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Research Report

In the Valley of the Shadow of Death: An Evaluation of Canada's Bill C-7's Balance of Autonomy and Protection

Samuel Kamalendran

Primary Research Advisor: Christopher Greenaway, Ph.D.

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Introduction

Medical assistance in dying, also known as MAID in Canada, denotes the "process that allows someone who is found eligible to be able to receive assistance from a medical practitioner in ending their life." [1] While a medical subject, the evolution of the laws and frameworks that permit and guide the administering of MAID intersects the courts and Parliament, all while sparking complex discussions pertaining to autonomy, vulnerability, and medical ethics. This complicated history has made it one of the most complex frontiers of medicine and law in modern end-of-life care, specifically in Canada, where the speed of legal developments has stirred substantial controversy.

Of the various legal developments in Canada since 1993, 2021's Bill C-7 has received substantial praise and opposition from various leaders in the field of assisted-dying. Such debate has given rise to copious amounts of scholarly and public literature defending and undermining the Bill, as the world gives notice to Canada's foray into a new realm of legalized assisted dying. Even with robust legitimacy granted to the Bill by the declaration of the courts and Parliament, Canada seems unsure of its next steps, as key thinkers speak out against the Bill and as eligibility for the mentally ill is repeatedly pushed back. While the federal government has explicitly stated its commitment to "supporting the autonomy of eligible persons to seek MAID while protecting vulnerable individuals and the equality rights of all Canadians," [2] the question remains: has such a balance been found?

Born from a research paper also exploring MAID conducted in a Canadian Politics class at the University of Toronto, this paper will employ quantitative and qualitative methodologies to evaluate Canada's MAID laws to determine if they are sufficiently protecting the most vulnerable in the country in the context of key court cases and through comparison to other assisted-dying permissive jurisdictions. Through these methodologies, the paper will highlight gaps in Canada's laws, propose policy suggestions, and respond to the question of whether a country can truly balance protection and autonomy. These findings will be shared through the Laidlaw Foundation via the Laidlaw Scholars Network to add to the growing corpus on assisted dying and nurture deeper conversation regarding the protection of the vulnerable, especially given Bill C-7's mental illness eligibility clause's expected induction year of 2027.

Research Question & Objectives

This research paper will respond to the question: *To what extent does Canada's Bill C-7 MAID framework balance patient autonomy with the sufficient protection of the most vulnerable individuals in the nation*? This study will respond to these questions by satisfying the following research objectives:

1. **Analyze** the landmark court cases that have shaped the legal framework of MAID in Canada, from Rodriguez v. British Columbia to Carter v. Canada to Truchon v. Superior Court of Canada
    a. **Quantify** and **analyze** the presence of key words pertaining to the advocacy or opposition of the advancement of MAID laws to identify correlations between terms and the results of each case and define the dominating sentiment.
    b. Compare and contrast the assisted-dying frameworks of Canada, the Netherlands, and the U.S. state of California
        i. **Conduct** a deep analysis of Canada's 2023 MAID report to identify potential risks to the vulnerable.
        ii. **Outline** and **contrast** the frameworks of the three jurisdictions to identify the key differences between them.
        iii. **Analyze** government data regarding assisted dying in their respective jurisdictions in light of their frameworks to identify strengths and weaknesses of different medico-legal approaches.
2. **Outline** a response to the question of whether a jurisdiction can be determined to have "balanced" autonomy by the proposal of a social theory.

Ultimately, the satisfaction of these objectives will lead to the development of evidence-based policy recommendations for Canada and other jurisdictions seeking to enhance their assisted-dying laws.

Literature Review & Theoretical Framework

Defining Medical Assistance in Dying

Just a brief foray into MAID-related literature will showcase the various terms used to describe different forms of assisted dying. Therefore, it is expedient to define these terms and specifically highlight the sometimes-slight nuances that differentiate them.

Euthanasia: Euthanasia is "a deliberate and intentional act taken by one person to end the life of another person suffering due to a disease or physical ailment."[3][4][5, p. 14-15]
Assisted Suicide / Physician-Assisted Suicide: Assisted suicide is a process during which individuals end their lives by themselves with the aid of others, typically medical professionals, through the provision of knowledge, medications, etc.[3][4]
Medical Assisted in Dying (MAID): MAID is a process during which a willing individual can be found eligible for and receive assistance from a medical practitioner to end their life. [6][1][5, p. 14] In Canada, MAID was introduced as a legal term after Carter v. Canada and covers both euthanasia and assisted suicide. According to section 241.1 of the Criminal Code, "MAID" includes: (1) the administration by a medical practitioner or nurse practitioner of medication that will cause a person's death at their request and (2) the prescription or provision by a medical practitioner or nurse practitioner of medication that a person can self-administer to cause their own death. An important note is that MAID does not include the withholding of medical treatment or the provision of palliative care.[5, p. 14]

A deeper look at these terms can unearth controversy even about the language used to describe these different processes. This analysis can be found in Appendix A.

The Evolution of MAID in Canada

Assisted dying emerged onto the Canadian legal scene in 1993, when Rodriguez v. British Canada (Attorney General) came before the Supreme Court of Canada and saw the challenge of section 241(b) of the Criminal Code, which prohibited assisted suicide. Despite ultimately losing the case after a close majority ruling, the case sparked new conversations about assisted dying, birthing the Special Senate Committee on Euthanasia and Assisted Suicide. [5, p, 15-16]

Two decades later, the same challenge arose, as a lawsuit involving two British Columbians argued that Criminal Code provisions against assisted dying violated their section 7 and 15 Charter rights. Despite winning in British Columbia's Supreme Court, the British Columbia Court of Appeal reversed the judgement, escalating the case to the Supreme Court of Canada, which voted unanimously against the constitutionality of 241(b) in Carter v. Canada, decriminalizing assisted death in Canada, and giving Parliament one year to create appropriate regulations. [5, p. 18-22] In response to the decision, the federal government established the Expert Panel on Options for a Legislative Response to Carter v. Canada, which consulted with Belgium, the Netherlands, Switzerland, and the U.S., along with other stakeholders, to develop recommendations for Canada's inaugural MAID regime. [5, p. 23] Besides them, other groups, such as the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying and the Special Joint Committee on Physician-Assisted Dying, which was established by the House of Commons and the Senate, also produced reports in December 2015 and February 2016, respectively. [5, p. 23-24]

The federal legal response to Carter v. Canada arrived in the form of Bill C-14, "An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)" on June 17, 2016. The Bill's preamble noted its interest in striking a considerate balance between the autonomy of individuals seeking MAID and the interests of "vulnerable persons in need of protection and those of society," and noted the government's commitment to developing non-legislative measures to improve end-of-life care [7]. The report also required the federal government to conduct reviews on requests for MAID by mature minors, advance directives, and requests for individuals where mental illness is the only underlying medical condition [7]. C-14 also mandated a federal monitoring program to collect MAID-related data to ensure proper insight into the legislation's real-life impacts and promote public transparency [8] and required a review of MAID after 5 years.[5, p. 27] Beyond the eligibility criteria, which were drawn from Carter v. Canada, the most significant addition, especially in light of Bill C-7, was the requirement that the individual has a "grievous and irremediable medical condition," [9] with such a condition being defined in Appendix B. Of these criteria, the RFND requirement is the most critical for two reasons. Firstly, it contrasted the Joint Parliamentary Committee's recommendation that no terms from Carter's suggestions are defined [5, p. 27], and secondly, it would lay the foundation of the next court case that would alter Canada's federal MAID framework: Truchon c. Procureur général du Canada. *Truchon* saw Quebec's Superior Court rule in favour of the Plaintiffs who argued against the RFND criterion in the federal MAID framework and the "end of life" criterion in Quebec's provincial MAID framework, *Act Respecting End-of-Life Care*, on the grounds that it violated Sections 7 and 15 of the Charter [10]. Canada's current MAID framework can be found in Appendix C.

Court Case Analysis

At the helm of all the political and legal developments pertaining to Bills C-14 and C-7 are the court cases that denied or allowed MAID's legislative advancements. As a medico-legal subject at its core, the allowance of MAID begins in the state's judiciary, where it is scrutinized to determine its alignment with the most fundamental values of society as encapsulated in the Charter. As noted, three court cases have defined the evolution of MAID in Canada: Rodriguez v. British Columbia (*Rodriguez*), Carter v. Canada (*Carter*), and Truchon c. Procureur général du Canada (*Truchon*). Together, they form a spectrum highlighting progressing views on assisted dying, with *Rodriguez* seeing its denial and *Truchon* removing the RFND criteria. This analysis will be completed by conducting a manual sentiment analysis by identifying the presence and context of key words pertaining to the advocacy or opposition of the advancement of MAID laws to determine which sentiment was more dominant in each case. The analysis will use eight key terms. Four of these terms typically indicate opposition to the advancement of MAID laws and include: (1) Vulnerab(le)(ility)(ilities) (2) Protection (3) Slippery Slope (4) Safeguard(s)(ing). The other four typically indicate advocacy and include: (1) (In)Equal(ity) (2) Choice (3) Autonomy (4) Discriminat(ion)(ate(s))(ing). For each court case, the total number of relevant instances of the terms will be totaled, and all instances will be categorized into "caution" or "advocacy." Findings will then be analyzed to identify trends in changing judicial opinions, highlighting how the courts viewed the conflict of autonomy and protection, and to determine if case rulings align with the dominant sentiment. Ultimately, this analysis will test the hypothesis that the verdicts of each court case correspond with the sentiment prominent in the court case. This methodology was initially designed to involve Python's Natural Language Toolkit (NLTK) for natural language processing. However, this approach shifted to manual analysis after it was determined that the software did not fulfill the imperative of confidently determining context, which at times required considering multiple levels of context, beyond nearby terms. As this approach was manual, it was critical to be cognizant of the risk of human error, which was minimized by the creation and adherence to a list of rules and guidelines regarding the categorization of terms. This list can be found in Appendix D.

Raw Data

		Rodriguez			*Carter*			*Truchon*		
		Total	Caution	Advocacy	Total	Caution	Advocacy	Total	Caution	Advocacy
Opposition	*Vulnerab(le)(ility)(ilities)*	38	24	15	36	17	19	129	60	69
	Protection	23	12	11	4	3	1	23	9	14
	Slippery Slope	4	3	1	7	4	3	8	2	6
	Safeguard(s)(ing)	13	9	4	21	9	12	28	11	17
Advocacy	*(In)Equal(ity)*	41	1	40	5	2	3	50	28	22
	Choice	39	11	28	12	0	12	39	16	23
	Autonomy	22	5	17	11	0	11	63	16	47
	Discriminat(ion)(ate(s))(ing)	31	1	33	1	0	1	22	12	10

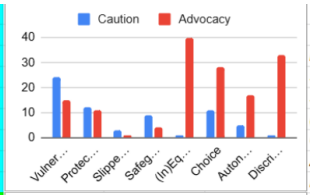
Figure 1

After evaluating all three court cases, all the raw data obtained was organized in the table above, which included the total instances of terms and the times the terms were used in the context of caution or advocacy. The data was then reorganized to become optimal for transformation into a graph. Graphs were then created for the data from each Court case to provide a visual comparison.

As the data from each case was only being analyzed within itself (the goal of determining which showed more caution vs. advocacy did not require intra-case comparison), the raw data did not need to be processed (by dividing each value by the number of page numbers in the case to account for major differences due to larger case sizes). Based on the original figures numerically and the graph visually, a final judgement based on which sentiment was dominant was noted on the rightmost side of Figure 2.

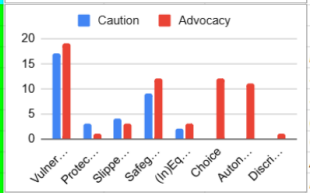
Figure 2

			Caution	Advocacy
Rodriguez	Opposition	*Vulnerab(le)(ility)(ilities)*	24	15
		Protection	12	11
		Slippery Slope	3	1
		Safeguard(s)(ing)	9	4
	Advocacy	*(In)Equal(ity)*	1	40
		Choice	11	28
		Autonomy	5	17
		Discriminat(ion)(ate(s))(ing)	1	33



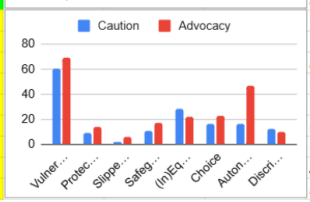
Vulnerab(le)(ility)(ilities)	Caution
Protection	Caution
Slippery Slope	Caution
Safeguard(s)(ing)	Caution
(In)Equal(ity)	Advocacy
Choice	Advocacy
Autonomy	Advocacy
Discriminat(ion)(ate(s))(ing)	Advocacy

			Caution	Advocacy
Carter	Opposition	*Vulnerab(le)(ility)(ilities)*	17	19
		Protection	3	1
		Slippery Slope	4	3
		Safeguard(s)(ing)	9	12
	Advocacy	*(In)Equal(ity)*	2	3
		Choice	0	12
		Autonomy	0	11
		Discriminat(ion)(ate(s))(ing)	0	1



Vulnerab(le)(ility)(ilities)	Advocacy
Protection	Caution
Slippery Slope	Caution
Safeguard(s)(ing)	Advocacy
(In)Equal(ity)	Advocacy
Choice	Advocacy
Autonomy	Advocacy
Discriminat(ion)(ate(s))(ing)	Advocacy

			Caution	Advocacy
Truchon	Opposition	*Vulnerab(le)(ility)(ilities)*	60	69
		Protection	9	14
		Slippery Slope	2	6
		Safeguard(s)(ing)	11	17
	Advocacy	*(In)Equal(ity)*	28	22
		Choice	16	23
		Autonomy	16	47
		Discriminat(ion)(ate(s))(ing)	12	10

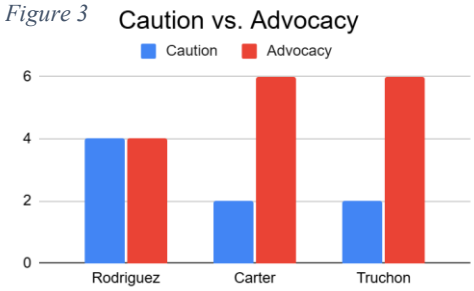


Vulnerab(le)(ility)(ilities)	Advocacy
Protection	Advocacy
Slippery Slope	Advocacy
Safeguard(s)(ing)	Advocacy
(In)Equal(ity)	Caution
Choice	Advocacy
Autonomy	Advocacy
Discriminat(ion)(ate(s))(ing)	Caution

Discussion

The first and most important finding directly pertains to the hypothesis coming into the analysis. The hypothesis has been found to stand true as there is an increase in the presence of advocacy terms from Rodriguez to Carter to Truchon.

Figure 3



This is represented in Figure 3, which visualizes the caution and advocacy findings of the earlier figure. Rodriguez's terms were split between caution and advocacy. This specific finding should be explored further as it is interesting that while having ultimately decided against decriminalized assisted dying, the court case clearly shows significant support for legal expansion. This can be explained by how the decision was the result of a narrowly split court of 5 to 4, which meant that there were judges who believed in the need to decriminalize assisted dying. In fact, the majority had their arguments conveyed by one judge, who took up 26 pages, while the dissenting judges were composed of three groups, all of whom took up 52 pages – twice as that the majority. This might explain why Rodriguez saw such a strong presence of advocating statements, especially among the terms typically aligned with caution. This hypothesis can be tested by returning to our raw data and examining whether caution or advocacy was prevalent on the swaths of the report written by the majority or the dissenting minority. This will be done by calculating what percentage of all the majority's statements were cautious and what percentage of all the dissenter's statements were advocating (e.g. sum of the total caution / advocating statements from the majority and minority; for the majority, determine what percentage of the sum is composed of cautious statements; for the minority, determine what percentage of the sum is composed of dissenting statements). The resultant graph (Figure 4) is located in Appendix E.

This raw data shows us that while the majority shows a significant inclination for caution, the dissenters also show a substantial preference for advocacy. It should be noted that for "inequality," while the percentages are equal, the actual numerical difference is considerable: 33 for advocating and 1 for cautious. These results help process the fact that caution and advocacy were equal for Rodriguez and highlight the impact of the narrow justice margin and the variance of written arguments in the case.

Moving on, as expected, according to the hypothesis, there is an increase in advocating statements in both Carter and Truchon. It should be noted that this increase is not progressive but instead both cases have the same proportion of terms for which caution and advocacy dominate. This can somewhat be explained by how even though Truchon set forward greater levels of permissiveness than Carter, ultimately, both are the same in how they reflect the advancement of MAID legislation. Moreover, both cases were unanimous in their voting (as Truchon was presided over by one judge, resulting in only one opinion being stated), which reduces the dilution of opinions that comes with a split court.

Zooming out of the dataset, it is insightful to understand why such substantial advocacy existed and specifically, why and how that influenced later decisions. Even though *Rodriguez* concluded without legal advancement of assisted-dying laws in Canada, it nearly did so. The 5-4 results indicated that even in 1993, justifications for assisted-dying, only on the basis of the Carter case, were very apparent. The advocacy that underpinned the four justices who voted in agreement with the appellant was strongly reflected in the court case, as seen in the presence of terms used to advocate for legal advancement. Such a close result and clear reasoning only required broader social shifts, reflected in the Supreme Court, to ultimately legalize assisted-dying, as seen in Carter, which proved this with an unanimous result. This discussion can be taken further to consider how the charter and judicial review shapes social values while also responding to society's views. In Miriam Smith's article, "Ghosts of the Judicial Committee of the Privy Council," [11] Smith theorizes that the court must be sensitive and react to public opinion to protect its legitimacy. Moreover, Smith draws on JR Mallory's analysis of the pre-Supreme Court Judicial Committee of the Privy Council, who wrote that while "the courts are slow to adapt to social change," "the advantage of this relative languor is that it permits public opinion to crystallize." This thinking can be applied to the Supreme Court to explain how it does not act to shape society pre-emptively but instead waits for public opinion to change before permanently codifying laws. This theory is epitomized in the case of assisted dying. While there was a strong enough Charter basis to justify assisted dying in 1993, it would have been unlikely that such a law would have been reflected in broader Canadian society. However, it can be presumed that social opinion slowly shifted, until a point in 2010, when 63% of Canadians generally supported legalizing euthanasia, according to a poll by the Angus Reid Institute [12]. Five years later, in *Carter*, such a preference was established in law. This speaks to the pattern of correspondence between social opinion and law and explains the progression of assisted-dying laws in Canada from Rodriguez to Carter. This discussion can be increased in depth by zooming in on *Truchon*. *Truchon* was fascinating as it occurred in a Quebec court, meaning that it did not have to represent the nation in the same way a Supreme Court ruling would. However, the case's results ultimately spread beyond Quebec, as the federal government chose to create a bill to reflect the precedent established in *Truchon* – despite not needing to [5, p. 29]. The key issue with establishing federal law based on a provincial court is rooted in the potential that the values of the two jurisdictions will conflict. This is especially relevant for Quebec, which, in the same Angus Reid poll, was the Canadian province with the highest level of support for legalizing euthanasia, at 78% of respondents. This preference was apparent in other questions in the poll as well, such as if a person who helps another individual commit suicide should not be prosecuted (56%) or if it is okay for a

parent to euthanize their child who suffers from a severe condition, as seen in the 1994 case of Robert Latimer (the majority of respondents from Quebec). Such high approval is contrasted by other provinces, such as Alberta, which offered the lowest amount of support for assisted dying, and the nation, with almost half of respondents from across Canada disagreeing with Latimer's act of euthanizing his daughter. With such a difference in social values, unique to a province, it becomes considerably dangerous to base federal law on a province's court, which rightfully exists to serve its jurisdiction but cannot be taken at face value for the nation, which possesses a greater variety of values.

Comparative Analysis & Data Review

Beyond the substantial data unique to Canada that can be used to analyze the effectiveness of the nation's assisted-dying laws, there are frameworks around the world which can be compared to each other to highlight the advantages and disadvantages of various approaches to MAID. Comparing such variations in approach along with government data can be integral to drawing out conclusions pertaining to which approach, with culture and circumstance considered, is the best at balancing autonomy with the protection of the vulnerable. This paper's analysis will consider three jurisdictions: Canada, California and Belgium. These regions were chosen because they rest on different places on the spectrum of permissiveness. Belgium was the second country to legalize euthanasia, only after the Netherlands, in 2001, and has been said to have "the world's most liberal euthanasia law," [13] with terminal illness not being a requirement and requests from minors, advance directives, and requests with mental illness being the sole condition permitted. California, on the other hand, represents a restrictive approach to assisted death, with the 2015 ABX2-12 End of Life Option Act limiting assisted death to individuals whose deaths are foreseeable within six months [14]. Canada rests between these two jurisdictions, as it does not require terminal illness for applicants but does not currently allow MAID for the mentally ill, minors, or those interested in advance directives (with the only similar, but fundamentally different, policy being the Waiver of Consent). With Canada between California and Belgium in terms of permissiveness, comparing the three countries can grant valuable insight into what legal approach to MAID yields the best results – information which can be used to synthesize policy recommendations.

This analysis will begin with comparisons of the legal approaches to MAID in California, Canada, and Belgium, followed by a summary of the key differences between them. This will serve to highlight which jurisdiction emphasizes autonomy through permissiveness and which emphasizes protection through restriction. The second part of the study involves analyzing the government reports reviewing statistics related to assisted dying in each jurisdiction, to consider how the vulnerable are protected, as revealed by demographic trends, the quality of oversight, and the range and depth of safeguards. The study will conclude by defining lessons regarding the implementation of MAID for Canada and other jurisdictions and attempt to respond to the question of which country promotes the best balance between autonomy and protection.

Comparison of Assisted-Dying Laws of California, Canada and Belgium (Appendix F)

The most obvious analysis to conduct at this point is to compare the permissiveness of the frameworks in California, Canada, and Belgium to determine which states prioritize autonomy and which elevate the protection of the vulnerable. From this study, it is clear that Belgium prioritizes patient autonomy the most, as is best evidenced by how it stands shoulders above the other states in its allowance of minors, advance directives, individuals with mental illness, and individuals whose deaths are not foreseeable. These aspects are the biggest differences between its approach and those of Canada and California, which emphasize caution through prohibitions for the mentally ill and minors. On the other end of the spectrum is California, which has the most restrictive framework, only permitting physician-assisted suicide – and not euthanasia - to those whose natural deaths will occur within 6 months. A key question at this point is: is it reasonable to label Belgium and California as the least and most concerned with the vulnerable, respectively, because of the permissiveness of their laws? This inquiry is important as, while permissiveness is objective and can be ranked, grading the value given to the vulnerable requires more than just the laws on their face. It requires a deeper dive into the implementation of the laws and the safeguards a state enforces, both of which are reflected in assisted-dying-related national data.

To more finely examine the balance between autonomy and protection of the vulnerable in California, Canada, and Belgium, the official annual reports on the assisted-death frameworks of the three countries will be scrutinized to gain insight into the real impacts of their various statutes. The protection of the vulnerable will be graded by (1) how effective a framework is in avoiding the creation of disproportionate negative impact on vulnerable demographics, and (2) the quality of the oversight the state enforces. As the study wishes to pinpoint Canada, and due to Canada's reports' greater depth, significant space will be allotted to analyzing key data points from Canada's framework to highlight gaps and risks and outline areas for potential improvement. Such examination will draw on Health Canada's (HC) data, analyses in the report, and observations which integrate the data into the big picture of overall effectiveness. For all three countries, their 2023 reports will be used, as that is the last year for which there are reports for Canada and California. Datapoints in each of the reports can be found in Appendix G.

Canada (Rank: 1)

Canada's report was titled, "Fifth Annual Report on Medical Assistance in Dying in Canada 2023," [15] and was published by Health Canada in December 2024. The first thing that is apparent is the report's exceptional length and depth. At 83 pages long, it is by far the longest report and is replete with various statistics related to MAID implementation, including data based on age, sex, race, medical condition, social supports, and MAID providers. Such careful and reflective consideration of the many nuances of MAID showcases the caution the Canadian government possesses and its significant interest in highlighting gaps in care. Such high oversight quality is objectively the best approach to ensuring that a jurisdiction's assisted-dying framework accurately fulfills its intended purpose to grant autonomy to patients while enabling sufficient protection for the vulnerable. Moreover, the report stands out due to its demographic data, which provides invaluable aid in the process of examining whether vulnerable populations are at higher risks of accessing MAID. Due to its length and exceptional detail, Canada's report is ranked as being of the highest quality among the three jurisdictions.

Belgium (Rank: 3)

Belgium's 2023 report came in the form of a Press Release from the Federal Commission for the Control and Evaluation of Euthanasia [16]. Composed of 5 pages, the report covers many key data points but does not note certain information which is present in other reports, such as how many requests were made for MAID besides the total number of ultimate deaths and ethnic demographic data. The report is the shortest among the three jurisdictions, which contrasts the country's level of permissiveness. Moreover, little time is spent analyzing and contextualizing the figures like Canada did. Due to its objective length and detail, it is ranked as having the report of the least quality. However, it is important to consider that unlike Canada and California, which have only introduced assisted dying relatively recently (and have recently made amendments), Belgium's laws have been in place 2002, with the only amendment for the inclusion of minors in 2014. Therefore, perhaps years of stable data have lessened the need for complex reports. Belgium's 2024 report was slightly longer at 8 pages and primarily increased its focus on examining the practitioners of MAID [17].

California (Rank: 2)

California's report was titled "California End of Life Option Act 2023 Data Report," [18] and was published by the California Department of Public Health (CDPH). At 18 pages in length, it is the second-longest report among the three jurisdictions and captures numerous facets of the assisted-dying regime in the state. Besides numerical data, it, alongside Canada, provides many graphics to visualize the data. Such effort seems more favourable in light of California's position as the most restrictive jurisdiction, as such detail indicates a solid interest by the government to properly reflect on assisted dying and enable the identification of gaps. Like Belgium, there is minimal analysis and contextualization of data. Like Canada, there is ample demographic data that provides valuable insight to trends of EOLA usage in respect to age, gender, education, and race/ethnicity. The report also describes characteristics of EOLA users, in regard to aspects like their insurance, what drugs were used, and whether the patient informed their family of their decision to access EOLA.

Analyzing Canada's "Fifth Annual Report on Medical Assistance in Dying in Canada 2023"[1]

This analysis will consider ten key parameters to highlight apparent discrepancies in access and the government's notes on them, to ultimately make conclusions about future steps for Canada's MAID framework. This analysis will be split into focusing on both Track 1 and 2, which deal with general access data (six parameters), and secondly, Track 2, to evaluate the veracity of claims that the removal of the foreseeable death clause could lead to the vulnerable prematurely accessing MAID (four parameters).

Figure 5

Category	**Figure**
Total MAID Deaths	15,343
Total # of provisions in Canada thus far	60,301
Median age	77.6 years
Track 1	14,721 (95.9%)
Track 2	622 (4.1%)
Total MAID requests	19,660
Deemed ineligible	915 (T1: 73.1%, T2: 26.9%)
Withdrawn:	496
Increase from 2022	15.8% (compared to growth from 2019-2022 of 31%)

[1] *While this report is commendable for its breadth and depth, Health Canada noted certain limitations, including the introduction of new variables for 2023, missing data due to time delays from provinces and practitioners transitioning to the new data collection framework, and the quality and reliability of self-identification data.

Age

Age-related data show no definitive signs of undermining the protection of the vulnerable.

Track 1 recipients were 75 or older (59.7%) compared to Track 2 (50.2%), while more Track 2 recipients were under 64 years (23.5%) as opposed to Track 1 (13.8%). Such statistics generally make sense as Track 1 is restricted to reasonably foreseeable deaths, which historically, results in users being more likely to be older, and Track 2 is restricted to unforeseeable deaths, which can impact all age brackets. However, this data is unable to prove that Track 2 users do not include vulnerable individuals who are more likely to experience pressure to access MAID. In other words, the alignment with the expectations regarding age are too broad to highlight. Just because more younger people are accessing Track 2, in accordance with the expectation that unforeseeable deaths will naturally be relevant for individuals from various age brackets, the fact that among these individuals, there were not vulnerable people pressured to access MAID cannot be ascertained. Moreover, while more older people accessed Track 1, in accordance with the expectation that foreseeable deaths are more relevant for the elderly, the fact that there were not vulnerable persons among these older individuals, due to loneliness [19], pressure from family and friends, or a sense of diminished value, cannot be ascertained. However, for Track 2, this concern is less of a concern than for Track 1 as in all cases (barring misapplications of policy/practitioner error in determining eligibility) a definitive motive is clear. **It is very important to note that analysts should not fall prey to the ageist strain of thinking that accessing MAID at an older age is more satisfactory because a person might be nearer to their natural death. The sin of this logic is that it relies on contextualizing the value of human life in regard to age – a type of thinking that can be horrifically applied to other traits, like ability, race, gender, etc. Therefore, in this analysis, the claim that age-related data does not show definitive signs of undermining protection is based on the expectation, according to past data and trends, that the majority of MAID users are elderly.**

Gender

Gender-related data shows no definitive signs of undermining the protection of the vulnerable.

While the gender difference between men and woman under Track 1 is minimal (51.2% vs. 48.8%), more women than men access Track 2 (58.5% vs. 41.5%) - a notable difference of 17%. However, HC remedies this concern by stating that these findings are consistent with general population health trends as women are more likely to experience long-term chronic conditions that cause prolonged suffering but do not usually cause a foreseeable death, which best fits under Track 1, while men experience higher rates of conditions like heart disease and cancer, which do create foreseeable deaths, which best fits in Track 2.

Requests Deemed Ineligible

Ineligibility-related data shows no definitive signs of undermining the protection of the vulnerable.

Ineligibility data is very valuable as it provides insight into whether current policies properly respond to the guarantee that individuals who are fundamentally ineligible for MAID will request to access it. In 2023, out of 19,660 requests, 915, or 4.65%, were deemed ineligible. Moreover, although Track 2 requests make up 4.1% of all MAID cases, they account for 23.9% of the total ineligible requests. These two figures, along with HC's note that the findings may underrepresent ineligible requests, show that, at the minimum, policy and practitioners are aligned to combat ineligible access. Also evident is an apparent prioritization of policy and the resultant protection of potentially vulnerable groups over autonomy, as evidenced by Track 2 experiencing higher rejections, which is expected given its more extensive eligibility criteria and the inherent risk of permitting individuals with unforeseeable deaths to access MAID. However, as noted in other analyses, there always exists the possibility that, despite positive overall trends which speak to the general strength of policy, vulnerable people may be accessing MAID unjustifiably. Therefore, while this data shows no definitive signs of undermining the protection of the vulnerable, there is always room for improving methodologies such as data collection to optimize the protection of the vulnerable.

Duration of Illness

Illness duration-related data shows some signs of undermining the protection of the vulnerable.

Illness duration-related data is also insightful as it can speak to whether a reasonable amount of time has passed before MAID is accessed. While this is not directly related to policy, as Track 1 applicants can access MAID 10 days after approval and Track 2 applicants have to wait 90 days [1], considering the duration ranges during which individuals access MAID can offer telling revelations. Namely, it can speak about general attitudes towards the convenience and feasibility of MAID and if there is truly a risk that easy access to MAID can lead vulnerable individuals to view it as an easy way out of potential suffering and to satisfy ableist societal expectations that dim the value of the sick and result in resorting to MAID prematurely – an argument heavily discussed in a letter to the Government of Canada from the United Nations' Special Rapporteurs on the rights of persons with disabilities and on extreme poverty and human rights and the Independent Expert on the enjoyment of all human rights by older persons [20]. As expected, the majority (41.4%) of Track 1 recipients lived for less than 1 year with a serious incurable illness. However, the key issue here lies in Track 2, which lacks the natural

safeguard of requiring foreseeable death. 36% of Track 2 users accessed MAID between 1 and less than 5 years of their illness, while the second largest bracket, at 31%, were ill for over 10 years. 4.4% accessed MAID under a year. These figures may seem very positive by how they appear to show that the vast majority of Track 2 users wait for a significant time before accessing MAID, pointing to sentiment that prioritizes living for as long as possible and rejecting MAID as an immediate option. However, it is imperative to consider the fact that Track 2 became law in 2021. Therefore, the many individuals who accessed MAID seemingly after numerous years may have only waited for such time because such an option was not available when they had desired it earlier. Thus, the significant number of long-term ill individuals makes sense, as they would make up the majority of potential MAID seekers. Moreover, the 2023 report is the first to report on duration of illness, with the closest the 2021 and 2022 reports came to such an indicator was concerning the duration of provisions of palliative and disability support services to MAID recipients. If such data were collected, the number of Track 2 deaths within a year could be considered to determine whether they increased, which would clearly speak to the increasing danger of recently disabled/ill individuals accessing MAID prematurely. Ultimately, determining whether illness duration-related data definitively shows the undermining of the protection of the vulnerable requires more years of data, which would reveal trends that speak to whether MAID is being sought by recently-disabled/ill individuals. Thus, the most feasible recommendation is to ensure that reporting captures such statistics accurately – a suggestion HC has already implemented as of the 2023 report, giving analysts the chance to evaluate pressing concerns. Nonetheless, 4.4% of Track 2 recipients were ill for less than 1 year. Ultimately, the law should ensure that every human life is sufficiently protected, and there certainly exists the risk that some of the 4.4% did access MAID for various concerning reasons, including belief in ableist stereotypes or pressure from others, despite the potential for a life worth living.

Nature of Suffering

Nature of suffering-related data shows some signs of undermining the protection of the vulnerable.

Nature of suffering data reports on the sources of suffering for MAID recipients reported by medical practitioners. For both Track 1 and Track 2 recipients, the most substantial natures were the loss of ability to engage in meaningful activities (T1: 95.5%, T2: 96.3%), a loss of ability to perform activities of daily living (87.3%, 83.1%), and a loss of dignity (64.9%, 70.4%) – continuing trends noticed from past reports. However, it is imperative to zoom in, specifically on the experience of Track 2 recipients, to determine the manifestations of risks. To do this, natures experienced more by Track 2 users were noted, and the percentage difference between the two for the selected categories was determined. This analysis was meant to determine which natures Track 2 users suffered more disproportionately from, which might highlight major differences in experience and risks in implementation.

Figure 6

Nature of Suffering	Track 1 (%)	Track 2 (%)	Difference (%)
Other	3.6	4.8	1.2
Isolation or loneliness	21.1	47.1	26
Perceived burden on family, friends or caregivers	45.1	49.2	4.1
Inadequate pain control	54.4	58.5	4.1
Loss of dignity	64.9	70.4	5.5
Loss of ability to engage in meaningful activities	95.5	96.3	0.8

Concerningly, the natures which Track 2 users suffered most from were experiences raised in literature against the expansion of the law to unforeseeable deaths, namely, experiences greatly dependent on negative mental outlooks, circumstances, and absent supports, such as the perceptions of being a burden on others, inadequately controlling pain, loneliness, and a loss of dignity [21]. Of these natures, by far, the largest difference was seen in isolation and loneliness, speaking to the weight of the fear rooted in lacking human connection, and more generally to the weight of mental suffering, beyond physical suffering. While this may be seen as a universal fear, the fact that it exists at under half the rate for Track 1 recipients highlights it as a critical issue for Track 2 users. The prevalence of such isolation and loneliness speaks against the notion that MAID is purely being accessed to relieve individuals from irremediable pain but points out how such a choice is rooted in various connected factors that one's disability may contribute to, but which can be responded to effectively via other means to alleviate its effects and permit a tolerable life. If isolation and loneliness are the frontrunners among the natures of suffering for those with unforeseeable deaths, health experts and policy makers should consider how such characteristics can be responded to, to ultimately reduce the number of individuals seeking MAID, and not allow individuals to access death as a solution to problems not necessarily mandating death. Moreover, the government can also find ways to address the other leading natures, including inadequate pain control and loss of dignity, to decrease the number of individuals seeking MAID. For both these challenges, the government could consider expanding access to personal support workers, long-term care homes, and disability support services, along with ramping up disability-specific mental health services and enhancing disability-focused community initiatives. Ultimately, such actions will hit the heart of the problem: social determinants that unnecessarily contribute to the consideration of MAID, instead of providing an endgame measure to pre- and mid-game obstacles [22].

Indigenous Peoples

Indigenous peoples-related data shows no definitive signs of undermining the protection of the vulnerable.

Key to an issue with as many nuanced risks as MAID is the consideration of certain minority groups that might suffer disproportionately from the relevant medico-legal framework. In Canada, a key demographic is the nation's Indigenous Peoples, who suffer from a lack of social determinants of health at even greater rates than the general public [23] and thus face concerns regarding the potential of MAID to inspire further harm [24]. As a high-priority concern, Indigenous peoples were present during the development of Bill C-7. However, they primarily critiqued it, with no Indigenous witness supporting the expansion of MAID through Bill C-7, an Indigenous-backed motion to avoid coercion and protect health care workers not passing in the senate, and Indigenous leaders present at a press conference born out of concern for the permission of mental illness as a sole criterion for MAID, which ultimately passed [5, p. 34]. Given the critical need to create policy that properly serves Indigenous peoples, HC noted its partnerships with Indigenous organizations and governments, as well as the conduct of knowledge exchange roundtables to gain Indigenous perspectives on MAID initiatives, which demonstrate the government's awareness of and response to this pressing need.

*To further the analysis of the weight of cases of MAID access among a demographic, the quantity of cases will be presented as a percentage of either total deaths (if known) or the demographic's population (regardless of the denominator chosen, it will remain constant for each analysis; in this case, population statistics will be utilized)
*Highlighted cells represent data that was calculated using supporting data
*For calculations involving <5, 4 is substituted as it is the upper limit of the quantity of possible individuals.
*For population insights, data from 2021 was used.

Figure 7

	Total	Track 2	% of Total	Population (as of 2021)	% of Population (in 2021)
First Nations [25]	80		0.52	1,048,405	0.00763
Métis [25]	36		0.23	624,220	0.00577
First Nations & Métis [25]	23		0.14		
Inuit [25]	<5		0.02	70,545	0.00567
First Nations, Intuit, or Métis [25]		<5	0.64 (of 622 T2 deaths)	1,743,170	0.000295
Indigenous [25]	143		0.93	1,807,250	0.00791
Caucasians [26]	~14698.59[2]		95.8	24,761,600	0.0594
East Asian (Chinese, Korean, Japanese) [26]	276.17		1.8	1,887,600	0.0146

To evaluate data regarding MAID usage among Indigenous peoples, such data was contextualized by determining the percentage of MAID usage in relation to a common denominator, which optimally would be deaths per demographic but due to a lack of data, was population. Determining percentages for each statistic enables the equal comparison of demographic data, which is then used to determine whether access to MAID for a specific demographic is proportionate to their overall population. This analysis found that the rate of MAID access among all Indigenous groups was substantially lower than the two demographics noted in the report which access MAID the most – Caucasians and East Asians, 0.56% and 0.15% of which accessed MAID, respectively. This contrasts with Indigenous peoples as a whole - First Nations, Métis, and Inuit - none of which exceeded 0.008% of the overall population. Moreover, the smallest percentage in the set pertained to any First Nations, Inuit, or Métis individual who accessed Track 2 MAID. Even if the highest possible number of individuals accessed Track 2 (4, as the report only indicates this number was less than 5), 0.000295% of the Indigenous population in Canada accessed MAID when their death was not foreseeable. This by no means guarantees that Indigenous individuals who did access MAID did not do so for reasons such as lacking real community, social and family support – issues which can be solved through other means, but which, due to underservice, inspire MAID. However, these statistics show that as of now, Indigenous people are not disproportionately accessing MAID. Like every other statistic, however, HC should be careful to analyze incoming and long-

[2] Among 9619 respondents of 15343 total cases, 95.8% identified as Caucasian. This percentage was applied to the total deaths to determine a rough estimate based on the sample (0.958 x 15343 = 14698.59 (rounding will not be done until the end of the process))

term data to ensure that such statistics remain stable and do not show signs of unusual and unjustified increases, which could happen, for example, due to increased MAID access to underserved communities. Moreover, HC can also consider expanding reporting and improve reporting for Indigenous peoples to maximize scrutiny and minimize risks of abuse.

Track 2 Specific Analysis

Self-Reported Disability

Self-reported disability-related data shows no definitive signs of undermining the protection of the vulnerable.

Self-reported disability related data is critical, specifically for considering the safety of Track 2, as it reveals how many MAID users self-reported as disabled, which can be used to evaluate the veracity of the fear that Track 2 may lead to disabled individuals unjustifiably accessing MAID due to factors like the propagation of ableist perspectives, which unnecessarily inspire death instead of promoting life [27]. Of 622 Track 2 users, 360 responded to the question, 210, or 58.3%, of whom, self-reported having a disability. Such a figure speaks to concerns of observers like the United Nations' Special Rapporteurs that Bill C-7's eligibility criteria may enable accumulated disadvantages from disability to cause indirect pressure that directs disabled persons to MAID. While it is no surprise that disabled people make up the percentage they do, given that the amended framework was designed to specifically cater to individuals without foreseeable deaths, the report's data confirms the fact that disabled individuals have responded to the new law and are accessing MAID, for reasons that cannot be confirmed to be truly justified. While it may seem acceptable that the largest age bracket in this regard is individuals from 65 to 74, it must be considered that rates of disability increase with age [28], which means that it is not guaranteed that these individuals accessed MAID after many years of suffering (in which case, the risk that MAID was accessed prematurely and without proper reflection diminishes), but instead might indicate that they resorted to MAID soon after the onset of their reduction in ability due to unjustified reasons and even negative influences, such as MAID being offered to sick and vulnerable individuals in hospitals. Moreover, this is also especially relevant among younger age groups, which, although less in number, are still present, and have a greater chance of reporting to MAID unjustifiably soon because rates of disability are lower among the young. Of course, in both scenarios, there are undoubtedly individuals who perfectly fit the mould which policymakers and advocates had in mind – individuals truly suffering from a grievous medical condition for which there is no appropriate treatment. However, simultaneously, there is a chance that there are individuals who are accessing MAID not as a last resort but as one of many options that were perceived as convenient or desirable. This sparks concern as such risk appears to demand a great depth of reporting, on not just the rates of disability or what type of disability was reported, but also on whether an illness truly impedes life to the point that life should be forfeited, to ensure that the core reason for MAID is an illness that truly alters living to the point that death is the most satisfactory answer – a determination that would mandate multiple levels of review. This concern is somewhat abated as a closer review of Canada's framework shows that MAID applicants must be reviewed by two independent medical practitioners, and those interested in Track 2, must also be reviewed by an expert in the relevant condition should either of the first two practitioners lack such expertise. Moreover, while every detail in evaluations may not be made public in annual reports, reporting amendments introduced in the 2021 revisions allowed for "the collection of data on all assessments following a person's request for MAID" [1] due to how information captured in written requests resulted in an incomplete picture of who requested MAID. These facets were included in "The Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying," [29] which, in Section 4.1 captured the procedural requirements for Track 2, which extensively required the indication that key steps in the MAID process were satisfied. Given that such safeguards do exist, maximizing protection, at this point, lies primarily in either ensuring that practitioners both properly enforce safeguards and report dealings accurately or increasing safeguards, through means such as requiring review by more and/or specific practitioners, such as psychiatrists or more experts. Therefore, despite high rates of disabled people accessing Track 2 MAID, due to obvious expectations for such a pattern and substantial safeguards and reporting frameworks, it can be concluded that self-reported disability-related data shows no definitive signs of undermining the protection of the vulnerable.

Neighbourhood Income Quintiles

Neighbourhood income quintiles-related data shows some signs of undermining the protection of the vulnerable.

Considering neighbourhood income quintiles can distill extremely valuable information that can be used to determine whether MAID is being accessed disproportionately by the financially insecure, who are considered vulnerable because of how financial instability can correlate with lacking social determinants of health, like housing and employment, and reduced access to supports, increasing the risk of unjustified access to MAID [30]. This idea is further emphasized by the fact that a review of a Canadian Pension Plan Disability Benefit application takes up to 120 days [31]. To obtain this data, HC linked residential postal codes of patients to a neighbourhood-level measure of income tool – a practice that produces approximations which may include miscategorizations. The report found that users of both Track 1 and 2 had proportionally higher incomes than the reference group of all deaths in Canada, which provides a

baseline assurance that those accessing MAID are not naturally more financially insecure. To further the examination, the income quintile data has been synthesized into the following tables.

Comparing Quintile Data with All Canadian Deaths in 2023

A valuable method in determining the reasonableness of data is by comparing it to broader population data to evaluate proportionality. The first analysis conducted will compare data from Tracks 1 and 2 individually and collectively with each other and with all Canadian deaths. Visually, the report's bar graph shows that deaths among all the quintiles for Track 1 and 2 for Males, Females, and both, and Canadian deaths are generally equal. Empirical analysis confirms this. Figure 8 shows the difference between percentages for each quintile and the percentage for all the Canadian deaths, along with averages of the differences. This table can be used to determine the ranges of percentages, to ultimately highlight any Track categories with peculiar data, which might point to potential abuse. The table reveals that quintile data is generally proportionate with denominator data, with the averages of difference ranging from 1.18% to 2.36%.

Figure 8

T1 Male	T2 Female	T1 All	T2 Male	T2 Female	T2 All	All Canadian Deaths
3.8	2.3	3	3.8	-1	1	14.8
1.3	0.4	0.8	1.9	2.6	2.3	16.7
0.8	0.2	0.5	-0.6	-0.4	-0.5	18.7
-0.4	-0.6	-0.5	-3.3	-3.3	-3.3	21.9
-5.5	-2.4	-4	-1.9	1.9	0.3	28.0
2.36	1.18	1.76	2.3	1.84	1.48	

Figure 9 conveys a similar conclusion by capturing the averages of each quintile percentage for every track category. The table also shows very close similarities between Track 1 and 2 access for both genders, and all deaths, speaking to the reasonable proportionality of the statistics. The table also reveals a fascinating detail. For quintiles 5 and 4, the average values are more than that of the denominator column, while the two columns share the same value for quintile 3, and the average values are less than that of "all deaths" for quintiles 2 and 1. This detail essentially reveals that proportionately, more people access MAID the higher their income quintile is. While this does not guarantee that individuals in any category, but specifically the poorer quintiles, are not accessing MAID due to their financial circumstances, it does show that people who are vulnerable due to finances are not accessing MAID at proportionately higher rates than more financially stable individuals.

Figure 9

Income Quintile	Average	All deaths
5	16.95	14.8
4	18.25	16.7
3	18.7	18.7
2	20	21.9
1	26.07	28.0

Figure 10 shows the differences between the percentages of each quintile for each Track. This analysis essentially reveals which Track category has the most fluctuation between each quintile, which can be informative because of how greater fluctuation might speak to peculiar experiences for individuals in that category that result in greater sensitivity to socioeconomic positions.

Figure 10

Track	Differences	Added differences
T1 M	0.6, 1.5, 2, 1	5.1
T1 F	0, 1.8, 2.4, 4.3	8.5
T1 All	0.3, 1.7, 2.2, 2.6	6.8
T2 M	0, 0.5, 0.5, 7.5	8.5
T2 F	5.5, 1, 0.3, 11.3	18.1
T2 All	3.2, 0.8, 0.4, 9.7	14.1
All deaths	1.9, 2, 3.2, 6.1	13.2

The largest added difference by far rests in the Track 2 Female category, which indicates greater rates of change between quintiles, and therefore, greater correlation between economic position and propensity to access MAID. This is highlighted in Quintile

1, which makes up the largest percentage of MAID users in the entire data set, at 29.9%. This contrasts with the highest quintile, which makes up the smallest percentage in the whole set. In essence, females with the lowest incomes access Track 2 at much greater rates, relative to the other categories, than those in the highest income bracket. This is concerning as it speaks to the possibility that financial insecurity is a contributing factor to decisions to access MAID, and the possibility that this is especially bad for women. Moreover, this finding is reflected in real-life cases, such as those of Sophia and Denise, who applied for MAID on a basis that was truly more related to social determinants of health due to low income, instead of medical decline [32].

Moreover, among all categories, females experience greater fluctuations than men (T1: 5.1 vs. 8.5; T2: 8.5 vs. 18.1), which points to the risk that female users of MAID are more greatly sensitive to precarious economic situations. This may be explained by how Canadian women have lower average personal incomes than men ($48,000 vs. 66,000 in 2022) [33] – a trend that might speak to why women appear to be more sensitive to negative financial circumstances.

Furthermore, Tracks 1 and 2 can also be compared, specifically to evaluate the thesis that Track 2 can be accessed by individuals on grounds other than purely medical decline. In accordance with this claim, all three Track 2 categories (Male, Female, and all) were substantially greater, individually and collectively, than Track 1 (combined 40.7 vs. 20.4). This indeed points to the possibility that greater influence is exerted by financial situations on individuals' decision to pursue Track 2 MAID, who are at a much greater risk than individuals in Track 1, as they can pursue MAID for reasons other than certain death – a safeguard which protects those in Track 1. Ultimately, the greater fluctuation for Track 2 can be seen to confirm fears around the risks created by its eligibility criteria regarding individuals accessing it for unjustified reasons prematurely. Moreover, the unique situation faced by females should raise alarms about the need to address gender-specific experiences and even possibly tailoring policy to protect demographics that show disproportionate tendencies, primarily due to external factors.

Neighbourhood Marginalization Quintiles

Neighbourhood marginalization quintiles-related data shows some signs of undermining the protection of the vulnerable.

Similar to Neighbourhood Income Quintiles, Neighbourhood Marginalization Quintiles relate MAID users to their neighbourhoods to gain insight into their socio-economic situations. This analysis focused on measuring residential instability (i.e. how many residents are renters), situational vulnerability (i.e. how many residents do not have a high school diploma), and economic dependency (i.e. how many residents are youth or seniors), and organized the data by noting the percentages of MAID recipients who fall into each quintile. Understanding this data, which speaks directly to vulnerability, can help identify gaps in policy that may permit vulnerable populations to access MAID at disproportionate rates for unjustified reasons. Regarding their findings, HC reports that in general, "people who received MAID do not disproportionately come from lower-income or disadvantaged communities" [15]. HC notes that Track 1 recipients lived in less or similarly marginalized neighbourhoods in comparison to the reference group of all Canadian groups by all three measures. Track 2 followed a similar suit, living in less marginalized neighbourhoods than the reference group for the categories of "economic dependency" and situational vulnerability." However, "residential instability" was not just less or equal but was significantly more top quintile-heavy than the other categories. Due to this section posing the most potential for impactful analysis, this study will focus on analyzing it.

Figure 11[3]

	Economic Dependency		Residential Instability		Situational Vulnerability	
Income Quintile	Average (T1, T2)	All deaths	Average (T1, T2)	All deaths	Average (T1, T2)	All deaths
5	8.4	30.6	34.75	27.8	15.5	20.5
4	18.35	20.9	21.9	22.5	17.9	19.7
3	21.9	18.4	18.3	19	19.75	19.7
2	25.8	16	14.3	16.7	20.4	19
1	25.5	14	10.75	13.9	26.45	21.1

Figure 11 captures the average Track 1 and 2 percentage values for each quintile for each category, to highlight telling trends. The clearest pattern that portrays Residential Instability as peculiar is its decrease from Quintile 5 to 1, as opposed to the increases from 5 to 1 for Economic Dependency and Situational Vulnerability. This is important as Quintile 5 represents the most deprived state, which means that an increase away from it means that the least amount of MAID recipients are in that category, forming the grounds for the general, reassuring conclusion that the most vulnerable are not disproportionately accessing MAID. Therefore, Residential Instability's trend is concerning, especially as, not only is it the largest bracket of MAID users, but its Quintile 5 percentage value is the highest in

[3] While calculating differences for income quintiles involved subtracting higher bar percentages from lower ones, this calculation will subtract the lower bar from the higher, as bars increase upward in size.

the entire data set at 34.75%, which reveals a potentially hazardous gap in policy and/or implementation that is allowing such a distinctive divergence from typical trends. Moreover, it should be noted that this size applies to both Track 1 and 2, with Track 1's value being the largest of its kind, and Track 2's value being the largest value across quintile and category, at an unparalleled 39.7%. This shows that such a correlation applies to both Tracks, highlighting the need for further exploration to evaluate actual safety. Ultimately, such a variation poses the risk that residential instability is a contributing factor to individuals' accessing of MAID – a claim fortified by real-life cases like that of Denise and Sophia, for whom a lack of accommodating housing may have been influential in their decisions to apply for MAID. Such a possibility shows the brazen failing of policy to protect individuals to may try to access MAID on grounds other than purely medical decline.

Like Figure 11, Figure 12 shows the differences between the percentages of each quintile for each Track, along with the total difference. This analysis reveals which Track experienced the most inter-quintile fluctuation, which can speak to whether individuals are more sensitive to their residential instability.

Figure 12

	Economic Dependency			Residential Instability			Situational Vulnerability		
Track	Differences in % Between Quintiles	Range	Added differences	Differences in % Between Quintiles	Range	Added differences	Differences in % Between Quintiles	Range	Added differences
T1	7, 5.6, 2.2, 1.2	5.8	16	7.5, 3.2, 2.6, 4.2	4.9	17.5	3.6, 1.1, 2.5, 5.8	4.7	13
T2	12.9, 1.5, 5.6, 0.6	12.3	20.6	18.2, 4, 5.4, 2.9	15.3	30.5	1.2, 2.6, 1.2, 6.3	5.1	11.3
All deaths	9.7, 2.5, 2.4, 2	7.7	16.6	5.3, 3.5, 2.3, 2.8	3	13.9	0.8, 0, 0.7, 2.1	2.1	3.6

The most telling values on this table are the "range" and "added differences" values, with "range" being the difference between the smallest and largest differences and "added differences" being the sum of the differences. Ultimately, both values are intended to reveal the level of fluctuation between quintiles. Small differences in this respect imply stability, proportionality, and equality among the quintiles, while large differences indicate greater inequality, which points to potential underlying issues that result in the correlation of facets like housing or finances with MAID access. On this table, the first things to notice in the figure are how 5 of 6 of the largest "range" and "added differences" values occur under Track 2, which fortifies claims about the risks of permitting MAID access for unforeseeable deaths due to how individuals may access MAID on those grounds without truly basing their decision on their health.

Moreover, the largest range and added differences values belong to Track 2 under the Residential Instability category, at 15.3 and 30.5, respectively – values that are the largest among their counterparts. With dominance in both range and added differences, it can be noted that Track 2 is unstable in both the difference between the largest and smallest quintile and in terms of how uneven the distribution among quintiles is. To go further in the analysis, the core of such volatile distribution should be considered; the weight of the 5th quintile. Boasting the first and third largest values in the entire graph, there is evidence to the claim that MAID is being disproportionately accessed by individuals who suffer the most deprivation in terms of residential instability. As noted before, this implies that housing concerns may lead individuals to seek out MAID, which emphasizes a lacking in policy/implementation to ensure that users are justifiably eligible for MAID. Just as in the Income Quintile recommendations, a salient suggestion is to further study, report, and alter laws in regards to correlations between residential instability and MAID to understand whether such determinants are truly influencing individuals in their decisions to seek out MAID.

Place of Residence

Place of residence-related data shows some signs of undermining the protection of the vulnerable.

While its importance may not appear salient at first, understanding the living circumstances of MAID users can shed light on the correlation, and possibly, the role, of social isolation and loneliness with MAID access. 83.7% and 75% of Track 1 and 2 users were reported as living in private residences, which is the section on which this study will focus. Among Track 1, the majority of users in private residences lived with others, which included family (45.9%), non-relatives (1.4%), and relatives (2.3%). This trend does not continue into Track 2, however, where the largest group was composed of users who lived alone (35.7), which was closely followed by those who lived with family (32.8%). While living alone does not guarantee loneliness or its impact in inspiring MAID access, such a high rate of individuals living alone highlights the risk of correlation. This risk is highlighted when considering that such high values are not proportionate to the 15% of adults aged 15 and older who lived in private households in 2021 in Canada [34]. Potential

recommendations in regard to a risk like this are the same as aforementioned suggestions, namely strengthening the evaluation process through steps like increasing the number of medical practitioner reviewers and vetting applicants to ensure that the only reason for interest in MAID is medical decline.

Comparative Analysis

Comparing Canada, Belgium, and California will involve considering key assisted-dying statistics from each of the three jurisdictions, except for the figures which are not available (namely, from Belgium's report). This comparison will consider if the figures are similar among the countries, and if not, will seek to develop an answer using contextual societal and cultural information, or highlight a key gap in the framework, along with recommendations.[4]

Figure 13

	Total requests/ prescriptions	Total deaths	Total Deaths since inception	Percentage of total national deaths	Inc. from 2022	Median age	Caucasian	Percentage of Caucasians	Male v female
Canada	19,660	15,343	60301	4.7% (326571)	15.8	77.6	95.8	61.75% (2021)	51.2/48.8
California [18]	1,272	884	4287	0.3% (290511)	0.67% decrease	78	85.4	34.09% (PD from 2023) [36]	50.1/49.9
Belgium [16]	N/A	3,423	N/A	3.1% (111,255) [35]	15%	70-79		≥83.7%	48.6/51.4

Figure 14

	Foreseeable	Unforeseeable	Advanced directives	Minors	Psychiatric
Canada	95.9% (14721)	4.1% (622)	0	0	0
Belgium	79.2% (2710)	20.8% (713)	0.6% (19)	0.029% (1)	1.4% (48)
California	100%	0%	0	0	0

Demographic Data

Gender: Differences in gender, for all jurisdictions, show no considerable risk, as, notwithstanding finer details such as Track 1 and 2, which are only relevant for Canada, men and women access MAID at virtually the same rate in Canada, Belgium, and California. This broadly speaks to the abilities of the frameworks of all jurisdictions to not directly cause one gender to access MAID at a disproportionate or unjustifiable rate.

Ethnicity: For both Canada and California, which provided ethnicity data in their reports, Caucasians make up the vast majority of MAID users, at 95.8% and 85.4%. To contextualize such figures, Figure 13 includes the percentage that Caucasians make up in the jurisdiction. For both Canada and California, Caucasians make up a disproportionate amount of MAID users relative to their presence in the broader population. Such disproportionality demands investigation into why one race/ethnicity dominates assisted dying. To answer this question dives into a complex exploration that greatly goes beyond the scope of this paper. However, one potential explanation can be derived from the study of inequalities in health of racialized adults. In a 2022 report published by Health Canada [37], out of the four categories which compared the health of 7 ethnic groups (Black, East/Southeast Asian, South Asian, Arab/West Asian, Latin America, All Racialized Populations, White), White Canadians received the highest scores. In essence, Caucasians perform among the very best in terms of health, which may be inferred to speak to higher access to healthcare and connectedness to the healthcare system. Such a trend can speak to a greater relationship among Caucasians with the healthcare system, which may lead to them having more trust in and being more inclined to engage in medical provisions such as MAID. This theory can be supported by a 2022 study, which conducted an empirical analysis of patient-related factors affecting trust in physicians in China and found that people diagnosed with chronic diseases indicate lower levels of trust in physicians; higher perceived quality of services improves trust; and

[4] Note: As California has different steps for individuals seeking MAID, namely the ability for individuals to obtain lethal medication long before its consumption, their application in this methodology needs to be clarified. In this comparison, all individuals who died due to assisted-dying (and who may have obtained such medication before 2023) will be included, and not just those who requested and used lethal medication in 2023.

socioeconomically disadvantaged population groups are less likely to trust physicians [38]. A 2018 study which focused on Korean adults found that stress and low self-rated health were associated with lower trust and that recent hospitalization was positively associated with trust in physicians. Both these studies point to how generally, greater overall health can be associated with higher trust, which might allow for someone interested in MAID to explore their options [39]. Moreover, the second noted finding regarding the impacts of recent hospitalization spark interest in expanding the study to consider if stronger health-care systems (both in regard to access and quality of service) correlate with increased MAID access. On its face, this correlation explain Canada's high access rate given that MAID is covered by provincial healthcare plans [40].

*1 indicates the best score, even if the original graph correlates the lower number with a negative performance.

LA: Latin American; W: White; E/SA: East/Southeast Asian; B: Black; SA: South Asia; A/WA: Arab/West Asian; ARP: All Racialized Populations

Figure 15

Category (Adults, 18+ Years)	1	2	3	4	5	6	7
Diabetes by Racialized group	LA	W	E/SA	ARP	A/WA	B	SA
Perceived Excellent/Good Mental Health by Racialized Group	B	W	SA / LA	ARP	E/SA	A/WA	
Average to High Life Satisfaction by Racialized Group	LA	W	E/SA	ARP	B / SA	A/WA	
Moderate to Severe food Insecurity by Racialized Group	E/SA	W	SA	ARP	A/WA	LA	B
Rankings	W (8)	LA (11)	E/SA (12)	ARP (16)	SA (18)	B (19)	A/WA (22)

Belgium's decision to not include such information might be explained by considering that the country's ethnic/racial diversity is substantially lower than that of Canada and California, with the leading ethnic groups being Belgian (75.2%), Italian (4.1%), Moroccan (3.7%) and French (2.4%) [41]. With such ethnic distributions, the vast majority of users would have likely been Caucasian, and due to general homogeneity, the government most likely did not find it imperative to include ethnicity-related data.

Median Age: In all three jurisdictions, MAID users have an average age in the 70s, with both Canada and California's statistics being 0.4 away from each other. Such equality between the jurisdictions is very positive as it indicates that MAID is being accessed according to medical expectations and prior trends which are universal across the jurisdictions. This equality is also very intriguing as it exists despite the varying levels of permissiveness between the three jurisdictions. California, which only allows MAID for individuals whose death is foreseeable has a median age of 78, while Canada, which allows MAID for both the foreseeable and foreseeable death tracks, has a median age of 77.6. Belgium, which is the least restrictive, and allows MAID for the unforeseeable, foreseeable, cases with only psychiatric conditions, and minors, has a median age in the range of 70-79. Ultimately, such similarities in age, despite differing policies, show that it is possible that permissive policies do not result in abuses of MAID which directly translate to younger individuals accessing MAID prematurely (however, this may be rooted in other causes, namely differing, jurisdiction-specific attitudes towards assisted dying). This, of course, does not speak to policies' ability to protect the vulnerable in other respects, like socioeconomic background. Moreover, it is critical to note that such similarity might be indicative of the lack of protection for the elderly, who may be more prone to coercion to access MAID due to loneliness and social pressure, among other factors. Ultimately, a review of Median Age shows no definitive signs of concern.

Percentage of Total National Deaths: This figure is extremely important as it contextualizes the number of deaths in relation to all deaths, offering a succinct view of the prevalence of MAID in each jurisdiction. Canada leads the pack, with MAID deaths composing 4.7% of all deaths. Following is Belgium, with 3.1%, and California with 0.3%. This category contains much more variation than age, as it indicates that there is a clear correlation between restrictiveness and the rate of MAID deaths. If California's figure, which corresponds to only permitting foreseeable deaths, is treated as the standard for protection of the vulnerable, Canada and Belgium are lacking. However, through the lens of personal autonomy, California would be cast as the weakest jurisdiction, while Canada and Belgium, whose higher MAID percentages reflect the state's permitting of consenting and free individuals to make decisions about their health, would be exalted. Moreover, it is peculiar that Canada, despite having slightly more restrictive laws than Belgium, has a rate that is 1.6 points higher than Belgium's. This might speak to social and cultural norms and attitudes concerning assisted dying, which in Canada are positive [42], which lead to higher numbers of individuals accessing MAID through the paths available. This claim, and the idea of the variable of social and cultural norms can be validated by considering Canada's MAID data from 2020, when Bill C-14 was enforced which only permitted foreseeable deaths. In that year, there were 7,595 cases of MAID, which accounted for 2.5% of all deaths in the nation [43]. While this indicates a significant difference between the rate of 2020 and 2023, of nearly two times, it should be noted

that such a difference occurred over 3 years. While this rate of growth corresponds with the development of Bill C-7 and accumulating years, 2023's 15,343 deaths is a significant increase from 2016's 1,018 deaths under the original regime – a fifteenfold increase. Interestingly, here is where numerous concerns regarding MAID are manifested. Within six years of legalization, deaths in Belgium, Switzerland, and the Netherlands increased by 3.4, 1.5, and 1.4 times [44] – compared to the 13 times during Canada's first six-years. Furthermore, as of 2023, MAID is the fourth leading cause of death in Canada (after cancer, heart disease and accidents) [45]. Moreover, the Netherlands attained 3% of total deaths 11 years after legalization, while Belgium required 21 years – a feat accomplished by Canada in 6 six years, in 2022. Moreover, a glaring misstep in the policy can be seen in Health Canada's 2022 prediction that Canada would reach the 4% mark in 2033 – 11 years off from the actual year of 2022. Such rapid developments can be explained by considering that the regimes of Belgium and the Netherlands opened 14 years before Canada, which meant that Canada's legalization happened in a time when more people were ready and interested in accessing MAID. In the big picture, however, such high figures are undoubtedly concerning and can point to cultural attitudes towards MAID that encourage access and result in unjustifiable deaths. However, this concern is abated to some extent when we consider that of all the MAID deaths, 95.9% were for those with foreseeable deaths, which means they almost definitely were justified due to the natural safeguard of foreseeability (save practitioner errors). Ultimately, understanding this situation requires answering 3 inquiries: is personal autonomy or the protection of the vulnerable more valuable; is Canada's permitting of individuals with unforeseeable deaths satisfactory; and are the policies in place to vet individuals enough to filter effectively? The first question is perhaps the most important as it defines the rest of the discussion as either fundamentally acceptable or unacceptable, as a society that values personal autonomy can justifiably grant increased access, while a country prioritizing protection can rightfully limit access. Moreover, while the first question may challenge the paper's notion that a balance is possible, it is important to understand that, in the practical sense, countries may be forced to decide between the two because the selection of one naturally limits the other. The key variable in this situation is a society's culture, which can create social notions that discourage cases of unjustified or questionable access to MAID, naturally protecting the vulnerable.

Increase from 2022: This figure is relevant as the comparison of data from the three jurisdictions best indicates a clear correlation between restrictiveness and the growth of MAID usage. Both Canada and Belgium, which are much more permissive than California, saw increases of around 15%, while California only saw an increase of 0.3% - a drastic difference. If protection of vulnerable people was the primary goal, California wins this category easily, as such a small increase is a testament to how the policy limits MAID access to purely medical decline. It is also interesting to note that Belgium saw an increase equal to that of Canada despite having assisted-dying laws for over 20 years, while Canada is in its 7th year of legalization.

Belgium Data Analysis

Data from Belgium's assisted-dying framework is especially intriguing given the many permissions it grants to individuals, including those with unforeseeable deaths, those interested in advance directives, minors, and individuals with solely psychiatric conditions. California can only be compared with Belgium in the category of foreseeable deaths, while Canada can be compared regarding foreseeable and unforeseeable deaths. This analysis is less about comparing countries, given Belgium's solitary stance on most aspects, but more about evaluating the presence or absence of natural, society-bred protections which either lead to greater or lesser usage of these unique provisions.

Unforeseeable Death: The first point to analyze is the employment of assisted dying by individuals whose deaths are not foreseeable, which is over 5 times higher than that of Canada. This can be cross-referenced with data from 2003 and 2013, which had rates of 93.9% and 84.1% respectively [46]. This shows a decreasing rate of increasing access to MAID among individuals with unforeseeable deaths, indicating what could be a stabilization. Interestingly, within one year of Belgium's regime, 6.1% of all MAID deaths were for the unforeseeable, while Canada is at 4.1% after 7 years. This difference highlights a clear difference in some level or variable between the two countries, specifically regarding individuals' willingness to access MAID for non-terminal conditions. This also reflects the respective countries' internal conflicts regarding MAID access – while Belgium published its framework with little opposition, Canada's journey was marked by constant questioning, especially when the nation attempted to legalize Bill C-7.

Advance Directives, Minors, Psychiatric Conditions: While some of these permissions would invite considerable debate and opposition in other countries, like Canada, Belgium passed the allowance of Advance Directives and Psychiatric conditions in its original 2002 law, which was followed by a lone amendment which permitted minors to access MAID. The goal here is to determine whether such permissions, which naturally invite substantial risk, actually witness the manifestation of those risks, or if the only safeguard available – social notions – can protect them. Generally, it appears that access through all these pathways is very minimal relative to the bigger set of MAID users. This is especially true for the Minors path, which one individual accessed and the advanced directive path, which 19 employed. Such figures appear reasonable given the size of the bigger pool and the history of assisted-dying in the country. A more significant concern lies in the psychiatric condition track, which 48, or 1.4% of all users, accessed. This figure is concerning due to the arguments posed by numerous individuals regarding the access of assisted dying on the sole basis of mental illness.

Returning the idea of social notions, it is very interesting to see how while in Canada, the rate of MAID and its growth as a whole is much higher than that of Belgium, MAID usage for unforeseeable deaths is considerably larger, in terms of both size and historical growth in Belgium. In any culture, social notions can act as both safeguards and instigators of personal choice. In Canada, where greater risk lies in unforeseeable deaths, it appears social notion has limited access to that Track. However, in Belgium, it appears access for unforeseeable deaths has stabilized at around 20%, while social notions greatly limit access to assisted dying for minors, the psychiatrically afflicted, and through the processes of advance directives.

Discussion

When looking back on this study, perhaps the most important aspect of properly implementing a MAID regime (or any policy framework for a key medico-legal issue) is oversight and reporting. Ultimately, one cannot speak on which direction a country's policy should go without considering their unique social and cultural setting, which ties to how they prioritize personal autonomy and protection of the vulnerable. However, what can be reflected on is the extent to which a country satisfies its own idea of what a regime should look like, which is best done by constantly analyzing data concerning implementation and access to identify gaps, weaknesses, and potential areas for improvement. Canada has truly shone in this regard, as its quality of oversight is exceptional and speaks to HC's conscientiousness and caution – traits which are imperative in Canada's pursuit of a balance between autonomy and protection. Canada's report exemplified quality oversight by its consideration of nuances which go beyond the data's surface and get at the heart of who is accessing MAID and why, through statistics like the neighbourhood income and marginalization quintiles. Such explorations contextualize data and is necessary to identify weaknesses in policy, especially pertaining to issues relevant for vulnerable demographics. Such an approach should be adopted by Belgium, California and any other jurisdiction that has or is seeking to develop MAID regimes.

Looking Back on Canada

The analysis of Canada-specific data revealed two notable weak points, which lack clear explanations and demand further exploration. In the neighbourhood income quintile, it was apparent that females were more sensitive to financial situations, especially in Track 2. Moreover, in the neighbourhood marginalization quintile, it appears that there is a correlation between increased residential stability and access to MAID, again, especially in Track 2. Moreover, the study also revealed risks associated with duration of illness and the natures of suffering, which spoke to the possibilities that attitudes towards MAID are leading more individuals to treating MAID as an initial response to illness, and that individuals may be accessing MAID based on natures of suffering that can associate more strongly with secondary characteristics of illness, resulting in MAID being accessed unjustifiably. These concerns are very relevant given their involvement with vulnerable populations and mandate HC and other stakeholders to investigate such findings to evaluate whether vulnerable individuals are truly lacking the protection they require. It is important to note that it is only because of such in-depth oversight that such a problem could be identified, emphasizing the salience of detailed reporting.

Which country balances autonomy and protection the best?

At the beginning of this study, the place of each jurisdiction of the spectrum of both autonomy and protection was identified. However, after having now considered specific government data, there is sufficient evidence to make a more fortified judgment concerning which regime balances the two interests the best. Note: This analysis is not meant to identify which regime is objectively the best (the reason for which will be discussed in the next section); instead, it is meant to identify the country that responds positively to the largest number of facets for both interests. This analysis will be conducted by grading the rank of each jurisdiction relative to the others in terms of 8 key indicators. The scores of each jurisdiction will be summed to determine the best MAID "acrobat."

Methodology Description & Notes

Face of Laws: Judgement is given based on what laws clearly prioritize autonomy or protection, based on the explicit permissions granted.

% of National Deaths: Judgement is based on the raw % data, but also considers the figure relative to the age of the regime. In this case, Canada has both the highest % and the highest % in the shortest amount of time.

Increase in Deaths from 2022: Like the last category, judgement is based on raw date, relative to the regime's age. While Canada may have the higher raw growth, Belgium's growth is higher considering how old the regime is.

Allowance of Unforeseeable Deaths: Judgment is based on the ratio of unforeseeable and foreseeable deaths.

Further Permissions: Judgement is based on which country grants the most permissions. In this case, Canada is not tied with California as a mental illness clause, while not enforced, is still codified in law, representing a higher tier of permission than California.

	Autonomy			Protection		
Category	Canada	Belgium	California	Canada	Belgium	California

Oversight	3	1	2	3	1	2
Face of Laws	2	3	1	2	1	3
% of National Deaths	3	2	1	1	2	3
Increase in Deaths from 2022	2	3	1	2	1	3
Allowance of Unforeseeable Deaths	2	3	1	2	1	3
Further Permissions	2	3	1	2	1	3
Totals	14	15	7	12	7	17
Country Totals	Canada	25				
	Belgium	23				
	California	24				

In the final rankings, Canada takes the top spot, with 25 points, having placed first in the autonomy section and second in the protection section. California follows, having accumulated substantial points in the protection category, as expected, and Belgium comes third, having a strong autonomy performance but being edged out by Canadian dominance in certain datapoints and specifically the oversight category.

Do These Findings Reflect Expectations

These findings do indeed reflect the original expectation that Belgium prioritized autonomy the most, California prioritized protection, and Canada was in the middle. Given Canada's place on the spectrum, it appears to balance both interests the best out of the three jurisdictions. Now, however, it is incumbent to turn to the signpost at the start of this page, which refers to a philosophical question that has arisen multiple times during the comparative study: is it possible to judge which country truly has the best balance? While we can objectively comment on the quality of oversight and the quantity of MAID users, and even draw out key lessons for other jurisdictions to apply, can the countries truly be ranked on their laws? The core basis of questioning the veracity of this inquiry revolves around the simple fact that each country's laws and philosophical approaches to issues like assisted dying originate from varying social, cultural, historical, and legal contexts that served needs unique to those jurisdictions. Therefore, any country's laws could easily be the best balance between autonomy and protection *for that country and its people*. In other words, there is no one best balance – instead, the extent to which a legal approach can be judged for balance is based specifically on that country's sentiment. Therefore, Canada might not actually be the best acrobat between the three countries - each country might have laws that perfectly cater to their wants and needs. The next section will explore why the paper disagrees with the idea that such judgment can be made and will provide an explanation as to why each jurisdiction enforces a different law and approach using the idea of "social-judicial equilibrium."

Social-Judicial Equilibrium

"Social-Judicial Equilibrium[5]" is firstly based on the tenet that it is the state's responsibility to create laws which reflect the values and social climate of a jurisdiction. This idea is rooted in a legal-positivist view of law, which validates laws not based on defined morality but due to its establishment in the government, people, legislation, and customs [47]. This idea was also noted by the French Judge and political philosopher Montesquieu, who in his 1748 piece, The Spirit of Law, wrote, "Better is it to say, that the government most conformably to nature is that which best agrees with the humour and disposition of the people in whose favour it is established" [48, p. 22] This idea is relevant as it explains why the jurisdictions of Canada, California, and Belgium – which are comparable in many respects – have such varying approaches to a complex medico-legal issue like assisted-dying. Each nation has its own values and customs – and these values, which may vary in the fine details, are what inform the way the state develops and enforces laws. Therefore, the laws of two unique states cannot be compared side by side as they are both sourced from different "humours" and "dispositions." It is for this reason that this paper could not take the liberty of definitively attributing the best balance of autonomy and protection to any of the three jurisdictions. This concept can be developed further, however, by withdrawing from the expectation that laws always perfectly reflect the views and/or needs of a populace. Without such a guarantee, the alignment of a state's laws with the people's dispositions can be viewed as an equilibrium, with perfect alignment at the center of the continuum. This perfect alignment is what can be named, "social-judicial equilibrium," and getting to that point is the process a society, often through the authority of the highest power of the land, undertakes as it develops its definitive opinion on social issues. The context in which this paper will proceed is specifically focused on states which have proceeded for a certain time with a specific perspective on an issue, but, overtime, have seen shifts in opinions,

[5] This theory is somewhat similar to Talcott Parsons' sociology concept of "(Social) Equilibrium," which refers to a broader sense of equilibrium and a society's tendency to maintain a certain balance, even after disturbances [49]. However, "Social-Judicial equilibrium" refers to society's inclination, specifically through the law, to align with shifting sentiment. This occurs in the sense of a progression, as opposed to returning to a former balance.

according to developed wants and needs, which mandates re-evaluations of current laws. Examples of such states, specifically for this analysis, include Canada and the United States, which have seen similar shifts in public opinion.

Defining the Achievement of Social-Judicial Equilibrium

The process of realizing the perfect alignment of a state's laws and the populace's desires is most importantly demarcated by what can be called "action." "Action," here, is defined as any legal, political, social or cultural movement that occurs with the intention of altering or preserving a law. Examples of such movement include judicial action, such as court cases (Rodriguez v. Canada), legislative changes (Bill C-14 and C-7, U.S. Civil Rights Act), protests and demonstrations (both in-person and online) (Civil Rights Movement [50], Black Lives Matter [51], Freedom Convoy [52]), distribution of literature and popularization of relevant schools of thought, and even violence, specifically during demonstrations (Bloody Sunday during the Selma). [53] While this "action" can happen anywhere, true development ultimately occurs in the courtroom, where laws, and sometimes the state itself, as it defends standing laws, are scrutinized by the Courts. As this process unfolds, society works towards establishing a core belief – a value that is viewed by the courts as best reflecting the interests of the people and the state. This value is expected to align with the perspective of the majority of the state. It should be noted, however, that it is possible that a court, if manipulated correctly through methods like court-packing [54], may tend towards reflecting a certain viewpoint, without proper consideration of the many nuances and sides of a legal problem.

While the beginning and middle of the process towards social-judicial equilibrium might be marked by hefty action, the end of the process can be recognized by the reduction in action that is seen and a clear establishment of the newly defined value through its codification and implementation through realms of power, such as medicine, law enforcement, and education. However, for an extremely significant issue marked by heavier action – specifically today, with an exceptional diversity of strains of thought - the issue will most likely not be completely void of action as both the opponents of the newly established law, alongside proponents fighting for their causes, continue to act. This is exemplified by both the work of activists who campaign against MAID developments like mental illness and the unforeseeable death clause, and also the plaintiffs of *Truchon* who pushed for further permissions. This is also seen in the continuation of racial violence after the passage of the Civil Rights Act, which includes the assassination of Martin Luther King Jr. in 1968 [55], the 2015 Charleston church shooting [56], the 1967 Detroit Riot [57], and the 1992 Los Angeles Riots [58]. Such efforts often can result in further legal changes – as evidenced by Truchon and the 1998 Lynching of James Byrd Jr., which resulted in the passing of Hate Crime laws in Texas and the passing of the 2009 Matthew Shepard and James Byrd Jr. Hate Crimes Prevention Act by the U.S. Congress [59]. The unrest that occurs after many codifications and legal changes shows that, in some cases, true equilibrium is not possible, as there are simply too many proponents of strong opinions that cannot be reconciled. This is epitomized in the history of abortion laws in the U.S., where abortion rights were struck down by the Supreme Court in Dobbs v. Jackson Women's Health Organization (2022) [60], 49 years after the same court ruled in favour of such rights in Roe v. Wade [61]. Such a change for such a controversial issue, especially within a half-century, speaks to how equilibrium, in its purest sense, is only a theory, specifically for issues as divided as abortion in states as diverse as the United States. However, such extreme division is not universal, as states can experience varying levels of opposition for different issues during shifts in opinion and law. A state that does emerge having found its equilibrium will experience a stage of rest from action as newly-defined values are established and propagated through family, culture and education. It should be noted, however, that the case of U.S.' progression with civil rights shows that a state can achieve social-judicial equilibrium in strictly the legal sense even with certain groups against it. In that case, the laws did reflect a concept grounded in inherent, objective morality that would remain unmoved for the rest of the country's history despite opposition, as noted by later action (protests, assassinations, riots, etc.). However, as that equilibrium was founded on an ideal that lawmakers believed to be tried and true, society in the U.S. has shifted socially and culturally more and more toward that ideal, especially as that ideal was propagated through education, policy, and culture.

Furthermore, even after substantial rest, the position of social-judicial equilibrium can be altered over time. This is seen in the change of colonial-era laws and attitudes regarding a subject like gay marriage, which historically remained illegal until social shifts in opinion that led to its legalization across the provinces in the early 2000s. It is expected, however, that after action and social shifts, there is some duration of legal rest that compliments the now codified social values of the generations that saw the laws become established.

Finally, a theory regarding social-judicial equilibrium that is relevant to assisted-dying is that social values and norms that determine a state's social-judicial equilibrium can either form organic safeguards or demand artificially-created policy to protect individuals – thus allowing laws to be more permissive – as society creates its own safeguards (medical or social) - or resulting in laws needing to be more restrictive. This idea can explain why some countries have seemingly extremely permissive laws, as their society might generally tend toward the protection of life. This might explain why only one minor accessed MAID in Belgium – in other words, other potential minors may have been dissuaded by family, social values, etc. However, this theory is weak when viewed through the protectionist standpoint because of how it ultimately depends on an unstable safeguard that is not guaranteed to be universal the same way hard policy is.

Returning back to our original comparison of Canada, Belgium and California, the determination of which nation has found the best balance of autonomy and protection is a challenge because of how jurisdiction possesses its own social-judicial equilibrium – crafted by unique histories, experiences, leaders, demographics, and social interpretations. Such values translate into laws that are equally right because of how they reflect the customs of society and are, theoretically, the best balance (in theory; not guaranteed in practicality, as seen in Canada, where substantial opposition exists). Therefore, the process of determining which country has the "best balance" is actually a matter of determining which country has laws that are nearest to its social-judicial equilibrium – as that would be the point that the laws find the best balance in respect to the jurisdiction's values. Such an analysis could be conducted to determine if a country has achieved social-judicial equilibrium and predict how far a country is from obtaining equilibrium.

Conclusion

To consolidate the paper's findings, its first methodology will be discussed. The analysis of *Rodriguez, Carter, and Truchon* displays a shift in the priorities of the Courts. By employing sentiment analysis, it was discovered that *Rodriguez,* despite ultimately prioritizing protection, showed the state's strong interest in guaranteeing autonomy. Two decades later, social shifts gave way for the Court, in *Carter,* to establish autonomy as the overarching priority, giving way for *Truchon* and ultimately Bill C-7 – a legal change that can be explained by the theory of Social-Judicial Equilibrium. Such a process is demarcated by its focus on providing medical autonomy to Canadians by offering more opportunities for patients to access MAID. The sentiment analysis ultimately points to the mandate of autonomy established by the courts – an idea that defined the development of Canada's MAID regime and enabled its considerable breadth and rapid expansion. This finding can be integrated with the second methodology - the comparative analysis - to further the discussion. With new routes for MAID access came the need to establish various protections, which speak to Canada's cautious approach to minimizing unjustified access to MAID. However, an analysis of Canadian data reveals areas where socio-economic vulnerabilities may correlate with MAID access, particularly under Track 2. These areas are evidenced by the paper's findings and include the heightened sensitivity of females accessing Track 2 to low income; the apparent correlation between increased residential stability and access to Track 2 MAID; potential risk associated with short duration of illness before accessing MAID; and the disproportionate prevalence of isolation and loneliness among Track 2 recipients. All these factors point to the risk that individuals are accessing MAID for reasons other than purely medical decline, especially within Track 2, which lacks the safeguard of foreseeable death. Moreover, while the comparative analysis with California and Belgium highlights Canada as having the best-balance of autonomy and protection, it also reveals how Canada has the highest national MAID access rate and has seen substantial growth that has outpaced California and Belgium. In response to this paper's research question, these findings ultimately point to how Canada's balance of autonomy and protection is commendable, even relative to other prolific jurisdictions. Its approach to MAID has been guided by patient autonomy, while protections serve to defend against abuses. In this regard, its protections are extremely robust and are designed with protection at the core, as patients must be reviewed by multiple medical practitioners. However, there exists evidence that such protections may not be enough in certain situations, specifically regarding social inequities, as while the vulnerable may appear to receive protection from overt coercion, they may be subject to pressure inspired by variables such as a lack of social determinants, which include financial and residential instability, that may result in unjustified MAID access. This lack of support can be tied to the literature of various thinkers who pinpoint the primary risk of Canada's MAID provisions as being that individuals who lack key supports can unjustifiably access it due to their situation [62, 63, 64]. In respect to this, it can even be argued that to achieve social-judicial equilibrium, the absence of community support must be addressed, as such an approach would satisfy the concerns of opponents to legal advancements while allowing for MAID to still be accessed justifiably. At this point, the argument can be shifted back to the very ideology behind the permissions of the law: a prioritization of autonomy that makes permissiveness the baseline approach. It can be argued that this outlook, fundamentally, is flawed as it opens up MAID to individuals with unforeseeable deaths and potentially, mental illnesses. To somewhat pacify this concern, social-judicial equilibrium theory acts to situate Canada on a continuum that experiences action in the process to finding equilibrium. If society, as represented by the courts and Parliament, truly seeks such permissiveness, society will find its way to it. However, the sheer amount of literature speaking against the Bill point to the possibility that this philosophical and medical conflict will only continue until both sides can find a compromise that is marked by Charter-enforced autonomy balanced with sufficient protections – specifically for the vulnerable. Ultimately, the paper has determined that Canada's approach is founded on autonomy; that there exists evidence that vulnerable individuals are unjustifiably accessing MAID; and that Canada's laws, while progressing towards social-judicial equilibrium, have not achieved it. Thus, it can be concluded that Canada has not found a "perfect" balance of autonomy and protection (with an emphasis on "perfect" – Canada's thus far is, as noted, commendable, and this critique applies to its capability of an even better balance). In this regard, there are areas that can be addressed to better balance autonomy and protection, and to ultimately achieve a level of social-judicial equilibrium in which parties across the ideological board are satisfied. As mentioned, Canada's protections are sufficiently broad, which forces such recommendations, which exist in the scope of Bill C-7's permissiveness, to either add on or approach the question through a different angle. Based on the findings in this paper, certain avenues for improving policy include:

1. Strengthen (even further) the vetting process for MAID applicants: As of now, Track 2 applicants must be approved by at least two independent medical practitioners and an additional one should either of the original two lacks expertise in the condition at hand. To respond specifically to the possibility that individuals are accessing MAID due to other factors, such as lack of social determinants of health which subtly coerce individuals to seeking MAID, the review of even more practitioners should be mandated. This might be satisfied by requiring two experts in the condition at hand or creating a new role of a reviewer who combines expertise in medicine, sociology, and psychiatry to determine if medical decline is the only reason MAID is being considered. Such a recommendation may seem to counter the autonomy Bill C-7 rests on, but logic shows that unless the State is satisfied with offering death as the solution for individuals for whom Canadian society has not fulfilled its role to protect and provide for, the State should take every means possible to ensure individuals are protected in the MAID process. This recommendation is complimented by recommendation 2.
2. Address a key root cause of the risk that vulnerable persons may seek to unjustifiably access MAID – a lack of social determinants: This recommendation is obviously extremely broad in its scope and deals with Canada's social systems as a whole. However, it has been noted by thinkers that it is cheaper to provide MAID to non-dying people is much cheaper than making the systemic changes to ensure sufficient support is provided to such individuals for dignified living [15]. Similar strains of thinking gave rise to the idea that Canada was "euthanizing the poor" – a phrase used in a piece in The Spectator that became the most-read article of 2022 [65]. This is further highlighted in a Parliamentary budget report that estimated that the cost of administering MAID would be 5 times less than the gross reduction of healthcare costs that would be seen under the MAID regime [66]. Despite its breadth, this suggestion is meant to inspire some form of response to cases of individuals who lack key health factors like housing or employment – two concerns which are evidenced by the paper's data analysis. This can be taken to guide HC to create stronger social nets for individuals who are made eligible for MAID through an illness. In a more feasible sense, it can catalyze policy changes such as altering the procedure that allows medical practitioners to bring up MAID for patients. While on the surface, this approach may seem detrimental to the autonomy of patients who would benefit from knowing all possible medical solutions, case analysis indicates the serious pitfalls of such a method. Perhaps the most notable case is that of retired CAF corporal and Canadian Paralympian, Christine Gauthier, who, while seeking a home wheelchair ramp, was offered MAID [67]. The issue was raised to Prime Minister Justin Trudeau and Veterans Minister Lawrence MacAulay, the latter of whom revealed that there were up to five cases of Canadian military veterans being offered MAID. While MacAulay noted the government's confidence that the issue was not widespread, such an occurrence speaks to the significant risk created by allowing practitioners to raise the option MAID – specifically when interacting with patients who are especially vulnerable to accessing MAID unjustifiably. A solution to this risk can be treated as a spectrum – the most restrictive option would be prohibiting practitioners from initiating MAID discussion. However, such a blanket prohibition, according to the Charter logic in Carter, is not justified. Moreover, at least while Bill C-7 remains law, it is reasonably required that MAID is presented as an option at some point. However, a feasible option to form a safeguard might be to ensure that MAID is offered last after every other possible medical response is discussed and determined, in collaboration with a medical practitioner, to not be optimal. This would minimize the risk of the repetition of a situation like the one faced by Gauthier by allowing more relevant solutions to be discussed, which will most likely address the issue without MAID being brought up. For the vast majority of patients, their concerns will be fully addressed by the various other means available – means that are appropriate for the concerns raised, as opposed to raising MAID for a concern such a wheelchair ramp.
3. Engage heavily in research and with community leaders before permitting the accessing of MAID based on the sole underlying condition of mental illness: As this paper did not focus on the MAID nuance of the mental illness clause, it will not seek to make specific recommendations based on reasoning that is common in literature on the subject. However, it will emphasize the critical need for lawmakers to assess whether such a permission can be granted while minimizing the risk to vulnerable persons. This recommendation is justified by the paper's determination that there are correlations between Track 2 and certain vulnerabilities, namely financial and residential instability. With such evidence pertaining to Track 2, for which ample argumentation has been posed in various arenas, the need to offer even greater scrutiny for the mental illness clause is spotlighted. The pressing nature of this concern is highlighted by arguments against the clause, including the implications of framing suicide prevention as "interference" in individuals' lives, the lack of access to care by mentally ill Canadians, and the violation of the right to equal protection against premature death for the mentally ill [68].

Potential Scope Expansions & Further Research Developments

The primary research development that can be pursued to compliment this research is to develop a framework that employs indicators to determine the proximity of a jurisdiction to their social-judicial equilibrium. This would apply, for example, to Canada, Belgium, and California, which could be analyzed using the model to evaluate if their current MAID laws have reached their steady state or if there is still change that can be expected. Such a research development might rely on qualitative and quantitative indicators such as the time

since a major legislative change, the frequency of court cases, public opinion polls, the intensity and volume of public discourse (articles, academic literature, etc.), stability in data, levels of disproportionately in access rates, specifically among vulnerable populations, and the laws' reputations, at home and abroad. Moreover, a framework for grading proximity can also be established. This could be a quantity that is produced by a model that combines figures on a scale or a categorization that qualitatively grades proximity.

Moreover, another key potential research development is the conducting of a type of policy transferability test to assess the feasibility of implementing the recommendations, made in the conclusion, in Canada.

Appendices

Appendix A

In Chapter 1 of *Unravelling MAID in Canada*, Trudo Lemmens and Ramona Coelho point out the increasing popularity of the term "MAID" both in Canada and in international debates, especially by proponents of legalization or expansion, and refer to it as "controversial because it obfuscates what is involved and seems particularly inappropriate since the law expanded outside the endo-of-life context." Even in the end-of-life context, they consider the term confusing as it conflates itself with palliative care and other similar medical practices. Lemmens and Coelho also propose that "MAID" was strategically chosen to avoid comparisons with historical instances of euthanasia and the problems arising in jurisdictions where euthanasia is legal and shift away from discourse regarding the potential tension with suicide prevention. While MAID could be sufficient for the provision of C-14, which was limited to "reasonably foreseeable deaths," Coelho and Lemmens suggest a new term for the process of "ending the life of persons with decades of life left" – "medically administered death." [5, p. 13-14]

The pro-legalization and expansion non-profit Dying with Dignity add to the terminology discussion by arguing against the term "assisted suicide" on the grounds that suicide and MAID are two different experiences: suicide typically stems from untreated mental illness and is often characterized by hopelessness or trauma, while MAID is a choice, regulated by law, provided by and involving medical professionals, and can be peaceful, demarcated by intention [69]. The organization also avoids the term "euthanasia" due to its historical associations, its use by the anti-choice movement in Canada, and its use to describe the putting down of animals. Moreover, some worried that these terms were heavily stigmatizing, according to a senior counsel of the Department of Justice before the Joint Parliamentary Committee decided on using the term "MAID" [5, p. 14]. Moreover, Véronique Hivon, Quebec's minister of social services and youth protection and overseer of the province's MAID portfolio, argued that assisted suicide and euthanasia were very different from MAID, or "aide medicale à mourir," as MAID is defined and occurs in a medical context. Coelho and Lemmens attempt to undermine this claim by pointing out that such a perspective does not consider the experiences of other countries, like Belgium and the Netherlands, which provided euthanasia under legal frameworks that informed Quebec's MAID laws [5, p. 14].

Moreover, in regard to provincial and federal responsibility, while the federal MAID regime applies to the entire country, provinces and territories can introduce healthcare legislation as long as it does not conflict with the Criminal Code. Moreover, they also have the right over certain of the federal law's aspects, such as its implementation, the regulation of medical professionals, and the prosecution of violations. As of now, however, only Quebec has adopted its own legislation, in its "Act Respecting End-of Life Care" established in December 2015.

Appendix B

Grievous and irremediable medical condition: [8]

1. A serious and incurable illness, disease, or disability
2. Causing an advanced state of irreversible decline in capability
3. Causing enduring, intolerable physical or mental suffering, which cannot be relieved under conditions the person accepts
4. The individual's natural death becomes reasonably foreseeable (or RFND)

Appendix C

Bill C-7 & Canada's Current MAID Framework

At the center of the controversy around Canada's MAID framework is the legislation that formed the Government of Canada's response to *Truchon* decision: Bill C-7, "An Act to amend the Criminal Code (medical assistance in dying)" [70]. The Bill was introduced to Parliament in February 2020 by Minister of Justice and Attorney General of Canada, David Lametti [71], and first passed in the House of Commons on December 10, 2021, with 213-106 votes in favour, with the majority of Conservatives and a few dissenting Liberals voting against it, while the NDP, Green, and the Bloc Québecois unanimously voted for it. The Bill then rose to the Senate, which held more extensive hearings than the House, especially as the argument arose that excluding MAID for the mentally ill was discriminatory. After back-and-forth discourse between Parliament and the Senate, various amendments, and a vote in the House on post-Senate changes, the Bill passed in the Senate, receiving royal assent on March 17, 2021. This version of the Bill included a sunset clause of twenty-four months before the mental illness eligibility was a criterion, for an expiration date of March 17, 2023. This date was extended twice, on March 9, 2023, and February 29, 2024, to March 17, 2024 and March 17, 2027, respectively. According to the Government of Canada, the changes in the Bill were "informed by Canada's experience with MAID, feedback from over 300,000 members of the Canadian public, experts practitioners, stakeholders, provinces and territories, and the testimony of over 120 expert witnesses heard throughout former Bill C-7's study by the House of Commons and the Senate" [1].

Perhaps the most notable change of Bill C-7 in light of Bill C-14 was the alteration of the RFND criteria in the definition of a "grievous and irremediable medical condition." The new framework no longer required RFND to be eligible for MAID, in accordance with *Truchon*'s ruling.

As of March 17, 2021, MAID applicants were required to meet the following eligibility criteria:

1. Be 18 years of age or older and capable of making decisions
2. Be eligible for public healthcare services
3. Make a voluntary request not under the influence of external pressure
4. Give informed consent to obtain MAID after having received all relevant information
5. Have a serious and incurable illness, disease or disability
6. Be in an advanced state of irreversible decline in capability
7. Have enduring and intolerable physical or mental suffering that cannot be alleviated under conditions the person considers acceptable

The alteration of RFND's presence is captured by Bill C-7's introduction of a two-track system for MAID applicants, which is based on whether an individual's natural death is reasonably foreseeable. RFND-specific cases are now included under Track 1, while individuals not approaching reasonably foreseeable natural death belong to Track 2. This new system also defines the procedural safeguards meant to ensure proper assessment of non-RFND cases while simplifying the process for RFND cases.

Track 1 Safeguards

For persons whose natural death is reasonably foreseeable, the following safeguards apply:

1. Requests for MAID must be made in writing and must be signed by one independent witness.
2. Two independent doctors or nurse practitioners must provide an assessment to confirm that all eligibility requirements are met.
3. The individual must be informed of the ability to withdraw their MAID request in any time and in any manner.
4. The individual must be given an opportunity to withdraw consent and must confirm their consent right before receiving MAID. However, this requirement can be waived in the following situations:
    a. The individual has been assessed and approved to receive MAID.
    b. The person is at risk of becoming incapable of making decisions before their preferred date to receive MAID.
    c. The individual makes a written arrangement with their practitioner to waive final consent, according to which the practitioner will administer MAID on the desired data should the patient lose capacity to provide final consent at that point.
        i. The agreement is not valid if, after having lost decision-making capability, the person demonstrates resistance to MAID by words, sounds or gestures.

In general, as noted earlier, these safeguards represent an easing from former procedures, as seen in the need for only one independent witness (as opposed to two under Bill C-14 [72]), the minimum 10-day reflection period between MAID request approval and MAID receipt was abolished, and a "waiver of consent" for individuals who may lose consciousness before the procedure was introduced.

Track 2 Safeguards

For persons whose natural death is **not** reasonably foreseeable, the following safeguards apply:

1. Requests for MAID must be made in writing and must be signed by one independent witness.
2. Two independent doctors or nurse practitioners must provide an assessment to confirm that all eligibility requirements are met. *If neither practitioner has expertise in the relevant medical condition, they must consult a practitioner who does.*
3. The individual must be informed of the ability to withdraw their MAID request at any time and in any manner.
4. *The applicant must be informed of available and appropriate means of relieving their suffering, including counselling services, mental health and disability support, community services, and palliative care, and must be offered consultations with professionals who facilitate such care.*
5. *The applicant and the practitioners must discuss reasonable and available means to relieve the individual's suffering and agree that the person has seriously considered them.*
6. *The eligibility assessments must take at least 90 days. However, this period can be shortened if the person is about to become incapable of making health care decisions, as long as both assessments are completed.*
7. The individual must be given an opportunity to withdraw consent and must confirm their consent right before receiving MAID.

There is also an option for patients who seek to receive MAID through self-administration of fatal substances to consent in writing for practitioner-administered MAID should, during self-administration, complications arise which render a loss of decision-making capacity but not death.

Data Collection and Monitoring

The revised law also improved data collection systems, as articulated in "The Regulations Amending the Regulations for the Monitoring of Medical Assistance in Dying," [2] to ensure a more complete picture of MAID implementation was obtained, to fulfill

the general objective of supporting transparency and trust in how MAID is accessed and delivered. These changes included:

1. Allowing for the collection of data on all assessments after an individual requests MAID
2. Modifying the Minister of Health's regulation-making power to:
    a. Expand data collection pertaining to race, Indigenous identity, and disability.
    b. Seek to determine individual or systemic inequality or disadvantage in the context of MAID's delivery.

Appendix D

Manual Sentiment Analysis Guidelines for Determining Caution vs. Advocacy

Format: Case / Key Word / Page Number / Paragraph Number; How it exemplifies guideline

Any keyword in the document can be considered as long as it is relevant in terms of its leaning towards caution or advocacy.

1. **Advocacy is selected when the considered passage shows favour to the advancement of MAID legislation (C-14, C-7, etc. - regardless of MAID timeline) and/or does not show restraint to advancement.**
    a. *Example: Truchon/Vulnerab(le)(ility)(ilities)/116/486; The passage advocates as the Court notes its request that an exemption should be granted for those who wish to seek MAID during the extended period of suspension of the prohibition of assisted-dying.*
    b. *Rodriguez/Choice/80/4; The passage advocates as the Justices seek to highlight how the appellant is being deprived of a choice which is available to the physically able, because of the danger posed by others who may abuse it.*
2. **Caution is selected when the considered passage resists advancement of MAID legislation or calls into question the facets of an advancement.**
    a. *Example: Truchon/Vulnerab(le)(ility)(ilities)/132/562; The passage is cautious as it frames the RFND requirement as seeking to "ensure the protection of vulnerable persons, who might be induced to end their lives in a moment of weakness," thus showing resistance to the advancement of removing the clause.*
3. **Key words in titles/subtitles are not considered as they could be considered to satisfy both conditions due to how they can indicate the court's desire to explore the way the law in question responds to a test, law, precedent, etc., thus, denoting the court's caution in ensuring the law is valid, but also show that the court is interested in advancing legislation by challenging prior precedent. This also applies to key words present in a testing context in other body paragraphs. An exception to this rule is if the title clearly indicates a leaning and is not used to denote an exploration without a conclusion.**
    a. *Example: Carter/Choice/13/2; The term choice here is used to describe the primary question behind this appeal. Its presence can be said to indicate solely advocacy or caution. Therefore, it is not considered.*
    b. *Example: Rodriguez/Protection/71/3; The key word here is used when describing the eligibility criteria for S. 12, to ultimately set up further discussion about the prohibition's compliance/violation of S. 12. Therefore, it is not considered.*
4. **Key words in footnotes are not considered as their context can be obscure at times, making them less feasible for impactful consideration. Footnotes, however, can be relied upon to help determine context for key words in body paragraphs.**
5. **When the context of a key word is not immediately clear through analysis of its nearby vicinity, the scope of consideration can be expanded to consider larger swaths of writing until context is determined. This might involve considering the litigant, the speaker, and/or the relevant court case.**
    a. *Example: Truchon/Autonomy/68-69/275-277; While the usage of the term "autonomy" may appear to resemble its use by advocates of MAID legislative advancement, broader contextual analysis shows the witness is speaking against the removal of the RFND requirement. Further analysis shows that the witness testified at the request of the Attorney General of Canada, supporting the claim of the caution of the passage.*
6. **A useful rule of thumb regarding determining context is considering the speaker as their words will virtually always align with their interests (e.g. Attorney General corresponds with caution and the Plaintiff/Appellant corresponds with advocacy). Rare exceptions include instances when a litigant quotes another party's opposing viewpoint without clearly refuting it.**
    a. *Example: Truchon/Vulnerab(le)(ility)(ilities)/128/550; This passage advocates as though the last part of the paragraph in its isolation may make it appear cautious, its origin in the applicants inspire an advocacy label. This is proved by how the applicants make such an allegation to emphasize that the "reasonably foreseeable" provision served to protect "vulnerable persons from being induced to end their lives in a moment of weakness" - the same purpose noted in Carter. This serves to discredit the claim that Parliament had other objectives and emphasizes the redundancy of such an analysis.*
7. **If the Court, during a broad overview, repeats an opinionated idea containing a key word stemming from a litigant, the key word is labelled in alignment with the context of that idea and speaker.**

a. *Example: Truchon/Vulnerab(le)(ility)(ilities)/113/472; The passage is cautious as the Court, while questioning if Carter created a constitutional right to MAID, notes the opinion of those opposed to any form of legalization concerning potential detriment to the most vulnerable.*
b. *Example: Truchon/Autonomy/104-105/429-433; As the passage summarizes details of the Dutch assisted-dying framework, which is demarcated by permissiveness greater than that of Canada at the time, it is not immediately clear whether the passage advocates or cautions. However, further analysis shows the witness' belief in the importance of the RFND requirement in light of the risks apparent in the Netherlands' framework. The fact that the witness was requested by the Attorney General confirms this.*
c. *Example: Carter/Vulnerab(le)(ility)(ilities)/7/2 (2 being the second paragraph on the page, as this sections numbered paragraphs); While the passage ultimately concludes that the prohibition on assisted-dying "infringes the right to life, liberty and security of a person," leading to its legislative advancement, within the passage, the Court repeats reasoning that proves that individuals' rights are not deprived arbitrarily. As the keyword is present in this latter context, it is labelled as cautious.*
d. *Example: Carter/Vulnerab(le)(ility)(ilities)/38/90; While the passage notes the trial judge's conclusion that the prohibition negatively impacted life, liberty, and security of the person, the Court repeats the opposing reasoning that the object of the prohibition to protect the vulnerable is very important. Thus the keyword is labelled as cautious.*

8. **If the Court, during an analysis or conclusion, repeats an opinionated idea containing a key word stemming from a litigant to undermine/support/refer to the idea, the key word is labelled in accordance with the opinion the Court is using the idea to support, and not in the context of the original idea.**
    a. *Example: Truchon/Autonomy/110/461; The court comments on the interpretation of potential risks as seen in foreign regimes and their potential to become apparent in Canada, drawing on both advocating and opposing views. In this case, when various perspectives are noted by the Court, it is imperative to comprehend the larger point the Court is making, which in this case is that "it is risk…to draw a parallel here with any potential future trend in Canada." Interestingly, basic analysis might consider this caution, as the Court is indeed displaying caution. However, such caution is regarding drawing parallels with foreign data, which implies the Court's leaning toward advocacy, as it does not want premature conclusions drawn from other regimes interfering with the unfolding of Canada's perspective.*
9. **If the Court or Litigant offer an opposing point (in light of their ultimate conclusion), the keyword is labelled according to the opinion of that opposing point - unless, the point is then relied upon to further critique the argument and is made a part of the conclusion.**
    a. *Example: Carter/Protection/22/29; The trial judge ultimately finds the prohibition to violate S. 15, but notes that the objective of the prohibition is indeed pressing and substantial and rationally connected to the purpose. This is not relied upon to justify the judge's claim but is noted. Ultimately, the prohibition's lack of minimal impairment is used to undermine it.*
10. **All key words found in the court cases (using the Control+F function) were manually verified to ensure their relevance to the analysis and to ensure they were not being used in a completely irrelevant context.**
    a. *Truchon/Protection/176/Regulations/b; Protection here is used in the context of protecting confidential medical information.*
    b. *Truchon/Equality/6/25; "Equal" here was used to refer to "equally intense psychological suffering," which is not relevant to discussions about equality in light of access to MAID.*
    c. *Rodriguez/Safeguard/42/1; "Safeguard" is used to describe the protection of interests, and does not represent legal/procedural safeguards, which are being pursued here.*
    d. *Rodriguez/(In)Equal(ity)/23-27/3-1; While the key word is profusely used, the passage itself serves to capture the precedent from a past case concerning how S. 15(1) should be analyzed. Therefore, key words in the passage are not considered.*
11. **Key words in extremely neutral phrases (which often present the two possible conclusions to a case) will not be considered. This also includes key words in the repetition of statutory provisions that are not stated in the context of an opinion or in backgrounds where key words are noted only without any leaning whatsoever. However, a specific test that seeks to determine validity in the light of a cautious principle is labelled as cautious.**
    a. *Example: Carter/Vulnerab(le)(ility)(ilities)/13/2; The passage reflects on the key question underpinning the case's appeal, and describes the idea in terms of the two priorities at hand: autonomy and protection of the vulnerable. With the statement, of the two options, both paths are equally open, disabling the creation of a solid conclusion to the context.*
    b. *Example: Carter/Vulnerab(le)(ility)(ilities)/41/99; The court desires for the government to show the rational connection between the prohibition and the goal of protecting the vulnerable. As this is being done with the standard being protection, to determine a lack of correspondence, the key word is labelled as cautious.*
    c. *Example: Carter/Protection/31/64; The standard here is the protection of individual autonomy and dignity, which sets up the conclusion of the prohibition's violation of the appellant's S. 7 rights. Therefore, it is labelled as cautious.*

d. *Example: Carter/Protection/20/21; The key word is present in the provision of Section 15 of the Charter. Its presence simply serves to set the ground for later discussion by providing two pathways, without giving any indication as to which side it supports.*
e. *Example: Carter/Safeguard/15/8; The key word is used here only to describe how data is available regarding the efficacy of safeguards, without any reference to whether the efficacy is sufficient or lacking. Therefore, this key word was not considered.*

12. **Key words in excerpts from other cases can be considered as long as the passage is being relied upon to make a point that leans toward advocacy or caution.**
    a. *Example: Rodriguez/Choice/30/1; While the key word is present in a passage from R v. Turpin, another court case, the reasoning provided underpins the later dissenting claims. Therefore, the key word is labelled as advocating.*

Appendix E

Figure 4

		Caution	Advocacy	Majority Percentage Aligning with Caution	Dissenting Percentage Aligning with Advocacy
Vulnerable	Minority, pg. 13-51 (Lamer)	8	12	100%	48%
	Majority, pg. 51-76 (Sopinka)	7	0		
	Minority, pg. 77-87 (L'Heureux-Dube and McLachlin JJ)	5	0		
Protection	Minority	4	7	100%	61.5%
	Majority	6	0		
	Minority	1	1		
Slippery Slope	Minority	1	1	100%	50%
	Majority	2	0		
Safeguard	Minority	1	3	100%	75%
	Majority	6	0		
Inequality	Minority	0	32	100%	100%
	Majority	1	0		
	Minority	0	1		
Choice	Minority	4	12	71.4%	85.2%
	Majority	5	2		
	Minority	0	9		
	Minority	0	2		
Autonomy	Minority	0	4	37.5%	88.9
	Majority	3	5		
	Minority	1	4		
Discrimination	Minority	1	28	0%	96.8
	Majority	0	2		
	Minority	0	2		

Appendix F

	California	Canada	Belgium
Name of Law / Date First Passed	End of Life Option Act (EOLKOA) / October 5, 2015	Bill C-7 (2021)	Act on Euthanasia (2002)
Method Permitted	Physician-Assisted Suicide	Physician-Assisted Suicide & Euthanasia	Euthanasia
Eligibility Criteria	-18 years or older Resident of California [73] -Have a terminal disease expected to result in death within 6 months -Be able to make medical decisions and not have impaired judgment due to a mental disorder -Be physically able to receive the drug.	-Be eligible for health services funded by a province/territory or the federal government [1] -18 years old and mentally competent -Have a grievous and irremediable medical condition -Make a voluntary request for MAID -Give informed consent to receive MAID	-Suffer from persistent, unbearable physical or psychological suffering [75] [76] -The suffering is due to a severe and incurable illness caused by an accident or disease -The request for euthanasia must be voluntary, deliberate and in writing repeatedly

Terminal Illness Required	YES (death within 6 months)	NO	NO
Age Restriction	18 years or older	18 years or older	None (Minors have been permitted since 2014)
Advance Directives	NO	NO	YES
Waiting Period	48 hours+ (48 hours between the two oral requests for the lethal medication)	Track 1: NO Track 2: 90-days	At least 1 month
Mental Illness as Sole Condition	NO	NO (until March 17, 2027)	YES
Physician Review	Two witnesses [74] Attending Physician Consulting Physician	Track 1 & 2: One witness Two Independent Doctors/Nurse Practitioners Additional for Track 2: An expert in the relevant condition should both practitioners lack expertise.	Foreseeable Death, Unforeseeable Death, Minors: Attending Physician, (First) Independent physician [77] Additional for Unforeseeable Death: Second Independent Physician (Psychiatrist or specialist in the patient's condition) Minor: Second Independent Physician (Child and adolescent psychiatrist or psychologist)

Appendix G

Canada's Datapoints: MAID requests and outcomes (requests by outcome and track), MAID provisions (2023 provisions in Canada by jurisdiction, provisions by track and age category, provisions by track and sex), Requests not resulting in MAID (reasons for ineligibility, reasons for withdrawal of request, reasons for natural death before MAID could be provided and median days between request and death), MAID assessments: grievous and irremediable medical conditions (most common serious and incurable illnesses [medical condition by track and sex, medical condition by age group], frailty and chronic pain [age and sex distribution among those who reported frailty, age and sex distribution among those who reported chronic pain], dementia [recipients reporting dementia as sole medical condition by track and sex], length of time living with a serious and incurable illness/disease/disability [by track], advanced state of irreversible decline in capability, nature of suffering [reported nature of suffering by track], determination of request as voluntary [reasons practitioners considered the request voluntary]), Socio-demographic considerations, access and inequality (importance and challenges of collecting data on identity, MAID by racial/ethnic/cultural group, Indigenous people who received MAID, persons with disabilities who received MAID [profile of respondents to disability question, frequency of reporting each type of disability, medical conditions reported among those with a disability], socio-economic and community analyses [neighbourhood income quintiles by track vs. all deaths, neighbourhood marginalization quintiles by track vs. all deaths, percentage living in urban areas by track vs. all deaths, percentage living in remote areas by province vs. population]), Social supports and use of health services (palliative care and disability support services [requirement/duration/accessibility of palliative care, requirement/duration/accessibility of disability support services, type of disability support services received], place of residence and living arrangement [place of residence and arrangement by track], means to relieve suffering [how practitioners determined serious consideration of alternatives]), MAID providers and delivery (MAID practitioners [case load by track, specialty of practitioner with expertise in condition], timing of MAID, location of MAID [profile of transfers overall and due to institutional policies by province]).

Belgium's Datapoints: Number of euthanasia cases carried out and language breakdown, Breakdown of patients by gender, Breakdown of patients by age, Location of euthanasia, Basis of the written request, Expected time of death, Conditions prompting the request for euthanasia, Suffering mentioned, Qualification of doctors compulsorily consulted, Technique and products used, Commission decisions, Patients living abroad.

California's Datapoints: Summary of EOLA prescriptions and deaths 2016-2023, Practitioners in the End of Life Option Activities, Summary of EOLA requests and prescriptions written in 2023, Outcome summary of EOLA prescriptions written including prior years and drugs ingested in 2023, Characteristics of individuals, Major illness categories for EOLA individuals in 2023, Major malignant neoplasm types for EOLA individuals in 2023, Demographics of the EOLA individuals who died following ingestion of an aid-in-dying drug (age, gender, education, race/ethnicity), Underlying illness of the EOLA individuals who died following ingestion of an aid-in-dying drug, Characteristics of the EOLA individuals who died following ingestion of an aid-in-dying drug (insurance, hospice and/or palliative care, aid-in-dying drugs, patient informed family of decision, physician or trained healthcare provider present at ingestion, location where aid-in-dying drugs were ingested)

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