

Understanding How Canadian Physicians and Public Stakeholders Rationalize MAiD Amid Bill C-7: A Critical Analysis

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Article abstract

Despite its legalization, the ethics of medical assistance in dying (MAiD) remain contentious due to an evolving eligibility criteria goalpost and the subsequent implications for individuals suffering from non-terminal conditions, namely mental illness. Given the expanding availability of MAiD, comparing societal narratives with those of physicians is important to inform the development of health policies and laws that reflect a variety of stakeholder values and concerns. This paper presents a critical qualitative analysis of two types of data: 1) interview responses from Canadian physicians regarding the practice of MAiD, and 2) Canadian digital news media, with the goal of determining areas of convergence and divergence in the narratives of both source types. This analysis captured four overarching themes: 1) autonomy and choice, 2) “dying with dignity” and harm reduction, 3) paternalism and vulnerability, and 4) the medicalization of suffering. In general, while both physicians and other stakeholders express a commitment to the principle of patient autonomy, all parties raised concerns about systemic inequities and the risk of MAiD being used as a proxy for addressing broader social determinants of health.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Understanding How Canadian Physicians and Public Stakeholders Rationalize MAiD Amid Bill C-7: A Critical Analysis

Midori Matthew^a

Résumé

Malgré sa légalisation, l'éthique de l'aide médicale à mourir (AMM) reste controversée en raison de l'évolution des critères d'admissibilité et des implications qui en découlent pour les personnes souffrant de maladies non terminales, notamment de troubles mentaux. Compte tenu de la disponibilité croissante de l'AMM, il est important de comparer les discours de la société et ceux des médecins afin d'éclairer l'élaboration de politiques et de lois en matière de santé qui reflètent les valeurs et les préoccupations des différentes parties prenantes. Cet article présente une analyse qualitative critique de deux types de données : 1) les réponses à des entretiens menés auprès de médecins canadiens concernant la pratique de l'aide médicale à mourir, et 2) les médias numériques canadiens, dans le but de déterminer les points de convergence et de divergence entre les discours des deux types de sources. Notre analyse a permis de dégager quatre thèmes généraux : 1) l'autonomie et le choix, 2) « mourir dans la dignité » et la réduction des risques, 3) le paternalisme et la vulnérabilité, et 4) la médicalisation de la souffrance. En général, si les médecins et les autres parties prenantes se disent attachés au principe de l'autonomie du patient, toutes les parties ont exprimé leurs préoccupations concernant les inégalités systémiques et le risque que l'AMM soit utilisée comme un substitut pour traiter les déterminants sociaux plus larges de la santé.

Mots-clés

soins palliatifs, méthodes qualitatives, aide médicale à mourir, AMM, projet de loi C-7, Canada, point de vue des médecins, opinion publique

Abstract

Despite its legalization, the ethics of medical assistance in dying (MAiD) remain contentious due to an evolving eligibility criteria goalpost and the subsequent implications for individuals suffering from non-terminal conditions, namely mental illness. Given the expanding availability of MAiD, comparing societal narratives with those of physicians is important to inform the development of health policies and laws that reflect a variety of stakeholder values and concerns. This paper presents a critical qualitative analysis of two types of data: 1) interview responses from Canadian physicians regarding the practice of MAiD, and 2) Canadian digital news media, with the goal of determining areas of convergence and divergence in the narratives of both source types. This analysis captured four overarching themes: 1) autonomy and choice, 2) "dying with dignity" and harm reduction, 3) paternalism and vulnerability, and 4) the medicalization of suffering. In general, while both physicians and other stakeholders express a commitment to the principle of patient autonomy, all parties raised concerns about systemic inequities and the risk of MAiD being used as a proxy for addressing broader social determinants of health.

Keywords

palliative care, qualitative methods, medical assistance in dying, MAiD, Bill C-7, Canada, physician perspectives, public opinion

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Due to an editorial oversight, this article was inadvertently omitted from the special issue, [MAiD in Canada: A Sober Second Look](#).

INTRODUCTION

In 2016, Canada legalized medical assistance in dying (MAiD) following the *Carter v. Canada* ruling. Initially, MAiD was restricted to individuals facing a "reasonably foreseeable" natural death due to a grievous and irremediable health condition (1). However, the passage of Bill C-7 in 2021 in response to Quebec's Truchon decision expanded eligibility beyond those on the trajectory toward a reasonably foreseeable natural death to request MAiD under specific conditions (2). Despite its legalization, the ethics of MAiD remain contentious due to an evolving eligibility criteria goalpost and the subsequent implications for individuals who are suffering from non-terminal conditions, namely those suffering from mental illness (3). This expansion has intensified public discourse around ethical and medical questions about the role of MAiD in addressing suffering that reaches beyond physical illness, and how the law frames the lives of vulnerable Canadians at risk (4-7).

As the scope of MAiD's eligibility continues to grow, it is necessary to consider the insights of physicians affected by or participating in administering the procedure to examine the novel ethical terrain and practical implications post C-7. Physicians operate within a framework of professional ethics and medical standards and so may grapple with how MAiD compares with considerations of patient autonomy, non-maleficence, and the implications of liberalizing a terminal procedure in the face of crises such as affordability and a lack of social services for mental health and disability. Simultaneously, societal perspectives such as those offered by members of the general public, politicians, activists, and academics are iteratively shaped by concerns at the individual level (such as freedom of choice) and the macro level through considering the role of MAiD in an equitable society.

The current body of bioethics research about the direction of MAiD in Canada does not adequately consider how the firsthand perspectives of clinicians involved in the practice compares with broader societal discourses. Given the expanding availability of MAiD, comparing societal narratives with those of physicians is important to inform the development of health policies and laws that are reflective of a variety of stakeholder values and concerns. This study examines how physicians conceive of MAiD in the wake of Bill C-7. The alignment or disjuncture between physician's firsthand perspectives and those put forth by stakeholders in digital news media (e.g., activists, politicians, and civilians) is analyzed to describe the climate of contemporary critical discourses. By examining these two data sources, this analysis brings attention to the ethical complexities that define the climate of MAiD in Canada.

METHODS

This paper presents a critical analysis of two types of data: 1) interview responses from Canadian physicians regarding the practice of MAiD, and 2) Canadian digital print news media, with the goal of determining areas of convergence and divergence in the narratives of both source types. A qualitative descriptive approach was used to elicit the perspectives of physicians across a variety of specialties to determine their moral rationalization regarding their decision to participate in or abstain from providing MAiD. Twenty-one in-depth semi-structured interviews were conducted with physicians practicing across Canada (see Table 1).

Table 1: Demographic characteristics of participants (n=21)

Area of medical specialty	Number	Percent	Age range	Number	Percent
Family medicine	8	38.1	18-29	1	5.8
Palliative care	6	28.6	30-39	1	5.8
Obstetrics	1	4.8	40-49	2	9.5
Internal medicine	5	23.8	50-59	5	23.8
Psychiatry	1	5.8	60-69	8	38.1
Sex			70+	4	19.0
Male	7	33.3	Involvement with WLT*		
Female	14	66.7	Yes	19	90.5
Years practicing medicine			No	2	9.5
>30 years	12	57.1	MAiD provider		
21-30 years	4	19.0	Yes	14	66.7
11-20 years	2	9.5	No	7	33.3
6-10 years	2	9.5	Number of MAiD assessments		
1-5 years	0	0.0	0 (does not assess)	5	23.8
<1 year	1	4.8	1-50	5	23.8
Geographic area of practice			51-100	3	21.1
Southern Ontario	16	76.2	>100	8	38.1
Northeastern Ontario	1	5.8	Number of MAiD provisions		
British Columbia	2	9.5	0 (does not provide)	7	33.3
Manitoba	1	5.8	1-50	6	28.6
Saskatchewan	1	5.8	51-100	5	23.8
			>100	3	21.1

WLT = withdrawing life-sustaining treatment

Interviews were conducted between October and December 2020 via Microsoft Teams. Recruitment was facilitated through an advertisement on the website of the Canadian Association of MAiD Assessors and Providers, along with convenience sampling of physicians known to members of the research team. A demographic survey, consent forms, and a document outlining the foci of the study were shared with participants prior to scheduling an interview. Interviews were transcribed verbatim and identifiers were removed to ensure participant anonymity. The duration of interviews ranged from 30 to 120 minutes. This project received ethics clearance from the University of Waterloo Office of Research Ethics (ORE #40801).

While the original goal of the interview guide was to elicit how physicians conceptualize MAiD provisions in comparison with their views of withdrawing life-sustaining treatment (WLT), the emergent nature of qualitative data revealed meaningful insights about how physician involvement in MAiD may be challenged in the wake of evolving laws, namely Bill C-7. To gain further insight and context regarding national social perspectives about this issue, a second data source — Canadian digital news media — was integrated into the analysis. Digital media sources consulted included English-language articles about MAiD and Bill C-7 published in Canadian news outlets since 2020, the year the Government of Canada published its legislative response to the Truchon decision, which found the “reasonable foreseeability of natural death” eligibility criterion unconstitutional. National, provincial, and municipal publications were included to capture a diversity of perspectives on Bill C-7 across the nation. The news media review was conducted from July to September 2024 in the wake of the federal government’s delay, until 2027, in expanding MAiD access to individuals solely experiencing mental illness (8). Purposive sampling was applied to capture news media that was reflective of central political and social concerns about the law; in particular, those which addressed mental illness, disability, and poverty. Articles focusing exclusively on descriptive accounts without critical analysis of C-7’s implications were excluded. The sample consists of thirty sources comprised of news articles, opinion editorials, and columns (see Table 2). The goal of this study was not to exhaustively capture each article published in this area since 2020, but to explore key themes about MAiD and C-7 by highlighting representative and detailed examples.

Table 2: Included sources in the digital news media review

Title	Source	Author(s)	Date
Canadian Senate passes Bill C-7, expanding assisted dying to include mental illness	Global News	J Bryden	18-Mar-21
As Bill C-7 reaches Senate, UN watchdog raises concerns about MAiD for persons with disabilities	CBC News	T Mahboob	02-Feb-21
Bill C-7, assisted dying and “lives not worth living”	Policy Options	JS Beaudry	14-Dec-20
Q and A with Heidi Janz: COVID-19 exposed ableism, assisted death Bill C-7 endangers those with disabilities	Edmonton Journal	L Boothby	25-Oct-20
How Bill C-7 will sacrifice the medical profession's Standard of Care	Policy Options	T Lemmens, MJ Shariff, L Herx	11-Feb-21
Senate amendment raises debate over medically assisted death for those with mental illness	CTV News	A Favaro, E St. Philip, AM Jones	10-Feb-21
Doctors condemn changes to Canada's assisted dying law as 'reckless'	CityNews	R Bernard	28-Nov-20
Canada's broken social safety net pushes people toward assisted dying	The Globe and Mail	B Murdoch	22-Apr-24
Doctors, disability advocates condemn parliamentary committee's recommendation to expand MAiD law	The Globe and Mail	E Anderssen	07-Mar-23
Quadriplegic Quebec man chooses assisted dying after 4-day ER stay leaves horrific bedsore	CBC News	R Watts	12-Apr-24
Manitoba woman devastated over delay in MAiD for mental illness	CBC News	C Kemp	04-Feb-24
When harm reduction meets medical assistance in dying	National Post	C Selley	20-Oct-23
Opinion: Why I so desperately need a medically assisted death	Ottawa Citizen	J Scully	02-Feb-24
Calgary judge rules 27-year-old can go ahead with MAiD death despite father's concerns	CBC News	M Grant	25-Mar-24
Misunderstanding of mental illness clouds MAiD expansion, patient and psychiatrist say	CBC News	A Zafar	01-Feb-24
Ontario man not considering medically-assisted death anymore after outpouring of support	CityNews	C Mulligan, M Bond	17-Nov-22
Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing	CTV News	A Favaro	13-Apr-22
Police investigating medically-assisted death of B.C. woman	CTV News	A Favaro	26-Apr-22
Opinion: Canada will never be ready to expand assisted death to those with mental illness	Ottawa Citizen	D Zekveld	09-Feb-24
Opinion: If medically assisted death becomes more accessible for Canadians, we have a moral obligation to make living well — through housing, mental health supports — accessible too	Toronto Star	N Dosani	11-Feb-21
I am a MAiD provider. It's the most meaningful — and maddening — work I do. Here's why.	Macleans	M Li	13-Feb-24
Canadians with mental disorders shouldn't be excluded from requesting MAiD	Macleans	M Gupta	04-May-23
'Make it stop': Charter challenge launched against Ottawa for excluding mental illness from MAiD	National Post	S Taylor	19-Aug-24
A timely reminder that the courts need to keep their noses out of individuals' medical decisions	The Globe and Mail	A Picard	02-Apr-24
Surge in medically assisted deaths under Canada's MAiD program outpaces every other country	Toronto Star	M Khalatbari	27-Jan-24
Opinion: I've seen what a good death looks like. I hope MAiD's future looks the same	The Globe and Mail	N Richler	01-Mar-24
Loneliness big factor in people choosing medically assisted death: Doctor	The Sudbury Star	L Stradiotto	03-May-24
MAiD law on the right to die should respect individual choice: ethicist	CBC News	N Ayed	16-May-24
Spina bifida patient says Montreal hospital staff twice offered MAiD unprompted	CTV News	M Gilmour	05-Jul-24
'Catastrophic Pandora's box': Disabled Ontarians speak out against proposed MAiD law	TV Ontario	M Gilmore	03-Mar-21

A thematic analysis was completed by moving between reading the articles and reviewing interview transcriptions to identify dominant themes between sources. The goal was to determine whether the concerns presented by the news media were reflective of those expressed by physicians who are either involved in or proximate to MAiD in clinical practice.

RESULTS

The results of this analysis are representative of thirty digital news media sources and twenty-one interviews with Canadian physicians. Perspectives in the articles included those of disability rights activists, ethicists, academics, politicians, journalists, and physicians. The diversity of stakeholder perspectives included through news sources moved away from an exclusively clinical perspective on Bill C-7's impact and instead considered a nuanced perspective from a variety of societal actors. The analysis captured four overarching themes: 1) autonomy and choice, 2) “dying with dignity” and harm reduction, 3) paternalism and vulnerability, and 4) the medicalization of suffering.

Theme 1: Autonomy and choice

Patient autonomy was the most dominant theme across all sources analyzed. Arguments in favour of both MAiD in its original state as well as justifying its expansion post C-7 are typically based on the idea that access to the procedure provides patients experiencing grievous illness with the choice to end their lives as they see fit, thus allowing them a degree of control in an otherwise intractable experience. From the perspectives of the physicians interviewed, autonomy was a central consideration to ethical medical practice. Whether in cases where patients had non-foreseeable trajectories of death or those with a terminal diagnosis, many physicians expressed that access to MAiD was a means of respecting a patient's right to make self-directed choices about their medical care.

The patient has chosen to make an end-of-life choice that is consistent with all other life choices they make... the fundamental freedom we give to people to make choices about their life extends to MAiD [when] suffering exceeds present quality of life. (Participant N, general practitioner, 30+ years of practice, provides MAiD)

Another physician challenged the notion posed by opponents that enhanced access to palliative care may negate the relevance of MAiD's expansion. They held that such arguments did not offer due recognition of the importance of patient choice:

There is critical importance in managing the autonomy of any patient... I challenge [those opposed] on the ridiculous notion that palliative care done well gets rid of the need for MAiD. Palliative care providers, in general, do a lousy job of managing that component of existential suffering. (Participant J, palliative care specialist, 11-20 years of practice, provides MAiD)

In defence of Bill C-7, one Canadian senator expressed his support on the basis of autonomy, arguing that "our bodies and minds belong to us." (9) Arguing in favour of MAiD liberalization, one Canadian ethicist held that patient autonomy "...is a fundamental value for patients experiencing mental illness." (10) Articles reporting first-hand accounts by Canadians experiencing mental illness show similar sentiments. One individual with a mental illness felt that the expansion of MAiD would "liberate [them] from... crushing oppression of not having bodily autonomy," (11) thus depicting the availability of the procedure as giving them the ability to determine the trajectory of their own life. While recognizing the novel ethical terrain raised with Bill C-7, one physician shared that their commitment toward enabling patient autonomy remained:

I feel uncomfortable by the new bill [C-7], but I feel very strongly about patient autonomy. I would tread with great caution [during provisions], but I'm not sure if I could even follow through. I haven't faced that yet. (Participant E, general practitioner, 30+ years of practice, provides MAiD)

There is debate within the medical community about how to balance autonomy with other ethical considerations, such as non-maleficence; namely, whether providing MAiD to patients with non-terminal illness may erode trust in the medical profession. Regarding this concern in the context of disability advocacy groups, one physician challenged this notion:

There's a lot of talk from disability groups that [Bill] C-7 will cheapen lives or reduce meaning in life, and I don't feel that way at all. I think it recognizes both their suffering and autonomy. (Participant P, general practitioner, 30+ years of practice, provides MAiD)

Theme 2: "Dying with dignity" and harm reduction

A second core theme prevalent in physician interview responses was the concept of death with dignity and reducing potential harms faced by a patient who does not have MAiD as an option. The idea of dying with dignity refers to the belief that patients should have a right to make decisions about the end of their life in a way that aligns with their personal wishes and reduces grievous suffering. This view of MAiD is informed by principles of harm reduction, where the availability of the procedure minimizes the negative social or physical consequences that arise when an individual attempts to take their own life. Physicians in our sample shared cases where a patient had committed suicide due to MAiD ineligibility under the previous law, and argued that Bill C-7 would offer a better form of death:

A few of my patients have committed suicide, they were spiritually suffering... I was devastated. Those are not good deaths. For the family, it's devastating. I want deaths to be good not just for the patient, but for families as well. They carry scars for the rest of their lives. (Participant P, general practitioner, 30+ years of practice, provides MAiD)

When a mentally ill person requests MAiD, some are very likely to die by suicide if you do not help them... the intent is to relieve suffering. (Participant M, psychiatrist, 11-20 years of practice, assesses for but does not provide MAiD)

Though arguments regarding the moral permissibility of MAiD have never been without controversy, dichotomous opinions as to the appropriateness of this idea have heightened in the wake of Bill C-7. Several articles reviewed called the idea of dying with dignity under the new law into question. An article published in the Toronto Star stated that "...we don't give marginalized people a chance to live with dignity, but we are all too eager to provide a path in dying with dignity." (12) The Ontario Disability Justice Network was quoted as stating that any legislation that affords a right to die but does not guarantee the right to live is

“inhumane.” (11) Without guarantees of access to a minimum standard of living, the expansion of the MAiD law puts vulnerable individuals “in circumstances where they [have] no other choice.” (13) These concerns become reality in cases such as that of a quadriplegic man living in Quebec who developed a bedsore while awaiting care in a hospital, and who qualified for and then received MAiD due to the severity of his condition and fear of becoming burdensome (14). In other cases, the multidimensional nature of patient suffering is complicated by factors such as comorbid physical and mental conditions, resulting in poor conditions of living. The interplay of these factors is difficult to navigate in MAiD provisions, as shared by one physician:

I had a marginally housed patient... it was dirty, it was smelly, he had a chronic symptom burden and a severe personality disorder. I gave him the gift of a dignified death, which was very meaningful to me and his family. I wanted to treat him fairly, not dismiss him due to his terrible housing and economic situation, but also wanted to ensure these things weren't the main reasons [that] he was or wasn't found eligible. (Participant C, general practitioner, 30+ years of practice, provides MAiD)

Theme 3: Paternalism and vulnerability

This theme explores the tension experienced by medical providers in protecting people from harm, particularly those who are part of vulnerable populations. The expansion of MAiD to individuals without a foreseeable trajectory to death has a marked impact on individuals who are physically disabled, severely mentally ill, or experiencing complications of chronic illness. Due to the widespread reporting of systemic injustices and inequitable treatment of vulnerable populations post Bill C-7, there are substantial ethical questions about the role of physicians in safeguarding the rights of marginalized individuals to engage in self-determination versus imposing unwelcome clinical judgment. Attending specifically to the potential of MAiD on mental health grounds, a psychiatrist interviewed by Maclean's held that “we can't say... how important it is to destigmatize mental disorders, and [then] pass laws that single out people with these disorders, portraying them as unable to make their own decisions... assessors may wrongly assume that they can't consent, or underestimate the severity of their suffering.” (15) This belief was echoed by a physician respondent who does not participate in MAiD:

There is a conflict between forcing inpatient treatments of psychiatric patients who are trying to commit suicide and who don't want to go on living versus allowing patients with medical illness to terminate their life. There's a value judgment there, there's one person we trust and another we're exerting paternalism on, that we know better than them... there's a double standard. MAiD either needs to be abolished completely, or everyone should have equal access. (Participant J, internal medicine specialist, <1 year of practice, does not provide MAiD)

Another physician interviewed by CBC News said that when MAiD was first introduced, she took patient requests at face value due to the basis of terminal illness. She now “discuss[es] transparently with a patient whether... MAiD is the right choice for them and help them understand [her] rationale and let them convince [her] that it is the right decision for them.” (16) This refined approach, as suggested by participating physicians, aims to protect vulnerable individuals who may feel that they are being pushed toward a premature death due to a lack of access to social supports and comprehensive mental health care. Without such safeguards, there is concern that C-7 will “displace the... professional rule of the standard of care, which obligates physicians to apply their... intricate knowledge to a patient's clinical circumstances and replace it with patient choice.” (17) The “standard of care” is informed by the idea that physicians have scientific expertise rooted in evidence-based medical research and standards set by professional organizations. The informational asymmetry between patient and provider places clinicians in a position of power in which they have a commitment to offer the safest and most suitable care option to a patient. Challenging the notion that providers of MAiD would do away with clinical discretion in the face of the evolving law, one physician respondent argued:

The language used by psychiatrists implies that we would see a patient and immediately accept their [MAiD] request without doing our due diligence or trying everything else that we possibly can. It's strange and quite offensive to me. (Participant M, psychiatrist, 11-20 years of practice, assesses for but does not provide MAiD)

Theme 4: The medicalization of suffering

Without supports to offer a minimum standard of living for individuals to live well within society, vulnerable individuals may be inclined to apply for MAiD due to lacking access to resources that enable them to live a good life. This theme addresses perceived implicit ableist assumptions in the expansion of the MAiD regime that subtly imply that the lives of disabled people are worth less than those who are able-bodied. The new bill is described as “part of an incomplete and harmful approach to justice for people who are sick, old, or disabled” (18) and attempts to apply medical solutions to social problems. In a highly publicized case of MAiD gone awry, a St. Catharines, Ontario, man with chronic back pain applied for the procedure due to his inability to subsist on ODSP (Ontario Disability Support Program) and fear of homelessness (19). While support from community organizations enabled him to meet his financial needs, he stated that “governments should be focused on fixing the issues causing poverty rather than the moral ramifications of those in poverty seeking MAiD” (19), gesturing to the importance of upstream solutions to health inequities. As the passage of Bill C-7 had overlap with the COVID-19 pandemic which resulted in a public health-led national vaccination campaign to reduce mortality rates, one physician interviewed pointed to the stark contrast between the issues:

In the middle of the COVID pandemic and we're so worried about keeping everyone alive, yet the long-term facilities are filled with abuses — and we want to provide more people with MAiD? It's just schizophrenic. (Participant B, palliative care specialist, 30+ years of practice, does not provide MAiD).

In an interview with the CBC, the United Nations watchdog for people with disabilities expressed concern about the liberalization of Canada's MAiD laws amid a lack of community services and affordable living options for those with disability. His worry was with regards to an "architecture of choice, [where] the various inputs into making our decisions will be... rigged when it comes to people with disabilities because of a lack of access to basic services to enable them to live with their condition." (20) Recounting cases of MAiD requests which were countered with treatment to the social determinants of health, particularly income, housing, and social inclusion, one palliative care physician stated that "...it should be reasonable to expect that the same energy put into passing MAiD will also be put into addressing the upstream factors that lead to poor health, like a national housing strategy, improving harm reduction services, implementing basic income strategies, and pharmacare." (21) One physician found that by addressing feelings of loneliness and social isolation, many patients withdraw their MAiD requests, thus validating the importance of community-based supports (22). Several articles included in this analysis also point to the fact that not all Canadians have equal access to palliative care, particularly those who are structurally vulnerable (22-25). These same concerns were reflected in our interviews with physicians:

How can we go forward with C-7 when we don't even provide universal access to palliative care or access to [social] resources? We don't have full psychosocial resources available. (Participant D, palliative care specialist, 6-10 years of practice, does not provide MAiD)

I struggle when people suffering come to the health care system... and sometimes I wonder if only we could get them better housing, more supports in the home, or psychotherapy, and not making decisions from emotional distress. Sometimes, we can't do anything, and a poor person is going to die of something else anyway, and there are no active remedies for the situation. This causes me a lot of grief — is the cause of their condition social suffering or illness? Our system lets people down. (Participant F, general practitioner, 30+ years of practice, provides MAiD)

DISCUSSION

This comparison of physicians' firsthand perspectives and digital news media provides important insights into the evolving health policy landscape of MAiD in Canada. By integrating both data sources, this study offers a textured, though not exhaustive, account of the current tensions and ethical considerations. While these narratives do not fully capture the nuance, diversity, or dynamism of the ongoing social debates surrounding MAiD in Canada, they nonetheless raise key themes across professional and public-facing discourse that can inform more responsive policy development.

The results showed that autonomy lies at the core of MAiD considerations, particularly from the perspective of physicians involved in the practice. This is consistent with the findings of recent research about MAiD in Canada (3,4,26,27). Many physicians felt that enabling access to MAiD is part of the fundamental freedom of self-determination and making decisions reflective of a patient's own values and lives, regardless of whether death was foreseeable. Texts capturing the perspectives of politicians, academics, and Canadians experiencing mental illness upheld autonomy as the central consideration in the expansion of MAiD laws, using the language of 'liberation' and 'empowerment' to justify expanding eligibility criteria. These opinions work on the underlying assumption that individuals are able to engage in medical decision-making free from the constraints of broader social structures, such as access (or lack thereof) to the resources necessary for ensuring the minimum standards of a good life. Autonomy-based perspectives, both in interviews and textual documents, typically did not consider the coercive influences of structural vulnerabilities such as poverty, a lack of access to community-based support, or other treatments that constrain the range of choices available through end-of-life care. Such responses show a static rather than relational conception of autonomy, wherein the right to 'choice' is taken at face value without recognition that autonomy may be enhanced or undermined through social context (28,29). Social commentaries and academic pieces have noted the disproportionate weight placed on autonomy in the development of MAiD legislation, to the detriment of values such as protection of the vulnerable (26,30,31). As self-determination necessitates that individuals are free from oppression and exist in a state of relative social equality (32), it is questionable whether such conditions are experienced equally across Canada.

Notably, physicians in our sample disagreed on the common policy assumption that expanding access to high-quality palliative care would reduce MAiD requests. Some providers emphasized that many of their MAiD-eligible patients were already receiving exemplary palliative care services yet continued to experience intolerable psychosocial suffering. This challenges the view that palliative care expansion alone could resolve MAiD-related distress. However, other physicians and commentators advocated for strengthening community care infrastructure under the presumption that MAiD requests may emerge from systemic gaps. This difference in perspective highlights how professional experiences and disciplinary norms shape understandings of suffering and the boundaries of medicine.

While harm reduction is a policy approach that is typically advanced in response to public health issues (e.g., drug use), recent scholarship has demonstrated its transferability to other contexts (33). Harm reduction is grounded in a recognition that the recommended solution to a complex problem is imperfect, and that as such, the option resulting in the least harm to an individual may be the best course of action. The findings of this study show that harm reduction arguments were advanced

alongside those holding that MAiD provides a dignified death for individuals experiencing intractable suffering. At the core of these views is the possibility that if denied access to a controlled medically assisted death, an individual may resort to harmful means to take their own life. Physician respondents spoke of encountering such cases in their respective medical practices, and articles written about Canadians experiencing non-terminal or mental illness cited their histories of suicidal attempts (34,35). The current literature contradicts this perspective, with one systematic review of international assisted suicide programs concluding that "...there is no evidence... to support the hypothesis that [MAiD] reduces non-assisted suicide." (36) Other textual sources questioned how Canadian society can express commitment toward dying with dignity when vulnerable individuals fail to receive the support necessary to live a minimally good life (11,12).

Paternalism, or the idea that select patients may be trusted while others are questioned, was considered. Most physicians felt that to prevent the development of a double standard with regard to patients deemed trustworthy and worthy of self-governance and those who are not, MAiD should not be restricted to the nature of the underlying condition. This follows from longstanding bioethical debates that situate autonomy and paternalism as oppositional constructs (37-39), with the false dichotomy that only one may prevail. Considerations of paternalism were given less attention by the writings of non-medical stakeholders (e.g., politicians, academics, or social commentators), which follows from the role that a physician plays as a 'healer' and a purveyor of medical expertise. There is a dissensus in the medico-ethical literature about the role of paternalism in MAiD. One perspective emphasizes the importance of case-by-case variability, arguing that sound clinical judgment should guide eligibility determinations regardless of whether death is reasonably foreseeable (4,40,41). Another contends that the medical standard of care requires physicians to withhold a terminal procedure if they believe other support measures could provide adequate relief. While these positions are not necessarily mutually exclusive, tension arises when clinical judgment leads to approving MAiD despite the availability of alternative interventions, highlighting an ethical conflict between respecting patient autonomy and adhering to professional obligations (17).

The final theme, the medicalization of suffering, underscores the risk of MAiD being perceived as a 'solution' to systemic failures, such as inadequate social services, rather than focusing on providing comprehensive support that allows individuals to live well. In general, the perspectives offered both by the physician sample and those analyzed through the digital media analysis achieved consensus on the reality of this issue. As one respondent noted, there is a distinctive contrast between the public health initiative to reduce mortality during the COVID-19 pandemic and the simultaneous expansion of MAiD — a juxtaposition that calls into question the consistency of societal values regarding which lives are worth saving. This critique of MAiD as a tool of medical ableism is echoed in recent literature (30,42). Critical responses to the post C-7 climate are troubled by the role of systematic inequalities as precipitating factors driving MAiD requests, and so argue that government instead focus on evaluating opportunities for improved services rather than continuing to expand the law (30,43). Concurrently, some participants argued that suffering is not always reducible to social context. For instance, looking to countries such as the Netherlands, where social safety nets are more extensive, some respondents noted that assisted death remains in demand even under more equitable conditions. Caution must thus be exercised in reducing MAiD requests to failures of policy, with recognition that conceptions of suffering are deeply subjective.

Together, the findings of this study contribute to naming the significant ethical quandaries that permeate the revised MAiD regime in Canada. The growing emphasis on autonomy, while central to respecting individual rights, can obscure the structural vulnerabilities that limit meaningful choice for many. As eligibility criteria continue to expand, policymakers must balance the imperative to respect patient preferences with a commitment to reducing inequality and bolstering the broader health care and social service systems. Rather than viewing these goals in conflict, a responsive MAiD policy must recognize that autonomy is only valuable when supported by the conditions necessary to live and die with dignity.

CONCLUSIONS

The expansion of MAiD through Bill C-7 has introduced considerable ethical, medical, and societal challenges in extending eligibility criteria to those whose deaths are not reasonably foreseeable. A joint analysis of physicians' perspectives and dominant narratives in digital news media found four central themes of concern: autonomy and choice, dying with dignity and harm reduction, paternalism and vulnerability, and the medicalization of suffering. While both physicians and public stakeholders emphasized a commitment to patient autonomy, participants expressed unease regarding the role of structural inequities and the risk that MAiD may be used as a response to unmet health and social needs. As such, effective health policy must move beyond legal eligibility frameworks to confront the systemic conditions that drive MAiD requests. While this analysis offers valuable insights into prominent discourses, it does not claim to capture the full complexity of the ongoing MAiD debate, which continues to evolve across cultural contexts. Policymakers must prioritize upstream solutions, such as strengthened mental health services, affordable housing, and robust social supports to ensure that all individuals have both the right to die with dignity and the opportunity to live well.

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