

# A New Category of Death

## Medical Assistance in Dying and Mental Illness in Canada

Ellen Badone

*McMaster University*

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**Abstract:** Since June 2016, federal law in Canada has permitted eligible adults to request medical assistance in dying (MAiD). Until March 2021, however, the law stipulated that only those whose natural death was “reasonably foreseeable” were eligible to access MAiD. At that time, the legislation was changed to permit MAiD for anyone with a “grievous and irremediable medical condition,” including mental illness. For the latter category, however, a series of delays in enacting the legislation has postponed it until March 2027. Using publicly available sources, including testimony at Senate hearings on this issue, this paper explores debates among psychiatrists on the issue of extending MAiD to those suffering solely from mental illness. While some psychiatrists claim that the denial of MAiD for grievous and irremediable mental illness is paternalistic and discriminates against the mentally ill, others argue that there is a lack of scientific evidence to support the idea that any mental illness is irremediable and that high-quality mental healthcare can alleviate suffering, making MAiD unnecessary. Still others point to the vulnerability of people with mental illness and their potential lack of capacity for decision-making, as well as to inequities in access to mental healthcare despite Canada’s publicly funded healthcare system. This paper analyzes these competing discourses and argues that one stems from an ethical stance of reasoning from first principles, while the other is based on a feminist ethic of care. Additionally, I suggest that the arguments against MAiD for grievous and irremediable mental illness are rooted in Cartesian dualism, which posits a clear distinction between mind and body. Ultimately, I conclude that MAiD, as a new conceptual category of death, remains in a liminal state, and that the debates over MAiD in Canada also reflect debates about the nature of embodied life.

**Keywords:** death; medical assistance in dying; psychiatry; Canada

**Résumé :** Depuis juin 2016, la loi fédérale canadienne autorise les adultes éligibles à demander l'aide médicale à mourir (AMM). Jusqu'en mars 2021, toutefois, la loi stipulait que seules les personnes dont le décès naturel était « raisonnablement prévisible » pouvaient bénéficier de l'AMM. À cette date, la législation a été modifiée afin d'autoriser l'AMM pour toute personne souffrant d'une « affection médicale grave et irrémédiable », y compris une maladie mentale. Pour cette dernière catégorie, cependant, une série de retards dans la promulgation de la législation a reporté son entrée en vigueur jusqu'en mars 2027. À partir de sources publiquement accessibles, notamment des témoignages lors des audiences du Sénat sur cet enjeu, cet article explore les débats entre les psychiatres sur la question de l'extension de l'AMM aux personnes qui souffrent uniquement de maladies mentales. Alors que certains psychiatres affirment que le refus de l'aide médicale à mourir pour les maladies mentales graves et incurables est paternaliste et discriminatoire à l'égard des malades mentaux, d'autres soutiennent qu'il n'existe pas de preuves scientifiques suffisantes pour étayer l'idée que toute maladie mentale est incurable et que des soins de santé mentale de haute qualité peuvent soulager la souffrance, rendant l'aide médicale à mourir inutile. D'autres encore soulignent la vulnérabilité des personnes atteintes de maladie mentale et leur incapacité potentielle à prendre des décisions, ainsi que les inégalités dans l'accès aux soins de santé mentale malgré le système de santé public canadien. Cet article analyse ces discours contradictoires et soutient que l'un découle d'une position éthique fondée sur des principes fondamentaux, tandis que l'autre repose sur une éthique féministe du soin. De plus, je suggère que les arguments contre l'aide médicale à mourir pour les maladies mentales graves et irrémédiables trouvent leur origine dans le dualisme cartésien, qui postule une distinction claire entre l'esprit et le corps. Finalement, je conclus que l'aide médicale à mourir, en tant que nouvelle catégorie conceptuelle de la mort, reste dans un état liminal, et que les débats sur l'aide médicale à mourir au Canada reflètent également les débats sur la nature de la vie incarnée.

**Mots clés :** mort ; assistance médicale à mourir ; psychiatrie, Canada

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## Introduction

Historically, death has been represented in religious and secular discourses as the only facet of human experience over which individuals have no control. The sole exception—suicide—remains morally problematic cross-culturally, a criminal act in many countries, and was until recently considered a sin in the Western Christian tradition (Bloch and Parry 1982, 16-17; Johnson 2021). However, since the turn of the twenty-first century, in a number of jurisdictions across

Europe and North America, as well as New Zealand and Australia, people who meet specific criteria have been afforded the opportunity to control the circumstances and timing of their death through medical assistance in dying. This new category of death was made legal throughout Canada in 2016, where it is known by the acronym MAiD (Medical Assistance in Dying). Wherever it has been legalized, however, medically assisted dying remains contentious. The transition to acceptance of this relatively new category of death has not been smooth, nor is it fully complete.

In this paper, I present several intertwining arguments. First, I claim that although MAiD is transforming the landscape of death and dying in Canada, MAiD itself is an unstable practice, in the process of being constructed by multiple actors and discourses. A specific instance of this process is the debate surrounding the provision of MAiD for people whose only illness is a mental disorder, or MAiD MD-SUMC (MAiD-Mental Disorder Sole Underlying Medical Condition). As I show in this paper, this category of assisted dying remains highly controversial.

My second objective in the paper is to delineate the contours of the debate about MAiD MD-SUMC in the Canadian psychiatric community. Although there are other voices in this debate, I have chosen to focus on two of the main advocates, for and against MAiD MD-SUMC. In the same way that an ethnographer pays deep attention through personal interviews to the words of their interlocutors rather than seeking a statistically significant sample, I examine in detail the publicly available materials produced by these two psychiatrists.

In so doing, I address the third issue that this paper is concerned with, the type of moral reasoning employed by these two actors. I argue that one discourse represents reasoning deduced from first principles, while the second is representative of a feminist ethic of care. As we will see, individual autonomy and choice, as well as the importance of creating a caring society, are key tropes in this debate, although they are used in somewhat unpredictable ways. While individual autonomy and choice are not conventionally associated with a feminist ethic of care, I show that both care and choice co-exist in the context of this discourse on MAiD.

Finally, through my analysis, I arrive at the conclusion that the controversy surrounding MAiD MD-SUMC arises from a heritage of Cartesian dualism, which sets up a misleading dichotomy between disorders of the body and

disorders of the mind. I suggest, therefore, that the debate about the legitimacy of MAiD MD-SUMC currently taking place in Canada is not only about cultural conceptions of death and dying, but also about how we envisage and understand embodied life.

### **Context: Anthropological and Legislative**

Before turning to debates about MAiD in Canada, it is important to consider some of the conclusions drawn by anthropologists studying medically assisted dying elsewhere. I also provide a brief overview of the legal framework established in Canada since 2015 for the provision of MAiD.

Two full-length ethnographic studies of medically assisted dying have been carried out in the US, a comparative context that is particularly relevant for Canada. Based on fieldwork conducted in Oregon and Vermont, medical anthropologists Anita Hannig (2019, 2022) and Mara Buchbinder (2018, 2021) make the argument that physician-assisted dying in the US enables individuals to script, orchestrate or choreograph their passage from the world. In other words, this transformation in dying enables some people to “author” their own death. However, as Hannig (2019, 70) points out, there is a difference between “authoring” and “authorizing.” She concludes that the state and medicine maintain regulatory oversight and control

over who may die and under what circumstances. The state—through its medical professionals—thus preserves the right to determine who gets to opt out of life and to differentiate between a moral and an immoral death (2019, 70).

The authorizing power of medicine and state law increases the moral legitimacy of “requested deaths” (Hannig 2019, 73). The new conceptual category of medically assisted dying depends upon legal parameters which are verified by physicians: in Oregon, for example, the person requesting assistance in dying must be terminally ill and have a limited term prognosis, they must be mentally and intellectually competent, and they must be able to self-administer the lethal medication (Hannig 2019, 68). Only these conditions separate medically assisted dying from the category of suicide, which continues to be illegitimate. As Hannig (2019, 69) concludes, “Indeed, if it becomes clear that a patient’s motivation for seeking aid-in-dying resides outside the limited scope of the law or is propelled by an ulterior desire to die, their ability to exercise that right can quickly be taken away.” This observation about biopolitical governance is

especially important to keep in mind when turning to consideration of debates in Canada about the legitimacy of MAiD provisions for people whose only reason for requesting it arises from a mental illness. As we will see, in Canada as in the US, many critics believe that an “ulterior desire to die” resulting from mental illness is not an acceptable reason for receiving MAiD. I will argue that this perspective stems from uncritical assumptions about the distinction between disorders of the body and those of the mind.

With the Carter ruling in 2015, the Supreme Court of Canada declared that the sections of the Criminal Code prohibiting medical assistance in dying contravened the provisions for “life, liberty and security of the person” in the Canadian Charter of Rights and Freedoms (Special Joint Committee on Medical Assistance in Dying 2023, 12; henceforth “Charter”). The 2016 federal legislation legalizing MAiD—Bill C-14—stipulated that access to medically assisted dying should be restricted to cases in which “natural death is reasonably foreseeable.” However, this requirement was challenged under the Charter in 2019, and in March 2021, the federal Parliament passed Bill C-7, which removed the “reasonably foreseeable” requirement and instituted a two-track process for MAiD (Health Canada 2022b, 27-28). Track One remains for individuals whose death is reasonably foreseeable and eases some existing safeguards.<sup>1</sup> A second track has been introduced for cases in which death is not reasonably foreseeable, which includes new and strengthened safeguards (Health Canada 2022a, 11; Special Joint Committee 2023, 1-3).

While the legal framework for MAiD in Canada is set out by the federal government, healthcare delivery is a provincial responsibility; therefore, each province must undertake the management and provision of MAiD. As with any new medical procedure, this process is overseen by provincial regulatory bodies—colleges of physicians—that are required to initiate protocols, guidelines, and standards of practice for MAiD (Health Canada 2022b, 32). A group of clinicians founded in 2016, the Canadian Association of MAiD Assessors and Providers, is attempting to promote best practices, guidelines and standards of practice that can be harmonized across the entire country (<https://camapcanada.ca>). MAiD is universally accessible to eligible patients under Canada’s publicly funded healthcare system.

The 2021 Track 2 category of MAiD includes people whose “sole underlying condition” is a mental disorder (MAiD MD-SUMC). However, these individuals were temporarily excluded from access to MAiD for two years to permit an Expert Panel on MAiD and Mental Illness, commissioned by the federal

government, to issue recommendations about MAiD protocols, guidance and safeguards for persons suffering only from a mental disorder (Health Canada 2022b). Under a “sunset clause” in Bill C-7, MAiD MD-SUMC was supposed to come into effect across Canada in March 2023 (Health Canada 2022a, 12). Owing to concerns expressed by psychiatrists, this deadline was extended for another year to March 2024 (Special Joint Committee 2023, 3). In early 2024, in response to further concerns put forward by psychiatrists and disability activists, the enactment of the law was postponed until March 2027 (Kirkup 2024). Debates about the provision of MAiD MD-SUMC are ongoing in the Canadian public and within the psychiatric profession. I now move to an analysis of certain arguments within these debates.

### **Arguments For and Against MAiD for Mental Disorders**

As outlined in the Final Report of the Expert Panel on MAiD and Mental Illness submitted to Canada’s federal Parliament in 2022, there are four main areas of controversy with respect to MAiD MD-SUMC. These include: determination of incurability and irreversibility of mental disorders; determining capacity for people with mental disorders; distinguishing suicidality from rational requests for MAiD; and finally, the intersection of structural vulnerability, mental disorder and MAiD (Health Canada 2022b, 9-11). In this section, I examine both sides of the arguments relating to these issues.

As an ethnographer, my usual research method involves talking directly to people, either through formal interviews or a combination of interviews and participant-observation fieldwork. Unlike an ethnography, this paper is based entirely on analysis of publicly available documents, including Government of Canada reports, academic publications, media transcripts, as well as material available on the websites of Dying with Dignity Canada, the Canadian Association of MAiD Assessors and Providers, (CAMAP), and university psychiatry departments. However, my approach to these publicly available sources does resemble ethnography in that I focus on particular individuals and give serious consideration to their words in order to illuminate social and cultural understandings about a specific issue. Here, I present a close reading of the positions taken by two psychiatrists who present differing perspectives in the debate on MAiD MD-SUMC.<sup>2</sup> The first, Dr. K. Sonu Gaing, is a Professor in the Department of Psychiatry at the University of Toronto and, in 2023, was appointed Chief of the Department of Psychiatry at the Sunnybrook Health Sciences Centre in Toronto. The second, Dr. Justine Dembo, is an Assistant

Professor in the same department, and a staff psychiatrist at Sunnybrook.<sup>3</sup> One of the journal articles cited in my summary of Dr. Dembo's arguments is co-authored by colleagues, a professor of philosophy and a medical doctor providing MAiD, who share her views (Dembo et al. 2018).

Before analyzing the arguments put forward by Dr. Gaind and Dr. Dembo, I want to briefly consider an unexpected factor that emerged in my research: gender. On first glance at the Final Report of the Independent Expert Panel on MAiD and Mental Illness, I was surprised to see that all but one of the ten panel members were women. Further research led me to an article by Daryl Pullman, a bioethicist at Memorial University of Newfoundland, who remarks on the leading role played by prominent Canadian women in the legalization of MAiD and subsequent changes to the law (Pullman 2020). Rather uncritically adopting Carol Gilligan's (1982) model of distinctively male and female ethical voices, Pullman observes that it seems paradoxical that these Canadian women advocate in favour of expanding MAiD eligibility, not from the vantage point of a feminist relational ethic of care, as explicated by Gilligan (1982), Noddings (1984), and Tronto (1993), but using a rhetoric of individualism, rights, and personal autonomy that is more closely associated with a "male" style of moral reasoning.<sup>4</sup>

Unlike Pullman, I am not advocating the kind of gendered essentialism inherent in Gilligan's framework. Nevertheless, I think it is possible to recognize two different ethico-moral perspectives in the psychiatric debate over the expansion of accessibility to MAiD in Canada. The first argues from the starting point of abstract moral principles like social justice, honesty and protection of the vulnerable. The second, while affirming these principles, advocates a case-by-case approach that would evaluate the particular circumstances of individual requests for MAiD with a view to alleviating suffering. The distinction between these two styles of moral reasoning is somewhat akin to that between Kantian deontology and Aristotelian exercise of judgment relative to the circumstances (Michael Lambek, personal communication, 10 November 2023). Whether these styles are linked to gender differences, with the first being characteristically male and the second female, is beyond the scope of this paper to determine. However, interestingly, this gender division holds for the two psychiatrists whose arguments I now examine in detail. As will be seen, my conclusion about the relationship between advocacy for MAiD and a feminist ethic of care contradicts that of Pullman.

I start with the arguments against provision of MAiD MD-SUMC, as expressed by Dr. Gaind. Gaind is not opposed to MAiD in general and has chaired his previous hospital's MAiD team (Coelho, Gaind and Lemmons 2025, x). However, he insists that the main safeguard for MAiD in Canada is the criterion enshrined in federal legislation that the medical condition of anyone requesting MAiD be "irremediable."<sup>5</sup> Given the current state of knowledge in psychiatry, Gaind concludes that "We still cannot in any reasonable or evidence-based way predict irremediability of mental illnesses..." (Gaind 2021; Gaind 2025). Since this basic safeguard cannot be guaranteed, he argues that people with only a mental disorder should be excluded from accessing MAiD. He claims that proponents of MAiD MD-SUMC are not being honest about the real issues at stake:

Our debate about MAiD should acknowledge the real question being debated: Should those with mental illness be able to get MAiD when they have suffered enough, even when they could get better? We should not pretend it is a debate about whether people would be getting MAiD for an irremediable condition, since evidence shows that cannot be predicted at this time and it is dangerous to provide death for one reason while pretending it is for something else (Gaind 2021).

Note that this style of argumentation involves logically proceeding from a first principle, the inability to establish the irremediability of a mental disorder, to a conclusion, that those with *only* mental disorders cannot be permitted to receive MAiD. Gaind suggests that MAiD MD-SUMC will inevitably lead to a "slippery slope" in which "the nature of suffering that motivates MAiD requests is likely to further expand beyond predominantly illness or medical disorders related suffering." This statement suggests that Gaind views mental disorders through a Cartesian lens as neither "illness" nor "medical". He continues his argument about MAiD MD-SUMC by stating that "rather than a framework providing death to those who want to avoid a painful death, the framework shifts to those who wish death to avoid a painful life" (Gaind 2020, 3). On *The Agenda*, a popular TV show dealing with current affairs, Gaind reiterated this view that people will seek MAiD "as escape from a painful life" (*The Agenda* 2022 transcript). Implicit in this argument is the moral principle that it is *right* to provide the means to achieve death without suffering in order to spare someone from a painful death, but *wrong* to provide the means to achieve death without suffering to spare them from a painful life. Similarly, the word "escape" holds moral connotations: a painless death should not allow people to "escape"

from life's suffering, or at least suffering that is not exclusively based in the physical body. Here, it seems that Gaind is subscribing (perhaps without realizing it) to a moral hierarchy that places physical suffering above mental suffering and that mental suffering, since it is "all in one's head," is less serious than physical suffering, as well as more likely to be transient and surmountable. Arguably, Gaind implies that those with mental disorders have a moral responsibility to overcome their suffering and live.

Gaind's second argument against provision of MAiD MD-SUMC involves assumptions about the structural vulnerability of people who are likely to request it. In his view, this category of people is marginalized in society, and their suffering from mental illness is exacerbated by poverty, inadequate housing, and inequitable access to mental healthcare and other social services. In his view, members of this population who opt for MAiD would not truly be making an autonomous decision to die, because structurally, they are not in a position to be able to make autonomous decisions. On *The Agenda*, he offered the analogy of people trapped in a burning house who are faced with the decision to jump out the window or burn to death: "If you have a burning building and someone decides to jump, that's not through autonomy that they want to end their lives." Instead of helping the person to jump under the guise of allowing them to exert their autonomy, Gaind urges his audience to say: "Put out the fire, stop the burning, design a safer building, or let's lead people to a safer exit" (*The Agenda* 2022 transcript).

Related to his concerns about structural vulnerability, Gaind implies that it is impossible to determine capacity for consent to MAiD for those who are mentally ill or to rule out the possibility of suicidality. He makes the argument that there is insufficient evidence to prove that clinicians are able to distinguish the latter from "rational" requests for MAiD in cases of mental illness. Moreover, he argues that current policy in Canada on MAiD MD-SUMC does not take into account data from European countries where it is permitted, relating to "the high prevalence of loneliness and unresolved social suffering of those receiving psychiatric euthanasia" (Gaind 2025, 72).<sup>6</sup> Gaind further claims that MAiD MD-SUMC is dangerous because there is no requirement for assessors to take into account "ambivalence" on the part of those requesting it, since "ambivalence has been long recognized in mental illness literature as being a marker for suicidality" (2025, 64). As a result, he contends that it is incorrect to term MAiD MD-SUMC "medical assistance in dying" since those receiving it are not dying, but only "wish to die" (2025, 64). Rather, in Gaind's view, the terms

“state-provided euthanasia... or state-assisted suicide” would be more appropriate for this type of death, which he fears would be predominantly provided to non-dying members of vulnerable, marginalized populations with the unvoiced goal of achieving “systemic cost savings... compared to the costs of prolonged care and community living” (2025, 84).

I now turn to the arguments in favour of MAiD MD-SUMC put forward by Dr. Dembo. From her perspective, refusing access to MAiD to people suffering solely from mental disorders stigmatizes this group of people and potentially minimizes the severity of mental suffering (Dembo 2021a). To avoid exceptionalizing or discriminating against people with mental illness, the Expert Panel on MAiD and Mental Illness, in which Dembo participated, refrained from making recommendations that would apply *only* to those requesting MAiD MD-SUMC. Instead, the Panel advocated protocols and guidelines that apply to all cases of Track Two MAiD, where natural death is not reasonably foreseeable (Health Canada 2022b, 9).

In line with this agenda of avoiding rigid distinctions between mental and physical disorders, Dembo points out that the brain is a physical organ, and that there are “neuroanatomical differences described in numerous psychiatric disorders” as well as comorbidities between physical and mental illnesses, like gastrointestinal symptoms in depression (Dembo 2021a). Continuing this argument, she notes that even under current MAiD legislation, which temporarily excludes those with only a mental illness, the most common reasons that people give for requesting MAiD are “psychological and existential distress, loss of independence and autonomy, emotional distress, and the inability to engage in activities the individual considers meaningful” (Dembo 2021a). Therefore, mental conditions are clearly already being taken into account in MAiD assessments for people with a physical illness. In her view, opponents of MAiD MD-SUMC are guided by a bias privileging physical over mental suffering. Contrary to this bias, she cites research indicating that:

the intensity of suffering in severe mental illness can be equal to that of the most severe physical conditions... in a large study of subjective wellbeing in Berlin, the authors found only end-stage liver disease ... was subjectively as severe as mental disorders (Dembo et al. 2018, 453).

In addition to Cartesian dualism, Dembo and her co-authors argue that an outdated form of medical paternalism is at the root of arguments to prohibit MAiD for people with only a mental illness (Dembo et al. 2018, 452). They observe that in contemporary Western medicine, the principle of patient

autonomy is paramount, and the categorical exclusion from MAiD of people with only mental illness contradicts this principle. Moreover, they cite research using a standardized capacity assessment tool that found between 70 percent and 80 percent of hospitalized patients with acute mental illness were competent to make treatment decisions. Although capacity can vary with the type of disorder, Dembo and her colleagues suggest that rates of capacity to consent to treatment, including MAiD, are likely higher among the unhospitalized population of those with mental illness (Dembo et al. 2018, 453). Therefore, Dembo argues that capacity must be assessed on an individual basis, rather than on a group basis. Rather than excluding requests for MAiD by those with only mental illness, Dembo suggests that with strong safeguards and guidelines in place, it is possible to do a rigorous assessment of such requests. She also comments that since MAiD is currently permitted for people with comorbid physical and mental illnesses, MAiD assessors are already assessing capacity for consent in the presence of a mental disorder (Dembo 2021a).

The two main arguments about capacity for MAiD MD-SUMC are that people with mental illness may be suicidal, and that they may have cognitive distortions that interfere with their ability to rationally request MAiD (Dembo 2021a). In Dembo's view, physicians and psychiatrists are able to do careful assessments to distinguish when a patient is motivated by an irrational desire to die. Furthermore, she observes that while a wish to die can be a symptom of mental illness, the two are not always associated (Dembo 2021a). Suicidal ideation can be present in many end-of-life situations, even when the patient has no diagnosis of mental disorder, so suicidality should not result in a blanket exclusion from MAiD. Likewise, cognitive distortions may be experienced by people with and without a diagnosis of mental illness, so a full and rigorous assessment of all people requesting MAiD is more appropriate than a categorical prohibition of MAiD MD-SUMC (Dembo et al. 2020, Dembo 2021a). Moreover, the availability of MAiD for mental illness only in Switzerland, Belgium, the Netherlands and Luxembourg has not resulted in an increase in overall societal suicide rates (Dembo et al. 2018, 453).

With respect to the issue of irremediability of mental disorders, Dembo acknowledges that this issue is difficult to determine, partly because of inadequate research. Nonetheless, she claims that even if more research were available, it would still be impossible to determine in a completely accurate way for each individual case whether a mental disorder is irremediable. She points out that the same is true with respect to physical illnesses, such as chronic pain,

or multiple sclerosis, for which individuals can now receive Track 2 MAiD. A blanket exclusion from MAiD for MD-SUMC, therefore, does not resolve the issue of irremediability (Dembo 2021a).

Furthermore, Dembo observes that physicians and patients in Canada make medical decisions in the face of uncertainty about prognosis and irremediability all the time; therefore, doing so for MAiD MD-SUMC is not a departure from current practice. She emphasizes that individuals requesting MAiD MD-SUMC need to be informed that it is possible, although unknown at this point in time, that new treatments could alleviate their suffering. Dembo supports the Expert Panel's recommendation that extensive treatment modalities must be attempted before a request for MAiD MD-SUMC is granted, to facilitate informed decision-making. Experimenting with numerous treatments enables "us to know whether someone's more likely to be on the treatment refractory end... which would be analogous to (an) irremediable condition" (Dying with Dignity Canada, 2023).

Dembo also addresses the issue of the intersection between mental illness, structural vulnerability and potential requests for MAiD MD-SUMC. She observes that precarious economic, housing, and social conditions are not restricted to individuals with mental disorders, and people with physical disorders can also experience structural vulnerability. Therefore, she argues, careful assessment of all requests on a case-by-case basis is preferable to outlawing MAiD MD-SUMC (Dembo 2021a). Dembo agrees with those who claim that access to resources and mental healthcare in Canada is not currently equitable, but she advocates lobbying for the improvement of publicly funded mental healthcare and social services *in parallel with* enabling the accessibility of MAiD MD-SUMC.. In her view, MAiD MD-SUMC is a "last resort," not a replacement for high-quality mental healthcare (Dembo 2021a). In fact, she claims that in her experience, if a psychiatric disorder is present when MAiD is requested, a full psychiatric assessment is carried out, and the request for MAiD can lead in some cases to "improved access to resources" through referrals (Dembo 2021a). In her view, MAiD assessors like herself will do rigorous case reviews when MAiD MD-SUMC is requested, exercise caution and propose alternative treatments and supports for individuals suffering from mental illness.

Dembo is confident that the guidelines and protocols recommended by the Expert Panel and CAMAP will mitigate potential harm. Specifically, as she points out, the Expert Panel recommended in 2022 that MAiD assessors must ensure that appropriate resources, such as housing and income supports, have

been offered to those requesting MAiD MD-SUMC. Subsequent to this recommendation, the federal government stipulated in 2024 on its MAiD website that in all cases of Track 2 MAiD, the patient must have been

informed of available means to relieve ... suffering, and offered consultations with professionals who provide services including, where appropriate:

- palliative care
- community services
- counselling services
- mental health and disability support services

and that patient and practitioners “must have discussed reasonable and available means to relieve your suffering, and all agree that [the patient has] ... seriously considered those means” (Government of Canada 2024, consulted 12 June 2025). Once individuals are made aware of their options, in Dembo’s view, they should be free to make the best decision they can, under the circumstances:

So we can’t exclude someone from MAiD who meets all the criteria and is suffering from that grievous and irremediable condition simply because they live in poverty or they’re on disability and disability is not enough. We have to allow someone to make an autonomous decision within their limitations of their own circumstances. Autonomous decision doesn’t mean there are no limitations. An autonomous decision means that someone weighs their own options within their own circumstances and makes their own choice (Dying with Dignity, Canada 2023).

Here Dembo’s position is similar to that of Jocelyn Downie, an expert in medical law from Dalhousie University in Nova Scotia, who supports better access to healthcare and social services if needed by those requesting MAiD MD-SUMC, but advises: “Don’t constrain access to MAiD, because you should never make individuals hostage to fixing systemic problems”<sup>7</sup>

## Discussion and Conclusion

It is important to recognize that Gaing’s style of argumentation involves logically proceeding from a first principle, the inability to establish the irremediability of a mental disorder, to a conclusion, that those with *only* mental disorders cannot be permitted to receive MAiD. Arguing from the principles of honesty (society should not lie to itself by claiming that MAiD MD-SUMC is being offered

on the grounds of irremediability of mental disorders when it is really being offered to enable people to escape suffering); justice (economically and socially marginalized people should not be offered MAiD as a solution to structural problems); and the primacy of scientific data (there is no clear evidence for the irremediability of mental disorders) Gaind arrives at the conclusion that a population—those with solely mental disorders—should be excluded from access to MAiD. In contrast, Dembo argues that MAiD MD-SUMC can be responsibly provided if appropriate guidelines and protocols are put in place so that rigorous assessments of individual requests and capacity to consent can be conducted for each case. In so doing, she claims, patient autonomy and choice will be respected for people with physical illness, those with only mental disorders, and those who live with both types of suffering.

Gaind suggests that MAiD MD-SUMC will inevitably lead to a “slippery slope” in which people will be requesting and receiving MAiD to enable them to escape from “a painful life” resulting from mental or psychological suffering (Brief for Senate Hearings on MAiD 2020, 3). As noted above, this perspective is informed by a Cartesian dichotomy between physical and mental disorders that valorizes the former above the latter. However, there is a long tradition of work in anthropology from Scheper-Hughes and Lock (1987) through Csordas (1990), Lambek (1998), Lakoff and Johnson (1999) to Kirmayer and Ramstead (2017) and Seligman (2018) that calls the distinction between mind and body into question. For example, drawing on neuroscience research on “grounded cognition,” Seligman argues that mental processes of perception and cognition are conditioned by the ongoing bodily experiences of particular bodies in specific social and material environments. Through a looping process, influences from mind, brain and body interact so that cognitive meanings and body are inter-connected in ways that impact both well-being and illness (Seligman 2018, 413). From this perspective, the separation between mental and physical suffering becomes blurred, a situation which is recognized in Dembo’s arguments in favour of MAiD MD-SUMC.

As bioethicist Daryl Pullman (2020, 12) claims, Dembo’s position is scaffolded in rhetoric invoking individualism and bodily autonomy which is not typically associated with the voice of a feminist ethic of care. Nonetheless, I am not convinced that an ethic of care is incompatible with these values. For example, individualism and bodily autonomy are essential to feminist advocacy for women’s reproductive rights. I would suggest that the caring, feminist aspect of Dembo’s argument derives from her insistence on the importance of assessing

suffering in particular cases and circumstances, rather than advocating for the principled blanket exclusion of a category of people from access to MAiD. Here Dembo's position aligns with a feminist, relational ethic of care in which an individual "bases her actions on the particular needs of those to whom she is connected," seeking to preserve "human connections, regardless of what principles might be at stake" (Simon 2001, 25).

As exemplified in the work of Anne-Marie Mol (2008), among others (Mol, Moser and Pols 2010), critical medical anthropology has largely followed the feminist view that care is a relational, social activity rather than a practice based on autonomy, individualism and choice (Mills et al. 2023, 69). However, evidence that an ethic of care can intersect with MAiD comes from research with nurses, social workers and pharmacists involved in MAiD provision in Canada (Mills et al. 2023). These healthcare workers conceive of care and choice as co-existing in the provision of MAiD and see themselves as enacting relational care for both dying patients and their families. They observe, however, that "rights-based rhetoric has been necessary to open the legal avenue for this type of care, which would not be possible without advocates who have framed it 'as a human right in a court of law'" (Mills et al. 2023, 71). Similarly, on the basis of an ethnographic study of right-to-die activists, Gandsman (2018, 335) concludes that "individual autonomy and self-determination are necessary rhetoric but fictions" (2018, 335). Moreover, in his view, care and choice are not mutually exclusive with respect to MAiD:

At the end, an assisted death may be less an act of absolute individual autonomy and choice but a culminating fulfillment of responsibilities to others, even an act of care that can serve as a final gift intended for others.

He contends that by choosing to die in a way that is not traumatic or burdensome for loved ones, those opting for MAiD are motivated by self-sacrifice and care for others, not uniquely a self-interested desire for autonomy.

In my own view, the argument that an entire population—those suffering exclusively from grievous and irremediable mental illness—should be excluded from access to MAiD to avoid violating abstract moral principles is ultimately less persuasive than the argument that each individual's eligibility for access to MAiD should be decided by evaluation of their particular circumstances, on a case-by-case basis. Similarly, while superficially compelling, the argument that Track 2 MAiD including MAiD MD-SUMC will result in the disproportionate euthanasia of marginalized, vulnerable members of society does not hold up in the face of evidence from studies reviewing actual cases of MAiD provision

in the province of Ontario and in Canada as a whole. According to a review of nearly 15,000 MAiD cases by the Ontario Office of the Chief Coroner, not even “a single ... patient had received MAiD because of poverty, poor housing, poor access to services, or any other social factor that could have been addressed” (Downar and Downie 2025). Notably, this report, together with one produced by the federal government, also revealed that

by every measure, MAiD recipients were actually *less* marginalized than people who die naturally, or people who live with chronic illnesses. Even among people who were not terminally ill... [Track 2] MAiD recipients were no more marginalized (and more privileged by many measures) than those who died naturally or who live with chronic illness (Downar and Downie 2025).

These findings support those of Buchbinder (2021) in Vermont, who concludes that medical assistance in dying there is predominantly accessed by people with greater than average social and economic resources and is thus an elite form of “aspirational” death. Equally important to note is the Canadian federal report’s finding “that MAiD recipients had extremely good access to palliative care and disability support services overall—far better than the average Canadian” (Downar and Downie 2025). These observations lead me to conclude that the arguments put forward by Dembo and colleagues who agree with her about permitting MAiD MD-SUMC are more convincing than those of its critics, like Gaiend and his associates (see Coelho, Gaiend and Lemmons eds. 2025).

It is important to observe that moral and ethical principles are implicit in the arguments on *both* sides of the debate about MAiD MD-SUMC expressed by psychiatrists in Canada. Clearly, as Hannig argues for the US, biopolitical governance in Canada defines what constitutes a moral or an immoral death (see Hannig 2019, 70). Significantly, in the US context analyzed by Hannig, medical assistance in dying for those with mental illness only is *not* condoned by the state, so legal measures are exercised to *prevent* it from occurring.<sup>8</sup> In Canada, however, federal law—the state—currently *permits* MAiD MD-SUMC, even though enactment of the legislation has been postponed until March 2027. It is not the state that seeks to disallow and delegitimize this category of death, but rather, biomedical spokespersons like Gaiend, as well as disability activists and some media figures.

Extending Hannig’s line of reasoning to Canada, we can see that in 2016, Bill C-14 created a new category of death that represents a transition in the

social and medical experience of dying because it enables control over, or the “authoring” of, one’s own death. In Canada, for mental disorders, there is a lack of consensus between the state and the medical profession regarding governance of this new type of death. While the state has legalized MAiD MD-SUMC, the medical authorities that the state relies upon to determine eligibility for MAiD are not uniformly in agreement about the moral legitimacy of the procedure when a mental disorder is the sole underlying medical condition. Some psychiatrists actively challenge whether MAiD MD-SUMC can be legally justified. In the US, as Hannig argues, without medico-legal authorization, medically assisted dying would fall into the conceptual category of suicide, an illegitimate, immoral type of death. This is the allegation that Gaiand makes for MAiD MD-SUMC in Canada. Arguably, the Canadian situation is even more ambiguous, since Bill C-14 permits physicians or nurse practitioners to administer the lethal drug rather than requiring patient self-administration, so MAiD MD-SUMC would technically constitute homicide, not suicide. Importantly, for Gaiand and those who agree with him, the medico-legal parameters that would justify MAiD MD-SUMC cannot be met given the contemporary state of medical research, since there is no conclusive evidence that any mental disorder is irremediable, and neither is it possible to distinguish whether a person with mental illness is suicidal or has capacity to consent.

Death—the final transition—is perhaps the most liminal of all *rites de passage*, since it is associated with so much uncertainty, especially about the existential state that lies beyond death. In Canada, MAiD has transformed this transition, allowing for a degree of certainty, at least in terms of the circumstances of the passage. Yet MAiD, as a new type of death, is itself in a liminal state. As the debates over the provision of MAiD MD-SUMC and the delays on enacting the legislation illustrate, MAiD is not currently (and perhaps never will be) a stable category in Canadian society. Moreover, these debates revolve around the thorny issue of Cartesian dualism, and call into question distinctions between mind and body and physical or mental disorders. Arguably, therefore, it is not only cultural constructions of death and dying that are being re-shaped by debates about MAiD in Canada, but also perceptions and understandings of embodied living in the world.

**Ellen Badone**

*McMaster University*

*badone@mcmaster.ca*

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## Notes

- 1 Notably, the previously mandatory waiting period between approval of a request for and provision of MAiD has been removed.
- 2 However, there is a wide variety of opinions among psychiatrists in Canada about MAiD MD-SUMC, with many undecided about whether it should be permitted (Dr. Justine Dembo, personal communication, 24 September 2024).
- 3 Dr. Gaiind was a member of the Council of Canadian Academies Expert Panel on Medical Assistance in Dying (MAiD) where a Mental Disorder is the Sole Underlying Medical Condition (MD-SUMC). Dr. Dembo was a member of the Independent Expert Panel on MAiD and Mental Illness advising the Federal Government of Canada, whose final report came out in May 2022. My summaries of their arguments are based on their statements published on the University of Toronto website, and Briefs that each clinician prepared for federal parliamentary committees. I have also relied on Dr. Gaiind's chapter in Coelho, Gaiind and Lemmons (2025), and his contributions to the mental health educational podcast PsychEd, which originated at the University of Toronto and brings together psychiatry residents and faculty to explore current research on psychiatric conditions and their treatment <https://www.psyched-podcast.org/blog/maid> (accessed 4 September 2024). For Dr. Dembo, I have also used material presented in her 2018 co-authored article in the *Canadian Journal of Psychiatry* (Dembo, Schuklenk and Reggler 2018), and in a webinar broadcast by Dying with Dignity Canada (End in Mind: MAiD and Mental Disorders. Dying with Dignity Canada, March 9, 2023 <https://www.youtube.com/watch?v=2P6foDX8HOc> <https://www.dyingwithdignity.ca/education-resources/end-in-mind-maid-and-mental-disorders/> (transcript)) (accessed 4 September 2024). An earlier version of this paper was sent to both psychiatrists for their input, but only Dr. Dembo responded.
- 4 More recent works on feminist ethics of care, not mentioned in Pullman's article, include Fraser (2016), Murphy (2015), Nadasen (2023), and Puig de la Bellacasa (2012).
- 5 Bill C-14 outlines the definition of a grievous and irremediable medical condition as follows:  
"Eligibility for medical assistance in dying

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria: ...

(c) they have a grievous and irremediable medical condition; ...

Grievous and irremediable medical condition

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; ...” (Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, [https://www.parl.ca/Content/Bills/421/Government/C-14/C-14\\_4/C-14\\_4.PDF](https://www.parl.ca/Content/Bills/421/Government/C-14/C-14_4/C-14_4.PDF)) (accessed 4 September 2024).

6 Gaind also claims that there is a 2:1 female-to-male gender imbalance among those receiving medical assistance in dying for mental illness only in European countries where the procedure is permitted (2025:72). However, no source for this statistic is referenced.

7 (Special Joint Committee on Medical Assistance in Dying 2023:36). <https://www.parl.ca/Content/Committee/441/AMAD/Reports/RP12234766/amadrp02/amadrp02-e.pdf> (accessed 4 September 2024).

8 Notably, arguments against the legalization of MAiD in US states for purely physical illness mirror the rhetoric of Canadian psychiatrists’ criticisms of MAiD MD-SUMC in Canada, echoing themes like the need to protect vulnerable, poor and disabled populations, as well as the potential for suicidality among depressed patients (Dugdale 2025).

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