, geographical scope, language, accessibility, and research focus. Specifically, eligible studies were required to be original peer-reviewed research or public opinion surveys published between 2015 and 2025. These studies must have been conducted within Canada and published in English. Furthermore, only studies with full-text availability were included. To ensure alignment with the research objectives, the studies needed to explicitly analyze public opinions or legal protections associated with MAID. The keywords used for the search are provided in **Table 1** below.

Table 1. Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Original studies	Other reviews
Studies published between January 2015-January 2025	Studies not published between January 2015-January 2025
Studies within the Canadian context	Studies outside of Canada
Peer-reviewed publications, public opinion polls	Dissertations, thesis, etc.
Studies published in English Language	Studies not in English Language
Articles accessible in full-text	Articles not accessible in full-text
Articles directly addressing public attitudes or safeguards related to MAID	Articles not directly addressing public attitudes or safeguards related to MAID

Exclusion criteria encompassed studies that examined MAID outside the Canadian context and those not published in English. Additionally, articles that did not directly address public attitudes or legal safeguards related to MAID, as well as those lacking full-text accessibility, were excluded from the review. The keywords used for the search are provided in **Table 1** below.

2.2. Search Strategy

A systematic search was conducted across PubMed, Google Scholar, the Cochrane Library, and BioMed Central. The search terms included:

- "Medical assistance in dying" OR MAID OR euthanasia OR "physician-assisted suicide"
- "Public attitudes" OR "public opinion" OR perceptions OR beliefs
- "Safeguards" OR protections OR regulations OR "legal measures"
- Canada OR Canadian OR "Canadian provinces"

Boolean operators "AND" and "OR" were used to generate advanced search strings across these databases.

2.3. Study Selection and Screening

The search yielded 5981 records. An initial selection based on titles and abstracts excluded 5938 papers. All remaining studies were imported into Rayyan software [25], where duplicates were identified and removed. Full-text screening was then conducted by the reviewer, and relevant articles were selected.

For each included study, key data were extracted into **Table 2**, detailing the authors, year of publication, title, study design, methods, aims, main findings, and a critical appraisal. Data synthesis was performed to identify common themes across the studies.

Table 2. Data extraction matrix.

Authors & Year	Title	Study design	Methods	Aims	Main findings	Critical appraisal
Rousseau *et al*., (2017)	A National Survey of Canadian Psychiatrists' Attitudes Toward Medical Assistance in Death	Cross sectional study	528 psychiatrists from Canada survey conducted.	Assess Canadian psychiatrists' support for MAID in general and based solely on mental illness. Identify factors related to attitudes toward MAID for mental illness.	72% supported the legalization of MAID under specific circumstances. Only 29.4% supported MAID based on mental illness. Factors decreasing support for MAID for mental illness included: The belief that it challenges psychiatrists' commitment to their patients. Having a personal faith. Past experiences with patients who recovered but may have sought MAID if eligible[1]	Large national survey, providing representative insights into psychiatrist attitudes. Highlights significant concerns and influences regarding MAID for mental illness. Low response rate (20.9%), increasing potential for response bias

Continued

Tatalovich R, (2020)	Morality Politics of Physician-Assisted Suicide: Comparing Canada and the United States	Comparative policy analysis	Review of legal rulings, public opinion surveys, media coverage, and political dynamics in Canada and the United States	Analyze the divergence in physician-assisted suicide (PAS) policies between Canada and the U.S. Understand the role of courts, public opinion, and institutional structures in shaping these policies	Canada's PAS policies resulted from a two-sided public debate, while the U.S. remained dominated by one-sided moral framing. Public support for PAS in Canada was consistently high, aligning with its legalization, whereas U.S. support varied based on wording and framing in polls. Federalism played a larger role in the U.S., with states leading reforms, whereas Canada's Supreme Court played a decisive role[2]	A detailed comparison of institutional and cultural factors influencing PAS. Highlights the importance of political culture and judicial decisions This study focuses more on institutional frameworks than personal experiences.
Althagafi A. *et al.*, (2019))	Canadian Neurosurgeons' Views on Medical Assistance in Dying (MAID): A Cross-Sectional Survey of Canadian Neurosurgical Society (CNSS) Members	Cross-sectional surveys	300 active members of the CNSS were involved. Online survey	Assess attitudes of Canadian neurosurgeons toward MAID and its legislative changes. Explore their willingness to participate in MAID and refer patients. Investigate views on potential indications for MAID and conscientious objection	66.3% supported decriminalization of MAID, while 18% opposed. 74.2% supported physicians' right to participate in MAID, but 65.9% would not personally provide it. 43.8% supported mandatory referral to MAID services, while 84% supported conscientious objection rights. Glioblastoma multiforme (65%), quadriplegia from spinal tumor/trauma (54%), and Parkinson's disease (24%) were the most common suggested indications for MAID. Concerns about ambiguity in the legislation, such as defining "reasonably foreseeable" death and criteria for mental illness or mature minors[3]	First study focusing on Canadian neurosurgeons' perspectives and provides valuable insights into specialty-specific challenges and ethical dilemmas. Low response rate (29.6%) may limit generalizability. Lack of data on participants' reasons behind specific attitudes. Limited to neurosurgeons, excluding other specialties.
Schiller *et al.*, (2019)	But it's legal, isn't it? Law and Ethics in Nursing Practice Related to Medical Assistance in Dying	Qualitative ethical analysis	Review of ethical dilemmas Interviews	Analyze the interplay of law, ethics, and morality in nursing practices related to MAID Examine the impact of MAID legalization on	MAID legalization conflates legal permissibility with moral acceptability, creating challenges for nurses. Nurses often rely on the legality of MAID to justify participation, sometimes overlooking personal ethical concerns.	Relies on hypothetical scenarios and qualitative data, which may lack generalizability.

Continued

Jeanneret *et al.*, (2024)	My Advocacy is Not About Me, My Advocacy is About Canadians": A Qualitative Study of How Caregivers and Patients Influence Regulation of Medical Assistance in Dying in Canada	Qualitative empirical study	semi-structured interviews with 34 participants from three Canadian provinces	Investigate the roles of caregivers and patients as regulatory actors in Canadian MAID systems. Explore how their actions influence law reform and the operationalization of MAID practices	Caregivers and patients act as "regulatory actors" by taking intentional actions to influence MAID laws and practices. Actions included public storytelling, providing feedback, advocacy for law reform, and development of resources. Key motivators were addressing system gaps, ensuring quality care, and improving access to MAID. Challenges include emotional burdens and barriers in navigating the system[5]	Limited to three provinces, reducing generalizability across Canada. Small sample size, especially for patient perspectives, there was 1 patient and 33 caregivers which is not a representative sample.
Crumley *et al.*, (2019)	Canadian French and English Newspapers' Portrayals of Physicians' Role and Medical Assistance in Dying (MAID) from 1972 to 2016: A Qualitative Textual Analysis	Qualitative textual analysis	813 articles (700 English, 113 French) published between 1972 and 2016 from national and local Canadian newspapers	Examine newspaper portrayals of physicians' roles in MAID from 1972 to 2016. Identify trends and themes across decades	Public support for MAID steadily increased over time, reflected in media narratives. Physicians were often portrayed as resistant but were acknowledged as key figures in the process[6]	Excludes post-legalization developments after 2016. Limited to newspaper portrayals, missing social media and other public discourse platforms
Sinding *et al.*, (2025)	The "Means Available to Relieve Suffering": Translating Medical Assistance in Dying Safeguards in Canadian Policy and Practice	Qualitative study and policy analysis	Five health professionals (HPs) involved in MAID coordination, assessment, and provision in Ontario. Semi-structured interviews exploring Track 2 MAID NVivo software used for thematic coding	Examine how HPs interpret and apply MAID safeguards in practice, focusing on the "Means Available to Relieve Suffering" (MARS). Highlight the complexities of front-line policy translation in Track 2 MAID contexts	HPs translated MARS safeguards beyond legal mandates, emphasizing relational care, creative interventions, and advocacy. Barriers included insufficient resources (e.g., housing, social services) and systemic constraints. Safeguards were seen as essential for supporting autonomy but could be undermined by inequities in resource access. HPs often combined legislative requirements with personal professional norms to meet patients' needs[7]	Small sample size limiting generalizability. Study is focused on a single region.

Continued

Brassolotto *et al.*, (2023)	Medical Assistance in Dying: A Review of Related Canadian News Media Texts	Qualitative media review and textual analysis	News articles about MAID published from 2015 to 2021. purposively sampled from digital platforms, including major Canadian media outlets (CBC News, The Globe and Mail, National Post, etc.). Focused on post-legalization and pre-/post-Bill C-7 discourse	Explore how Canadian media portrays MAID. Analyze how representations reflect and influence public opinion and policy debates	Public discourse shifted from moral debates about the permissibility of MAID to policy debates on its implementation and implications[8]	Limited to English-language sources, excluding significant French media coverage. Focused on prominent media outlets, potentially underrepresenting grassroots perspectives
Joolaee *et al.*, (2021)	Medical Assistance in Dying Legislation: Hospice Palliative Care Providers' Perspectives	Qualitative descriptive study	Semi-structured interviews with 48 hospice palliative care providers (HPCPs) in Vancouver and Toronto, Canada (2018-2020)	Explore positive aspects of MAID legalization from the perspectives of HPCPs. Highlight implications at individual, team, and institutional levels in the context of hospice and palliative care	MAID provides a new end-of-life (EOL) option for patients experiencing intolerable suffering. Empowers patients by offering control over their EOL decisions. Brings relief and closure to patients and families. Improved logistical processes for MAID implementation. Institutional policies facilitated smoother MAID referrals, assessments, and provisions[9]	Limited representation of HPCPs opposed to MAID. Study findings may not fully generalize to other regions or HPCP demographics
Thomas *et al.*, (2023)	Medical Assistance in Dying: A Review of Canadian Health Authority Policy Documents	Qualitative content analysis	17 MAID policy documents from 16 Canadian health authorities across provinces and territories Open and thematic coding using NVivo software	Examine the content of Canadian health authority policies guiding MAID practices. Identify variations in guidance, ethical principles, and implementation strategies	Policies emphasized themes such as team-based care, informed patient choice, eligibility criteria, safeguards, conscientious objection, and organizational responsibilities Institutional oversight and support for healthcare providers' well-being (e.g., debriefing after MAID cases) were critical components. Some policies were underdeveloped or lacked explicit ethical frameworks, creating variability in practice guidance[10]	Policies reviewed were published before the introduction of Bill C-7, limiting their relevance to current legislation

Continued

Dhamanaskar & Abelson, (2024)	Public Deliberation for Ethically Complex Policies: The Case of Medical Assistance in Dying in Canada	Policy Analysis	Review of Canadian and international MAID public deliberation efforts.	Evaluate existing public engagement efforts regarding MAID policies in Canada. Propose public deliberation as a solution for addressing ethically complex MAID policy decisions. Highlight challenges and opportunities in implementing deliberative practices	Public engagement in MAID policy is limited to surveys, hearings, and brief consultations, often lacking depth. Issues include self-selection bias, overrepresentation of organized interests, and limited inclusion of marginalized voices. Deliberative approaches allow informed, diverse, and values-based discussions, offering better public input into ethically contentious policies. Challenges include designing inclusive deliberations, addressing polarization, and ensuring transparency about how public input informs policy[11]	Focuses on public deliberation without equally examining alternative models of public engagement
Knox & Wagg, (2023)	Institutional Resistance to Medical Assistance in Dying in Canada: Arguments and Realities Emerging in the Public Domain	Qualitative analysis	89 media articles and 22 legislative or policy-related documents published since 2016. Sources included Canadian News stream, And government documents Thematic analysis was conducted using ATLAS.ti software	Explore public and institutional resistance to MAID in Canada. Identify stakeholder arguments about institutional non-participation and its implications for access to MAID	Proponents argued for religious freedoms, while opponents contended that only individuals, not institutions, possess moral conscience Critics claimed MAID undermines the sanctity of life; proponents viewed it as compatible with alleviating suffering Barriers to MAID access disproportionately affected rural areas and vulnerable populations[12] Lack of uniform policies created inconsistent experiences for patients and providers	Relied on secondary data from media and policy documents. Did not capture firsthand experiences from patients or providers

Continued

Bozinoff Lorne, (2015)	Support for assisted suicide increases across four years	Public opinion poll	Interactive voice response survey, random sampling 1440 Canadian Voters	To assess the percentage public support for MAID across 4 years (2011-2015)	There was an increase from 67% (2011) to 77% (2015). Opposition to the practice has decreased significantly, from 16% in 2014 to 12% in 2015. Approval is common to the youngest (81%) and boomers (55 to 64 - 81%) but not to the oldest (65+ - 69%), among the wealthy ($80K to $100K - 80%), in Quebec (83%), but not in Alberta so much (69%)[13]	The study used an interactive voice response telephone survey, which may exclude individuals without access to phones or those who are uncomfortable with automated surveys. Non-response and potential biases in who participates could impact the overall findings.

2.4. Study Designs: Strengths and Weaknesses

1) Cross-Sectional Studies

- **Strengths:** Provide a snapshot of public attitudes or professional opinions at a given time, allowing identification of associations between demographic factors and MAID attitudes. Large sample sizes enhance representativeness.
- **Weaknesses:** Do not establish causality and are vulnerable to selection bias, particularly with low response rates. Attitudes may change over time, limiting generalizability.

2) Qualitative Studies (Interviews, Thematic Analysis, Policy Reviews)

- **Strengths:** Offer in-depth insights into public attitudes, ethical concerns, and healthcare professionals' experiences. Useful for exploring nuanced perspectives on MAID safeguards, access, and decision-making.
- **Weaknesses:** Limited generalizability due to small sample sizes and subjective interpretation. Reliance on self-reported data can introduce biases such as social desirability bias.

3) Public Opinion Polls

- **Strengths:** Provide quantitative data on public opinion trends across demographics, facilitating large-scale representation and tracking attitude shifts over time.
- **Weaknesses:** Susceptible to question wording, response biases, and non-representative samples (e.g., exclusion of certain populations in telephone surveys). Often, there is a lack of depth in exploring the reasons behind attitudes.

4) Comparative Policy Analysis

- **Strengths:** Enables understanding of how Canada's MAID policies compare internationally, offering context for policy evolution.

- **Weaknesses:** Focuses on legal and institutional perspectives rather than direct public attitudes, limiting applicability to individual experiences.

5) Media and Textual Analysis

- **Strengths:**
  - Captures public discourse on MAID through media, social media, and policy documents, revealing societal concerns and evolving sentiments.
  - Highlights framing and agenda-setting in media portrayals, offering insights into how MAID is understood and accepted.
  - Identifies policy discussions by presenting expert opinions and legislative challenges related to MAID.
- **Weaknesses:**
  - Subject to editorial biases and political leanings, potentially skewing representations of public opinion.
  - Lacks personal narratives and individual perspectives, as media coverage tends to focus on high-profile cases or political debates.
  - May oversimplify complex ethical, medical, or policy considerations, leading to a one-dimensional understanding.

2.5. Sampling Strategies: Strengths and Weaknesses

1) Random Sampling (Public Opinion Polls, Surveys of Healthcare Professionals)

- **Strengths:** Enhances representativeness and reduces selection bias, improving generalizability across demographics.
- **Weaknesses:** Low response rates can introduce bias, particularly if certain groups (e.g., older adults, religious populations) are underrepresented.

2) Purposive Sampling (Qualitative Interviews, Policy Reviews, Textual Analysis)

- **Strengths:** Enables targeted recruitment of individuals with relevant expertise or lived experiences, ensuring rich, detailed data.
- **Weaknesses:** Limits generalizability due to non-random selection, potentially reflecting only specific subgroups rather than the broader public.

2.6. Ethical Considerations

As this study involved a review of existing literature, ethical approval was not required. All data were sourced from publicly available, peer-reviewed studies. Research involving primary data collection had obtained ethical approval and informed consent, ensuring participant confidentiality.

3. Results

A total of 13 studies were included in the review: 1 public opinion poll, 2 policy analyses, 2 cross-sectional studies, and 8 qualitative studies. All studies focused on MAID in the Canadian context, with one study providing an international comparison to the United States. The studies covered various demographics, including

Canadian voters and healthcare providers. The qualitative studies analyzed policy documents, interviews, news articles, and ethical dilemmas related to MAID. Table 2 shows the summary of the results of the studies selected for inclusion

List of Papers Reviewed

The search results presented in Figure 1 above (the PRISMA flow chart) show the summary of the papers used in the study. The databases provided a total of Five thousand nine hundred and thirty (5930) research papers, of which only thirteen met the inclusion criteria for this systematic review (See Table 2).

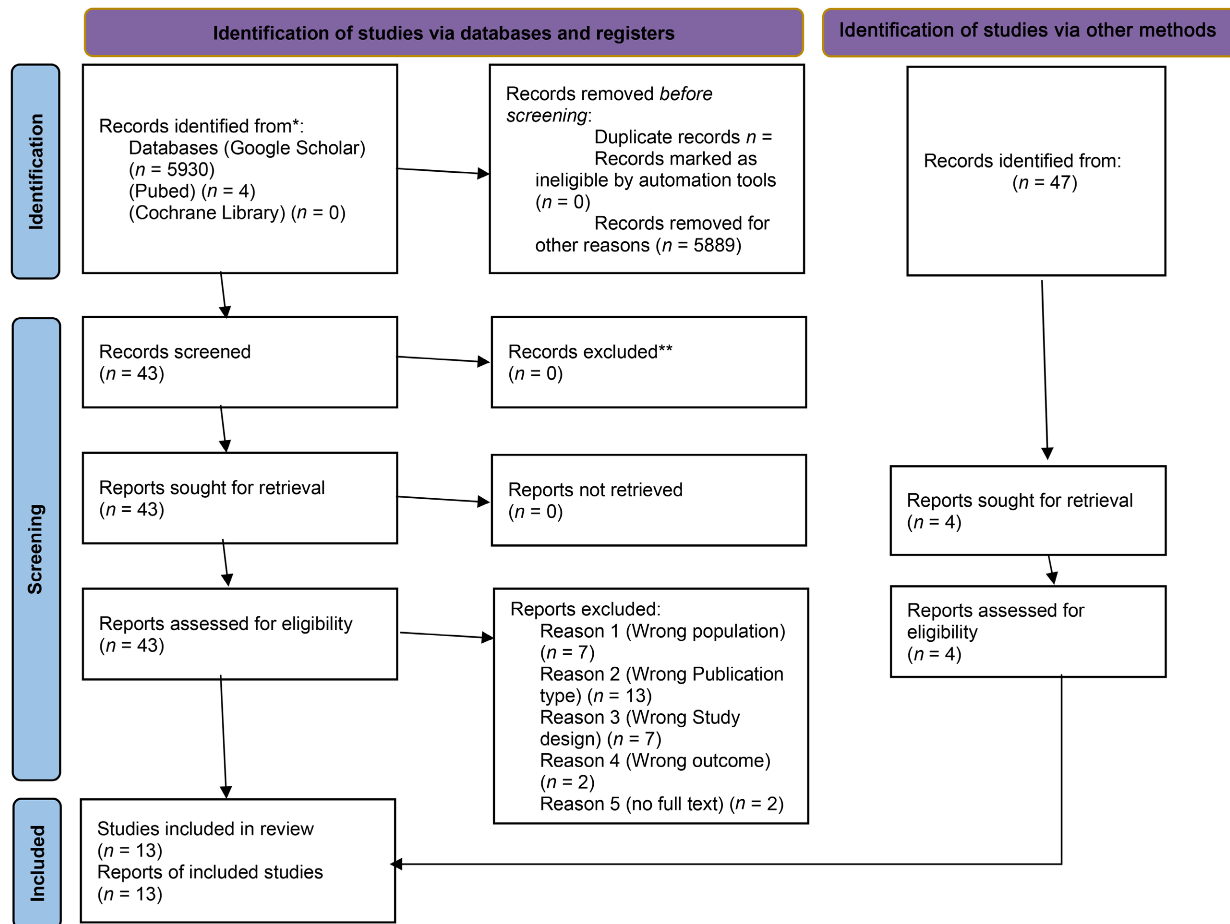


Figure 1. PRISMA flow chart of the selected study.

4. Public Attitudes towards MAID

Since the legalization of MAID in 2016, public opinion has shown a positive shift. A comparative analysis reported that public attitudes in Canada are more supportive of MAID than in the United States [20]. Studies have consistently found high levels of public support for medical assistance in dying. Brassolotto *et al.* (2023) reported that approximately 75% - 85% of Canadians support the legalization of MAID [19]. Similarly, Crumley *et al.* (2019) documented an increase in public acceptance from 45% in 1968 to 77% in 1990, attributing this growth to media portrayals emphasizing patient autonomy [13]. From 2011 to 2015, polls

among Canadian voters showed an increase in support for MAID from 67% to 77% [14].

Public support varies across demographic groups. Individuals from urban areas and those with higher levels of education tend to be more supportive of MAID, while opposition is more common among older individuals and those with strong religious beliefs [20]. A study among psychiatrists found that 71.8% of respondents supported MAID, while a survey among neurosurgeons reported that 66.3% supported its legalization in Canada. Additionally, 72.4% of neurosurgeons supported physicians' rights to participate in MAID. However, these studies also revealed opposition, with 61.2% of psychiatrists opposing mental illness as a sole indication for MAID [17] [18].

A common concern, even among supporters, is the potential coercion of vulnerable populations into choosing MAID due to economic reasons or caregiver pressure [26].

4.1. Public Support and Opposition by Demographic Groups

Age: Younger individuals exhibit higher support for MAID than older individuals. A 2015 public opinion poll found that 81% of individuals aged 18 - 34 supported MAID, compared to 69% of those aged 65 and older. Younger demographics tend to emphasize personal autonomy and the right to die with dignity, while older individuals often express concerns about vulnerability and potential coercion [14].

Religion: Religious beliefs play a key role in opposition to MAID. Studies indicate that atheists and agnostics are significantly more likely to support MAID, whereas Catholics and Evangelical Protestants exhibit the highest levels of opposition. One survey found that over 70% of non-religious respondents supported MAID, compared to fewer than 50% among highly religious individuals [12].

Education Level: Higher education levels correlate with greater support for MAID. Individuals with post-secondary education demonstrate increased awareness and acceptance, particularly regarding safeguards and ethical considerations. One study found that university graduates were 15% - 20% more likely to support MAID than those with only a high school education [21].

Socioeconomic Status: Economic disparities influence perceptions of MAID. Higher-income individuals tend to express greater confidence in the healthcare system's ability to regulate MAID appropriately. In contrast, individuals from lower-income backgrounds express concerns about potential coercion, fearing financial hardship and limited palliative care access might lead vulnerable populations to choose MAID out of necessity rather than autonomy [21].

Geographic Location: Regional differences in support for MAID are evident. Quebec has the highest support at 83%, while Alberta has the lowest at 69%. This disparity may stem from cultural attitudes, religious composition, and political ideologies. Quebec, the first province to legalize MAID independently, framed it as part of end-of-life care, which may have contributed to its higher acceptance [14].

4.2. Professional and Ethical Considerations among Healthcare Providers

Healthcare Providers' Perspectives:

- **Psychiatrists:** 71.8% support MAID, but only 29.4% support it for mental illness due to concerns about irreversible decisions made by patients experiencing temporary psychological distress [18].
- **Neurosurgeons:** 66.3% support MAID legalization, but 65.9% state they would not personally administer it, citing moral and ethical concerns [17].
- **Nurses and Hospice Care Providers:** Many express moral distress over participating in MAID, even when legally permissible, particularly in palliative care settings [15] [16].

4.3. Attitudes toward MAID Safeguards

Support for Safeguards: The majority of the public and healthcare professionals support safeguards such as independent assessments and psychological evaluations. However, recent changes—such as the removal of the 10-day reflection period and expansion to non-terminal illnesses—have been met with mixed reactions [3].

Concerns About Vulnerability: Many critics argue that existing safeguards are insufficient to protect vulnerable populations, particularly individuals with mental illness, those in financial distress, and people with limited healthcare access [26]. A study found that 61.2% of psychiatrists opposed mental illness as a sole condition for MAID, fearing it would alter their professional obligations toward suicide prevention [18].

4.4. Media Influence and Public Engagement

Media Framing: Over time, media narratives have shifted from ethical debates on autonomy versus the sanctity of life to policy-focused discussions on safeguards and accessibility. This shift has played a role in increasing public acceptance of MAID [19].

Public Deliberation: Studies indicate that meaningful public engagement is limited. Public deliberation efforts are often criticized for overrepresentation of organized interest groups while failing to include marginalized voices. Calls for greater transparency and inclusive policy making have been emphasized to ensure ethical implementation [27].

4.5. Ethical Principles in MAID

Autonomy is cited as the primary ethical principle justifying MAID, based on the argument that individuals should have the right to choose the manner and timing of their death. Some hospice palliative care providers describe it as a "patient's last chance to express control over their lives" or a final act of empowerment [15] [16]. However, safeguards may restrict autonomy when an individual's decision-making capacity is questioned.

Dhamannaskar & Abelson (2024) highlighted other key values in the MAID

debate, such as equity, fairness, and protection of vulnerable populations, emphasizing the need for public engagement to explore these values fully. Beneficence also justifies MAID by aiming to relieve suffering, though some argue it conflicts with the principle of non-maleficence, particularly among healthcare workers [27].

Concerns have also been raised about equitable access to MAID, particularly for marginalized populations, as socioeconomic and geographical disparities may hinder access. Ethical dilemmas arise when healthcare workers' moral or religious beliefs conflict with their professional duty to administer MAID [15]. Some commentators advocate for healthcare providers' right to abstain from MAID procedures for reasons of conscience. However, debates persist on whether these conscience rights should extend to entire healthcare institutions. Thomas *et al.* (2023) found that only a few policies address institutional conscientious objections, primarily in faith-based institutions, which are required to post their policies publicly to inform patients of available options [26].

4.6. Factors Influencing Attitudes towards MAID

Demographic, cultural, and personal factors significantly influence perceptions of MAID. Rousseau *et al.* (2017) reported that younger individuals and those with secular values tend to be more supportive, while older individuals, those with strong religious beliefs, and conservative groups often oppose it [18]. Indigenous communities have also expressed concerns about the individualistic nature of MAID, which contrasts with their communal values surrounding life and death [27].

4.7. Public Perception of MAID Safeguards

Public perception of Medical Assistance in Dying (MAID) safeguards varies, with some measures being positively received while others raise concerns. Among the most effective safeguards, independent assessments by two physicians are widely regarded as essential in preventing coercion and ensuring informed decision-making. The previously required 10-day reflection period was seen by some as a valuable safeguard against impulsive choices. Psychological evaluations, particularly for individuals whose decision-making capacity may be compromised, were also viewed as necessary. Additionally, the requirement to reaffirm consent immediately before administration was considered a strong measure in preserving patient autonomy.

However, certain safeguards were perceived as less effective or problematic. The removal of the 10-day reflection period under Bill C-7 raised concerns that decisions might be rushed, particularly for vulnerable individuals. The expansion of MAID to include mental illness, postponed until 2027, was opposed by many psychiatrists and healthcare providers due to difficulties in assessing long-term psychiatric outcomes and concerns about suicide prevention. Variability in institutional policies, particularly among religious healthcare institutions, led to inequi-

table access, especially in rural areas. Furthermore, a lack of public understanding about MAID's legal criteria and safeguards raised concerns that some patients might not fully grasp their rights and options. Socioeconomic barriers also played a role, as limited access to healthcare—especially palliative care—could lead some individuals to choose MAID out of necessity rather than genuine desire.

Potential improvements to MAID safeguards include enhancing public awareness and education, which is highly feasible and could improve informed decision-making while increasing public trust. Reintroducing a short reflection period of three to five days is a moderate possibility that could balance concerns about impulsivity with patient autonomy. Strengthening safeguards for individuals with mental illness is more challenging but could be addressed through rigorous assessment frameworks involving multiple specialists and extended evaluation periods. Improving equitable access to palliative care would require systematic investment but could ensure that MAID remains a choice rather than a last resort due to inadequate healthcare. Additionally, clearer institutional guidelines could help standardize practices across healthcare facilities while respecting religious institutions' rights, ensuring that all patients are informed of their options.

4.8. Incorporating Indigenous Perspectives in MAID Policy Development

Medical Assistance in Dying (MAID) raises complex ethical concerns within Indigenous communities, where decisions about life and death are often collective rather than individual. Indigenous-led research and community consultations are essential for ensuring culturally safe policies that align with Indigenous values and traditions. Indigenous perspectives emphasize interconnectedness, which may conflict with MAID's focus on personal autonomy. Research by Indigenous scholars and Elders can provide insight into the impact of MAID on Indigenous families and communities, barriers to accessing palliative care and traditional healing alternatives, and ethical concerns surrounding collective decision-making in end-of-life care.

Engaging Indigenous communities, Elders, and healthcare providers is crucial for developing culturally appropriate MAID policies. Supporting Indigenous-led research will help explore MAID's implications, while the creation of Indigenous advisory councils can ensure that policy development reflects Indigenous perspectives. Enhancing cultural safety training for healthcare providers and improving access to palliative care by integrating traditional healing practices are essential steps. Ongoing consultations with Indigenous communities will help address evolving concerns and build trust in healthcare systems.

A culturally inclusive approach to MAID requires prioritizing Indigenous voices in research and policymaking. Ensuring equitable access to care, recognizing communal values, and addressing systemic barriers will create a more just and ethical framework for end-of-life care in Indigenous communities. By fostering dialogue and collaboration, policymakers can develop MAID policies that respect

Indigenous traditions and promote culturally safe healthcare practices.

5. Discussion

Public attitudes towards Medical Assistance in Dying (MAID) have become increasingly favorable over time, influenced by media representations, evolving societal values, and heightened awareness of end-of-life options. However, opposition persists, particularly concerning the expansion of eligibility criteria and the potential for coercion among vulnerable populations.

Age is a significant determinant of public attitudes toward MAID. Studies indicate that younger individuals exhibit higher levels of acceptance, aligning with broader generational shifts toward personal autonomy and freedom of choice. A public opinion poll by Bozinoff (2015) demonstrated that younger respondents were more likely to support MAID [14]. This generational difference is partly attributable to younger individuals' inclination toward progressive values. Conversely, older individuals tend to support MAID more strongly when the discussion is framed around personal experiences with terminal illness [20]. While younger demographics may prioritize autonomy, older individuals with firsthand exposure to terminal illness often perceive MAID as a compassionate end-of-life option.

Religious beliefs play a crucial role in shaping public attitudes toward MAID, often serving as a strong predictor of opposition. Surveys have reported higher levels of support among atheists and agnostics, while religious individuals—particularly Catholics and Evangelical Protestants—demonstrate lower levels of approval [12]. Tatalovich (2020) identified strong religious beliefs as a significant factor in opposition to MAID [20]. Many religious individuals cite the sanctity of life as a foundational principle, viewing the deliberate termination of life as incompatible with their faith. Future research should examine whether younger religious individuals express greater support for MAID compared to their older counterparts. Overall, religious affiliation remains a key determinant of attitudes toward MAID.

Geographical location also influences public perspectives on MAID. Bozinoff (2015) reported that Canadian voters in Quebec expressed higher support for MAID compared to those in Alberta [14]. Quebec was the first province to legalize MAID through Bill 52 in 2014, framing it as an integral component of end-of-life care prior to the Supreme Court of Canada's ruling in 2015 [1]. Differences in regional support may be attributed to variations in religious and political demographics, with more conservative and religious populations exhibiting lower levels of approval. Additionally, disparities in healthcare access between urban and rural areas may contribute to differing attitudes. Public engagement in regions with lower support can play a critical role in addressing misinformation and fostering trust in MAID policies [26].

Education level is another significant factor influencing attitudes toward MAID. Research indicates that individuals with higher levels of education, partic-

ularly post-secondary education, demonstrate greater acceptance of MAID [14]. This may be due to increased exposure to legal frameworks, ethical debates, and medical knowledge. Individuals with academic backgrounds in healthcare-related fields have expressed greater confidence in MAID procedures [19]. Conversely, those with lower levels of education may have limited familiarity with the legal and ethical safeguards associated with MAID, potentially contributing to opposition [21]. Despite the general correlation between education and support for MAID, other variables—such as religious beliefs and cultural background—may override educational influences. For instance, a highly educated individual may oppose MAID due to religious convictions. Thus, while education is a key factor, it operates within a broader interplay of demographic and ideological variables.

Socioeconomic status also plays a pivotal role in shaping attitudes toward MAID. Studies have identified a correlation between income levels, healthcare access, and perceptions of MAID. Knox and Wagg (2023) found that individuals from lower socioeconomic backgrounds often express concerns regarding coercion and the potential for financial hardship to influence end-of-life decisions [21]. Higher-income individuals, who generally have greater access to healthcare services, may exhibit greater trust in medical safeguards and MAID regulations. Addressing concerns among lower-income populations through enhanced public engagement and transparent policymaking is essential to ensuring equitable access to MAID [26]. These findings underscore the need for policies that promote healthcare equity and increase public awareness across all socioeconomic groups.

Public perception of MAID safeguards has been largely supportive, yet concerns persist regarding their adequacy. Jeanneret *et al.* (2024) noted that many individuals consider safeguards essential for protecting vulnerable populations from coercion and abuse [28]. Brassolotto *et al.* (2023) highlighted that safeguards such as independent assessments, mandatory waiting periods, and psychological evaluations are generally viewed positively by the public [19]. However, the removal of waiting periods and the expansion of eligibility criteria under Bill C-7—particularly for individuals whose death is not reasonably foreseeable—have raised ethical concerns [3]. The inclusion of mental illness as a sole eligibility criterion has been particularly contentious. A study among psychiatrists found that 61.2% opposed its inclusion, citing concerns that individuals with untreated psychiatric conditions might make uninformed decisions [18]. The central ethical challenge regarding safeguards lies in balancing patient autonomy with the protection of vulnerable populations. Additionally, concerns regarding disparities in access to MAID services must be addressed to ensure equitable implementation. While safeguards enhance trust in MAID, continuous public education and policy refinement are necessary to maintain ethical integrity and public confidence.

6. Conclusions

The legalization of MAID in Canada has sparked complex ethical, legal, and societal discussions. Over time, public support for MAID has increased, largely driven by shifting societal values that emphasize autonomy, dignity, and personal choice.

Media influence and legislative reforms have also played a crucial role in shaping public attitudes. Despite growing acceptance, opposition persists, particularly among religious, conservative, and older individuals who emphasize the sanctity of life and the potential for coercion.

A key issue in the ongoing debate is the effectiveness of safeguards designed to protect vulnerable individuals from external pressures. While mechanisms such as independent evaluations and waiting periods have received broad public support, recent legislative changes—including the removal of the 10-day reflection period and the potential extension of MAID to individuals with mental illness—have raised ethical concerns. Although medical professionals generally support MAID in cases of terminal illness, its application in non-terminal conditions remains contentious. These debates highlight the need for ongoing assessment and potential refinement of MAID legislation.

Public attitudes toward MAID are shaped by multiple demographic factors, including age, education, religious beliefs, geographic location, and socioeconomic status. Generally, younger, secular, and more educated individuals demonstrate higher levels of support, whereas opposition is more pronounced among religious and conservative groups. Furthermore, disparities in access to MAID services, particularly in rural and economically disadvantaged communities, underscore the need for equitable healthcare policies.

To address these challenges, enhanced public engagement and education are essential. Many misconceptions about MAID stem from a limited understanding of its processes and safeguards. Transparent communication from policymakers, healthcare professionals, and advocacy organizations can bridge knowledge gaps and foster informed public discourse. Additionally, incorporating healthcare professionals in policymaking can help ensure that safeguards remain ethically sound and practically effective in protecting patients.

Future research should focus on evaluating the impact of legislative changes on both patients and healthcare providers while identifying areas requiring additional safeguards. Investigating the perspectives of marginalized and vulnerable populations is crucial for shaping policies that prioritize equity and justice. Public discussions on the ethical complexities of MAID, including its application in cases of mental illness or disability, will help ensure that laws reflect societal values while upholding ethical principles.

Ultimately, the evolution of MAID policy in Canada reflects broader societal trends favoring patient autonomy and end-of-life rights. As the legal framework continues to develop, it is imperative to balance respect for individual choice with the protection of vulnerable populations. By fostering transparent policymaking, inclusive public discussions, and rigorous ethical oversight, Canada can navigate the complexities of MAID while prioritizing both compassion and accountability.

Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] Carter, L., Johnson, H., Shoichet, W., Appellants, G.T., *et al.* (2015) Attorney General of Canada Respondent. https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html

[2] House of Commons of Canada (2016) Statutes of Canada 2016 Chapter 3. https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent

[3] House of Commons of Canada (2021) Statutes of Canada 2021 Chapter 2. https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent

[4] Supreme Court of Canada (1993) Rodriguez v. British Columbia (Attorney General), [1993] 3 SCR 519.

[5] Government of Canada (1985) Criminal Code, RSC 1985, c C-46. Department of Justice. https://laws-lois.justice.gc.ca/eng/acts/c-46/20141216/P1TT3xt3.html

[6] Government of Canada (1982) Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, Being Schedule B to the Canada Act 1982 (UK). https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/index.html

[7] Government of Canada (2016) Medical Assistance in Dying Law. Department of Justice. https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html?

[8] Superior Court of Quebec (2019) Truchon v. Canada. https://vlex.com/vid/truchon-v-procureur-general-819818681#:~:text=Truchon%20v.-,Pro-cu-reur%20G%C3%A9n%C3%A9ral%20Du%20Canada%3A%20Superior%20Court%20Of%20Quebec%20Finds%20Limiting,To%20End%20Of%20Life%20Unconstitutional

[9] Assemblee Nationale Du Quebec (2014) First Session Fortieth Legislature Bill 52 an Act Respecting End-of-Life Care.

[10] Government of Canada (2020) Legislative Background Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision. https://www.justice.gc.ca/eng/csj-sjc/pl/ad-am/c7/p4.html

[11] Close, E., Downie, J. and White, B.P. (2023) Practitioners' Experiences with 2021 Amendments to Canada's Medical Assistance in Dying Law: A Qualitative Analysis. *Palliative Care and Social Practice*, **17**. https://doi.org/10.1177/26323524231218282

[12] Angus Reid Institute (2015) For Immediate Release Canadian Public Opinion Poll.

[13] Crumley, E.T., Sheppard, C., Bowden, C. and Nelson, G. (2019) Canadian French and English Newspapers' Portrayals of Physicians' Role and Medical Assistance in Dying (Maid) from 1972 to 2016: A Qualitative Textual Analysis. *BMJ Open*, **9**, e020369. https://doi.org/10.1136/bmjopen-2017-020369

[14] Bozinoff, L. (2015) Media Inquiries: For Immediate Release Support for Assisted Suicide Increases across Four Years.

[15] Joolaee, S., Ho, A., Serota, K., Hubert, M. and Buchman, D.Z. (2021) Medical Assistance in Dying Legislation: Hospice Palliative Care Providers' Perspectives. *Nursing Ethics*, **29**, 231-244. https://doi.org/10.1177/09697330211012049

[16] Schiller, C.J., Pesut, B., Roussel, J. and Greig, M. (2019) But It's Legal, Isn't It? Law and Ethics in Nursing Practice Related to Medical Assistance in Dying. *Nursing Philosophy*, **20**, e12277. https://doi.org/10.1111/nup.12277

[17] Althagafi, A., Ekong, C., Wheelock, B.W., Moulton, R., Gorman, P., Reddy, K., *et al.* (2019) Canadian Neurosurgeons' Views on Medical Assistance in Dying (MAID): A Cross-Sectional Survey of Canadian Neurosurgical Society (CNSS) Members. *Journal of Medical Ethics*, **45**, 309-313. https://doi.org/10.1136/medethics-2018-105160

[18] Rousseau, S., Turner, S., Chochinov, H.M., Enns, M.W. and Sareen, J. (2017) A National Survey of Canadian Psychiatrists' Attitudes toward Medical Assistance in Death. *The Canadian Journal of Psychiatry*, **62**, 787-794. https://doi.org/10.1177/0706743717711174

[19] Brassolotto, J., Manduca-Barone, A. and Zurbrigg, P. (2022) Medical Assistance in Dying: A Review of Related Canadian News Media Texts. *Journal of Medical Humanities*, **44**, 167-186. https://doi.org/10.1007/s10912-022-09764-z

[20] Tatalovich, R. (2020) Morality Politics of Physician-Assisted Suicide: Comparing Canada and the United States. *International Journal of Canadian Studies*, **57**, 71-91. https://doi.org/10.3138/ijcs.57.x.71

[21] Knox, M. and Wagg, A. (2023) Institutional Resistance to Medical Assistance in Dying in Canada: Arguments and Realities Emerging in the Public Domain. *Healthcare*, **11**, Article 2305. https://doi.org/10.3390/healthcare11162305

[22] Sinding, C., Kumar, K., Smith, P. and Ivanyi, K. (2025) The 'means Available to Relieve Suffering': Translating Medical Assistance in Dying Safeguards in Canadian Policy and Practice. *Social Policy and Society*. https://doi.org/10.1017/s1474746424000629

[23] Page, M.J., McKenzie, J.E., Bossuyt, P.M., Boutron, I., Hoffmann, T.C., Mulrow, C.D., *et al*. (2021) The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews. *BMJ*, **372**, n71. https://doi.org/10.1136/bmj.n71

[24] Huang, X., Lin, J. and Demner-Fushman, D. (2006) Evaluation of PICO as a Knowledge Representation for Clinical Questions. *AMIA Annual Symposium Proceedings*, Washington, November 11-15, 2006, 359-363.

[25] Ouzzani, M., Hammady, H., Fedorowicz, Z. and Elmagarmid, A. (2016) Rayyan—A Web and Mobile App for Systematic Reviews. *Systematic Reviews*, **5**, Article No. 210. https://doi.org/10.1186/s13643-016-0384-4

[26] Thomas, R., Pesut, B., Puurveen, G., Thorne, S., Tishelman, C. and Leimbigler, B. (2023) Medical Assistance in Dying: A Review of Canadian Health Authority Policy Documents. *Global Qualitative Nursing Research*, **10**. https://doi.org/10.1177/23333936231167309

[27] Dhamanaskar, R. and Abelson, J. (2024) Public Deliberation for Ethically Complex Policies: The Case of Medical Assistance in Dying in Canada. *Healthcare Policy/Politiques de Santé*, **20**, 83-93. https://doi.org/10.12927/hcpol.2024.27410

[28] Jeanneret, R., Close, E., Downie, J., Willmott, L. and White, B.P. (2024) 'My Advocacy Is Not about Me, My Advocacy Is about Canadians': A Qualitative Study of How Caregivers and Patients Influence Regulation of Medical Assistance in Dying in Canada. *Medical Law Review*, **32**, 301-335. https://doi.org/10.1093/medlaw/fwae012