

## About the Authors



### Janine Brown, PhD

Janine Brown is a Registered Nurse and Associate Professor at the University of Regina with a PhD in Health Sciences from the University of Saskatchewan. Her research focuses on medical assistance in dying (MAiD), ethically complex care, and end-of-life decision-making. Her work is published in journals such as *Qualitative Health Research*, *Journal of Loss and Trauma*, *Journal of Palliative Medicine*, *BMC Medical Ethics*, and *Healthcare Policy*, contributing to national and international conversations on MAiD policy, practitioner participation, and patient- and family-centred care.

**Affiliation:** University of Regina, Faculty of Nursing



### Katherine B. Knox

Katherine B. Knox is the provincial department head and an Associate Professor at the University of Saskatchewan, Department of Physical Medicine and Rehabilitation. She is a primary investigator with the Cameco MS Neurosciences Research Center at the University of Saskatchewan, and her clinical research focuses on long-term outcomes and quality of life for people with multiple sclerosis.

**Affiliation:** University of Saskatchewan, College of Medicine, Department of Physical Medicine and Rehabilitation



### Lilian Thorpe

Lilian Thorpe is a geriatric psychiatrist providing consultation liaison services in the Saskatoon area. She has been extensively involved with medical assistance in dying since 2016, has assessed over 1,400 patients since then, and is a Professor in the College of Medicine at the University of Saskatchewan.

**Affiliation:** University of Saskatchewan, College of Medicine, Department of Community Health and Epidemiology



### Lorelee Herter

Lorelee Herter is a proud mom to three children, a grandma to four, and lives with her husband, Arlen, on their family farm in southwest Saskatchewan. Lorelee has been living with MS since 2005.

**Affiliation:** University of Regina, Faculty of Nursing

## About the Authors



### **Mir Nabila Ashraf**

Mir Nabila Ashraf completed her Master's in Aging Studies at the University of Regina, with a research focus on digital health, chronic disease self-management, and end-of-life care among older adults. Her community-engaged work emphasizes equitable, patient-centred approaches to improving access to health information and quality of life.

**Affiliation:** University of Regina, Center on Aging and Health



### **Michael C. Levin**

Michael C. Levin is the Saskatchewan Multiple Sclerosis Clinical Research Chair and Professor of Neurology and Anatomy, Physiology and Pharmacology. Actively caring for persons living with multiple Sclerosis, Dr. Levin's research interests include developing novel small molecules to treat progressive forms of MS, for which there are marginal treatments.

**Affiliation:** University of Saskatchewan, College of Medicine, Department of Anatomy, Physiology, Pharmacology, and Neurology



### **Ilia Poliakov**

Ilia Poliakov completed medical school at the University of Calgary (2010) and a neurology residency at the University of Saskatchewan (2015). He later completed a fellowship in Multiple Sclerosis and Neuroimmunology and is now the Director of the Saskatoon Multiple Sclerosis Clinic while contributing to medical education and multiple sclerosis research.

**Affiliation:** University of Saskatchewan, Department of Medicine, Division of Neurology

# Navigating End-of-Life Choices: Perspectives of Individuals Living with Multiple Sclerosis on Medical Assistance in Dying in Various Hypothetical Situations

Janine Brown, PhD; Katherine B. Knox; Lilian Thorpe; Lorelee Herter; Mir Nabila Ashraf; Michael C. Levin; Ilia Poliakov

## Abstract

---

### Background

Saskatchewan's multiple sclerosis (MS) prevalence rate is among the highest in the world. Although quantitative research has demonstrated a high hypothetical interest in assisted dying among individuals living with MS (ILMS), the underlying reasons potentially influencing their consideration of medical assistance in dying (MAiD) have not been explored qualitatively.

### Methods

An Interpretive Description methodology was used for this project. The dataset included 27 interviews (22 ILMS, five key informants), demographic data, interviewer field notes, and reflective content. Participants discussed their perspectives on MAiD across a range of hypothetical situations. Inductive reflexive thematic analysis and content analysis were completed.

### Results

When presented with hypothetical disease trajectory scenarios, participants indicated they *would* or *may* consider MAiD if experiencing unbearable pain (n=21), the need for continuous care (n=16), or perceptions of being a burden to others (n=14). Fewer participants reported that loss of pleasurable activities (n=6) or changes in living arrangements alone (n=8) *would* or *may* prompt consideration of MAiD. Four interconnected themes characterized participants' reasoning: 1) a shifting identity, 2) navigating

resource disparities, 3) the weight of guilt, and 4) care concerns for family.

### Discussion

ILMS may consider MAiD for various reasons. Decision-making at the end-of-life exists within a complex matrix of individual guilt and concern for family members while reappraising quality of life and accessing support through disease progression.

## Introduction

---

Multiple Sclerosis (MS) is a chronic and progressive neurological condition that often leads to physical, cognitive, and psychological challenges.<sup>1</sup> Globally, the prevalence of MS is 23.9 cases per 100,000 population,<sup>2</sup> while Saskatchewan, Canada, has one of the highest MS prevalence rates at 313.6 cases per 100,000 population.<sup>3</sup> Within the MS disease trajectory, individuals may experience increasing stigma from invisible symptoms,<sup>4</sup> cognitive dysfunction,<sup>5</sup> and chronic pain,<sup>6</sup> impacting their quality of life. Individuals may also experience emotional distress<sup>7</sup> and face complex decisions about planning for an uncertain future.<sup>8</sup> Considering the increasing life expectancy of individuals living with MS (ILMS),<sup>9</sup> and that MS remains a progressive and incurable illness, many ILMS express concerns about future loss of autonomy and the financial, emotional, relational, and professional impacts of their illness.<sup>10</sup> These realities make end-of-life (EOL) care planning a vital yet often under-discussed aspect of MS management, as it reflects individuals' values,

preferences, and wishes for future care. However, care providers may face challenges in discussing EOL care due to uncertainty about prognosis and the individual's emotional and ethical context.<sup>11</sup> As a result, this risks underrepresentation of ILMS and their families' perspectives in EOL decision-making.

With the passage of Bill C-14 in 2016 and the subsequent enactment of Bill C-7, those with and without temporal proximity to natural death may now be found eligible for medical assistance in dying (MAiD).<sup>12</sup> In 2024, the provision of MAiD accounted for 6.9% of reported deaths, an increase from 2023, with cancer as the most noted underlying medical condition, followed by neurological conditions.<sup>13</sup> The removal of the requirement for temporal proximity to death has prompted ethical discussions regarding autonomy, vulnerability, and adequate support available to individuals living with disabilities.<sup>14,15</sup> For ILMS, the changes require a deeper understanding of EOL care options to support informed decision-making.

Two quantitative studies have explored ILMS perspectives regarding assisted dying<sup>16,17</sup>; however, to our knowledge, no qualitative studies have focused on understanding how individuals living with MS personally interpret and negotiate EOL choices, including assisted dying when legally available. This paper will explore ILMS' perspectives on EOL care, involving MAiD, across various hypothetical situations.

## **Methodology & Methods**

---

### **Study Design**

This qualitative exploratory study was grounded in the interpretive description methodology. This methodology contributes to a detailed description of the phenomenon and an understanding of disease-related consequences in a clinical context through an iterative, inductive process.<sup>18</sup> Ethical approval was obtained from the University of Regina (REB #029). The analysis reported here, focused on examining ILMS' perspectives on EOL care and MAiD within hypothetical scenarios, constitutes one component of a larger qualitative study with multiple distinct objectives funded by the Saskatchewan Health Research Foundation.

### **Study Setting and Participants**

Our team included a Saskatchewan-based patient-partner who has been living with MS

since 2005. This patient-partner and their spouse actively contributed to all stages of the project, including grant writing, data analysis, and knowledge mobilization. The research team also comprised a physiatrist, a nurse researcher, a master's student in aging studies, a MAiD provider, and two neurologists specializing in MS. Participants were recruited from the MS clinical research database using the following goal parameters: 1) 75% female representation, 2) 30% with an expanded disability status scale score of 8 or higher, 3) 30% diagnosed within the last 5 years, and 4) one-third residing outside the two urban areas. Additional recruitment occurred through posters in MS clinic areas, the MS Society, social media outreach, and snowball sampling.

### **Data Collection**

After participants reviewed the information and consent document, a mutually acceptable interview time and modality were agreed upon. At the start of the interview, the interviewer reviewed the consent form with the participant, obtained and documented informed consent on the recording, and provided a link to a Qualtrics demographic and contextual self-report survey that included validated self-report measures for the Multiple Sclerosis Impact Scale-29 (MSIS-29)<sup>19</sup> and the Patient-Determined Disease Steps (PDDS)<sup>20</sup> to ascertain disability level. The semi-structured interviews invited participants to respond to hypothetical disease scenarios similar to those presented in previous quantitative studies on ILMS and assisted dying,<sup>16,17</sup> and allowed space for conversation, clarification, and exploration. Interviewer field notes and reflective content were also collected at the conclusion of each interview.

### **Data Analysis**

The demographic and contextual data were summarized using frequencies and percentages. We conducted both content and thematic analyses. For the thematic analysis, we followed Clarke and Braun's Six-Step Data Analysis Process.<sup>21</sup> Two research team members repeatedly reviewed the transcripts to familiarize themselves with the data, then identified and inductively coded them with NVivo 12, to produce initial themes. These initial themes were then reviewed and refined by other research team members. These themes, accompanied by narrative definitions and supporting quotations, were collated, and the structure of the results was formulated.

We conducted a content analysis to explore ILMS' perspectives on MAiD across different hypothetical scenarios using an inductive coding approach. One researcher reviewed each transcript and categorized each hypothetical situation in an Excel template, after which a second researcher reviewed the transcription and cross-checked each case. The descriptive counts were reported in percentages and were presented in a bar chart.

## Results

We conducted interviews with 22 ILMS and five key informants. One ILMS did not complete the demographic data collection survey.

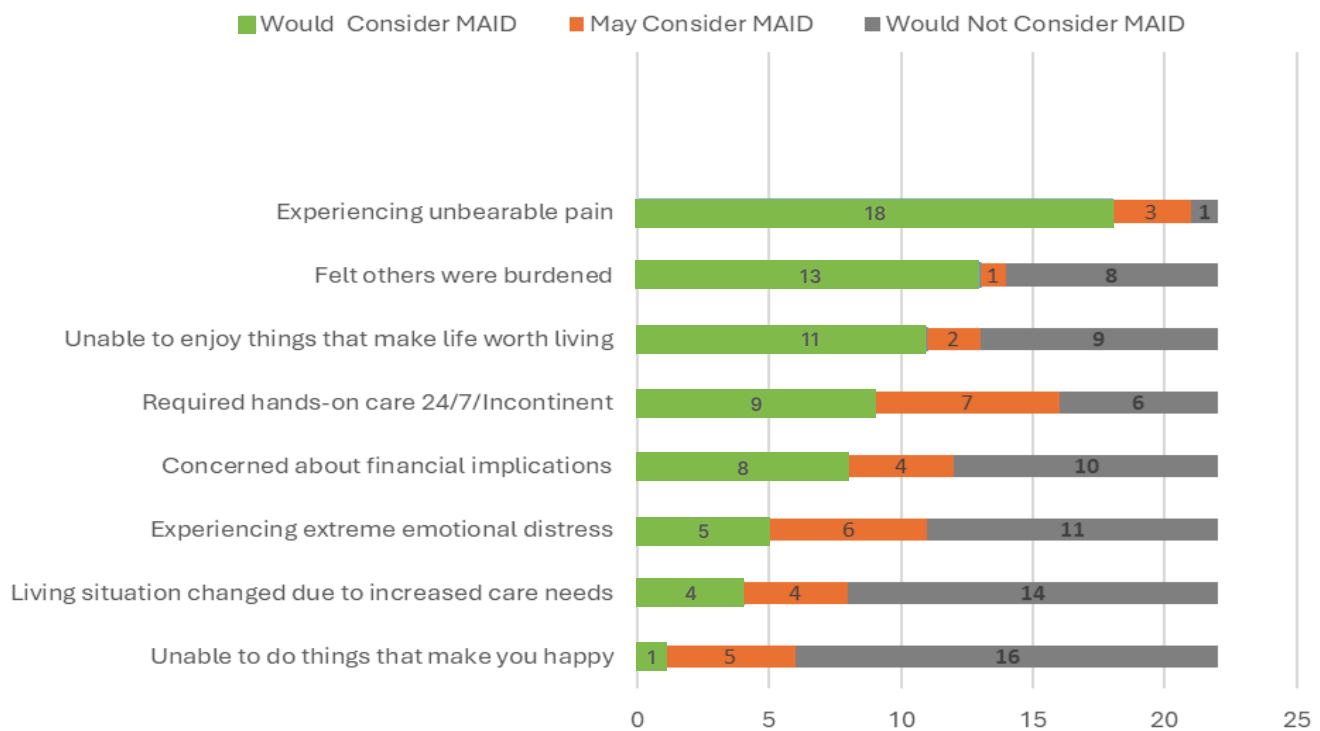
### Demographic and Contextual Data

Among the 21 ILMS, the majority were women (66.67%), with approximately half aged 18–44 years (57.14%). Approximately two-thirds were married, and about 45% were employed. Most participants had some level of post-secondary education. The majority (15 of 21) had been living with MS for 4–14 years, reflecting a mid-

range disease duration, while only a few had been recently diagnosed or had lived with the condition for more than 20 years. The MSIS-29 scores reflected a moderate level of symptom burden, with average physical and psychological impact scores of 36.2% and 35.2%, respectively, on a scale where 100% indicates the most severe symptom burden. The PDDS scores showed that nearly one-third of ILMS reported no functional limitations, while others experienced varying degrees of disability, ranging from mild impairments to reliance on mobility aids such as canes, bilateral supports, or wheelchairs. Additional contextual details are provided in **Table 1**.

### Content Analysis

When conducting the content analysis (n=22 individuals living with MS) on the hypothetical situations presented, we organized responses into three categories: participants would consider MAiD, participants may consider MAiD, or participants would not consider MAiD. The corresponding results are presented in **Figure 1**.



**Figure 1.** Individuals living with multiple sclerosis; perspectives on medical assistance in dying (MAiD) as an end-of-life option in various hypothetical situations; *courtesy of Janine Brown, PhD, et al.*

Variable	Category	n (21)
Mean (%) Patient-Determined Disease Steps	Normal (No limitations)	7 (33.33%)
	Mild Disability	4 (19.05%)
	Moderate Disability	1 (4.76%)
	Early Cane Use	2 (9.52%)
	Late Cane Use	2 (9.52%)
	Bilateral Support	3 (14.29%)
	Wheelchair Use	2 (9.52%)
Mean (SD) MSIS-29 Impact Scale	Physical (raw)	48.95 ± 21.08
	Physical (%)	36.2 (26.3)
	Psychological (raw)	21.67 ± 9.71
	Psychological (%)	35.2 (26.9)
Mean (%) Living Situation	Live alone independently	1 (4.76%)
	Live alone with support	1 (4.76%)
	Live with others independently	10 (47.62%)
	Live with others with support	8 (38.10%)
Mean (%) Household Size	2 persons	9 (42.86%)
	3 persons	7 (33.33%)
	4 or more persons	5 (23.80%)
Mean (%) Spirituality/Faith Importance	Not at all important	6 (28.57%)
	Slightly important	4 (19.05%)
	Moderately important	6 (28.57%)
	Very important	4 (19.05%)
	Extremely important	1 (4.76%)
Mean (%) Travel Distance to Primary Care	<10 km	15 (71.43%)
	11–100 km	5 (23.81%)
	100–300 km	1 (4.76%)
Mean (%) Use of Homecare Services	Yes	1 (4.76%)
	No	20 (95.24%)
Mean (%) Homecare Frequency	Daily	1 (4.76%)
	2–3 times/month	1 (4.76%)
	Unknown / Not applicable	19 (90.48%)
Mean (%) Types of Assistance	Rehabilitation/Physiotherapy	6 (22.22%)
	Emotional support	4 (14.81%)
	Housekeeping	4 (14.81%)
	Errands (e.g., shopping)	4 (14.81%)
	Companionship	3 (11.11%)
	Prefer not to disclose	3 (11.11%)

**Table 1.** Contextual Information of Participants Living with Multiple Sclerosis; *courtesy of Janine Brown, PhD, et al.*

\*note only variables with a response are noted

\*\* only 21 ILMS completed the contextual survey

**Abbreviations: MSIS-29 Impact Scale:** Multiple sclerosis impact scale 29; **SD:** standard deviation

## Themes

When discussing EOL care in various hypothetical situations, the participants' perspectives were clustered into four themes: 1) a shifting identity, 2) navigating healthcare resources, 3) the weight of guilt, and 4) care concerns for family. The exemplary quotations

illustrating the themes are incorporated into **Table 2**.

### A Shifting Identity

Participants emphasized the importance of shifting their self-identity and adapting their life focus along their illness trajectory, which helped them reappraise their quality of life as

Theme: A Shifting Identity
<p>"If there's nothing that you experience that makes you happy, or you're unable to do those things, it means finding something else that might or does." (ILMS 11)</p> <p>"I still feel like you have life to live. Yeah, maybe going to the bathroom, or having a bath or a shower looks different, but at the end of the day, you accomplish the same thing." (ILMS 18)</p> <p>"A big part of my identity has shifted. I've relied more on trying to enjoy what I can still do, which is being with my family and eating food. If I get even more disabled, it'll still be the same in that there will be a whole new set of things I can't do anymore that I can adjust to." (ILMS 20)</p>
Theme: Navigating Healthcare Resources
<p>"There just isn't enough support. I think healthcare as a whole, for anyone with a chronic illness, there's not enough physio. There's not enough OT. There's not enough long-term care or home care. It just becomes they're just doing the best with what they have...There's just not enough to go around." (KI 5)</p> <p>"I mean, there's definitely a lack of emotional support in that. I have a trained psychologist, but I know many MS patients don't, and they don't have that luxury, because they can't afford it through private benefits." (ILMS 16)</p> <p>"It's great to say, 'Oh, we have this wonder drug or device that you can use,' but if it's not affordable and accessible, then that's not helpful." (ILMS 19)</p>
Theme: The Weight of Guilt
<p>"I do know that if, and when, I make that decision, it is going to be what's best for me. Which is very hard for me to do, because I never put myself first, because I'm a mom, right... it doesn't matter how sick I am, he [my son] is going to want me around." (ILMS 15)</p> <p>"I was on six or seven different medications...The health insurance paid for 90% of it. But, if I hadn't had that, and my family, or my husband, had to bear that, those medical costs, that's where I say, I don't want to be a burden, financially or physically. That would be one of the reasons why I would choose MAiD, personally, that would be huge." (ILMS 14)</p> <p>"That is-is very uncomfortable for me and I feel like I will feel very guilty. I feel like I have let her down or like I'm giving up. I feel like that will be the hardest part." (ILMS 5)</p>
Theme: Care Concerns for Family
<p>"I guess I'm only concerned about my kids. I don't really care so much what happens to me, I don't really know how else to describe it." (ILMS 18)</p> <p>"But I just don't know if I'd be able to go through with it, because yeah, it affects the people around you so much more than it affects you." (ILMS 9)</p> <p>"I think it's highly desirable that they [family] be involved, and I will say this in part to the patients sometimes. You know, after this has happened, it's not going to bother you. You'll be dead. What is the effect of this going to be on the people who are still here?" (KI 2)</p>

**Table 2.** Resultant Themes Exemplar Quotations; *courtesy of Janine Brown, PhD, et al.*

**Abbreviations:** ILMS: individuals living with multiple sclerosis; KI: key informant; MAiD: medical assistance in dying; MS: multiple sclerosis; OT: occupational therapy; PT: physical therapy

their disease affected their daily functioning. They further identified that this shift helped them focus on quality of life in new ways. Although they acknowledged that this process was not easy, they emphasized that this adaptive mindset enhanced their quality of life.

### **Navigating Healthcare Resources**

Participants described a persistent gap between the resources they needed and those they could access. These resource shortages affected their quality of life and shaped their EOL considerations. Financial barriers, such as the costs of medications, mobility aids, emotional support, and home-based care were often prohibitive. Although participants wanted opportunities to discuss EOL options and goals of care, they felt limited time during healthcare appointments made this difficult. This lack of support frequently left them feeling vulnerable and forced to navigate a complex care system on their own.

### **The Weight of Guilt**

Participants expressed feeling guilty when considering EOL decisions and the possibility of MAiD. The guilt manifested in multiple ways, including the guilt of becoming a financial and physical burden to close ones, the guilt of giving up, the guilt that their care was impacting their family's future, the guilt of prioritizing their own wishes, and the guilt of leaving family members to make difficult decisions. At times, the weight of this guilt led them to avoid conversations about goals of care.

### **Care Concerns for Family**

Participants discussed how their disease and future care choices would affect their families. They were further concerned that their EOL care decisions, especially if choosing a MAiD death, could impact their families to a greater degree than themselves. The emotional weight of decision-making was described not only as a personal burden but also as a worry for those who would be left behind.

## **Discussion**

---

Our qualitative research findings suggest that concerns about pain, functional decline, loss of independence, and the emotional burden placed on family members may contribute to choosing a medically assisted death. These insights align

with previous research on why individuals may choose an assisted death.<sup>13,21</sup> For example, in the Berkman (1999) study,<sup>16</sup> unbearable pain and fear of not enjoying life to the fullest (49% and 42% respectively) were factors that definitely or probably would result in considering an assisted death. Similarly, the study by Marrie et al.<sup>17</sup> reported that unbearable pain, causing a financial burden for family or caregivers, and being unable to do things that made one happy were factors identified by 65%, 41% and 34% of participants, respectively, as reasons they would definitely or probably consider an assisted death.

Our study highlighted the emotional complexity of EOL choices and identified that emotional or financial concerns for loved ones may influence decisions when reflecting on hypothetical scenarios. Psycho-emotional factors such as suffering, fear of loss of decision-making control, and concerns about dignity often influence decisions about EOL care options.<sup>22</sup> Collectively, these findings suggest that both personal and relational concerns shape EOL decision-making, as individuals weigh their own suffering alongside worries about becoming an emotional burden to loved ones.

Participants acknowledge that their EOL decisions may have profound, lasting effects on their families. This recognition suggests a need for holistic care planning that includes family members as an integral part of the EOL decision-making process. Prior evidence shows that family members can experience judgment, guilt, trauma about their role in the process, and distress during and after the MAiD death.<sup>23,24</sup> Integrating family early in EOL care discussions may help with emotional preparation, support communication, and improve understanding of choices.

Our study found that although certain services such as mobility aids, medications, and home care are theoretically part of healthcare systems, their costs, access processes, and eligibility requirements often make them difficult to access. This aligns with previous research showing that socio-economic status,<sup>25</sup> structural and societal issues, and knowledge of EOL options<sup>26</sup> can influence the EOL experience.

### **Strengths, Limitations and Future Research**

Strengths of our study include the use of both content and thematic analysis, which enabled a comprehensive understanding of the phenomenon and enhanced the depth of

interpretation by systematically identifying patterns and relationships within the data. However, several limitations should be noted, such as potential response bias, as individuals who did not wish to discuss EOL and/or MAiD would not have self-identified as potential participants. Additionally, we acknowledge that participants' responses were based on hypothetical situations, which may or may not reflect their actual contexts or EOL decisions. We also did not specifically seek to capture the perspectives of immigrant, minority, or Indigenous communities, whose distinct cultural and spiritual values may significantly influence EOL care preferences. As the study was conducted within a single Canadian province, the findings may not be generalizable to other regions or healthcare systems. Future research should include the perspectives of family members, caregivers, and policymakers, while accounting for cultural and geographical variation.

## Conclusion

This study contributes to the growing understanding of the complex contextual factors that may influence EOL decision-making when MAiD is a legal option. The results emphasize that EOL decisions are inherently relational and situated within social, emotional, and systemic contexts. Healthcare professionals and policymakers should recognize that EOL decisions may extend beyond individual preference and are deeply intertwined with family dynamics and access to supportive services. As MAiD legislation and EOL care practices continue to evolve in Canada, ongoing dialogue that includes patients, families, and policymakers is essential.

## Correspondence

**Janine Brown, PhD**

**Email:** Janine.Brown@uregina.ca

## Financial Disclosures

**J.B.:** None declared.

**K.B.K.:** None declared.

**L.T.:** None declared.

**L.H.:** None declared.

**M.N.A.:** None declared.

**M.C.L.:** None declared.

**I.P.:** None declared.

## References

1. Gilmour H, Ramage-Morin PL, Wong SL. Multiple sclerosis: prevalence and impact. *Health rep.* 2018;29(1):3-8.
2. Khan G, Hashim MJ. Epidemiology of multiple sclerosis: global, regional, National and sub-national-level estimates and future projections. *J Epidemiol Glob Health.* 2025;15(1):21. Published 2025 Feb 10. doi:10.1007/s44197-025-00353-6
3. Al-Sakran LH, Marrie RA, Blackburn DF, Knox KB, Evans CD. Establishing the incidence and prevalence of multiple sclerosis in Saskatchewan. *Can J Neurol Sci.* 2018;45(3):295-303. doi:10.1017/cjn.2017.301
4. Lakin L, Davis BE, Binns CC, Currie KM, Rensel MR. Comprehensive approach to management of multiple sclerosis: addressing invisible symptoms—a narrative review. *Neurol Ther.* 2021;10(1):75-98. doi:10.1007/s40120-021-00239-2
5. Chiaravalloti ND, DeLuca J. Cognitive impairment in multiple sclerosis. *Lancet Neurol.* 2008;7(12):1139-1151. doi:10.1016/S1474-4422(08)70259-X
6. Kalia LV, O'Connor PW. Severity of chronic pain and its relationship to quality of life in multiple sclerosis. *Mult Scler.* 2005;11(3):322-327. doi:10.1191/1352458505ms1168oa
7. Whitehouse CE, Fisk JD, Bernstein CN, Berrigan LI, Bolton JM, Graff LA, et al. Comorbid anxiety, depression, and cognition in MS and other immune-mediated disorders. *Neurology.* 2019;92(5):e406-e417. Published 2019 Jan 28. doi:10.1212/WNL.0000000000006854
8. Koffman J, Penfold C, Cottrell L, Farsides B, Evans CJ, Burman R, et al. "I wanna live and not think about the future" what place for advance care planning for people living with severe multiple sclerosis and their families? A qualitative study. *Plos One.* 2022;17(5):e0265861. Published 2022 May 26. doi:10.1371/journal.pone.0265861
9. Marrie RA, Yu N, Blanchard J, Leung S, Elliott L. The rising prevalence and changing age distribution of multiple sclerosis in Manitoba. *Neurology.* 2010;74(6):465-471. doi:10.1212/WNL.0b013e3181cf6ec0
10. Talente B, Finseth LT, Blake N, Costello K, Schmidt H, Vandigo J, et al. Patient experiences with the impacts of multiple sclerosis & disease-modifying therapies. *ClinicoEcon Outcomes Res.* 2025;17:199-215. Published 2025 Mar 15. doi:10.2147/CEOR.S489929
11. Connolly T, Coats H, DeSanto K, Jones J. The experience of uncertainty for patients, families and healthcare providers in post-stroke palliative and end-of-life care: a qualitative meta-synthesis. *Age Ageing.* 2021;50(2):534-545. doi:10.1093/ageing/afaa229
12. Buote LC, Wada K, Russell-Mayhew S, Feldstain A. Maid in Canada: controversies, guidelines, and the role of psychologists in relation to Bill C-14. *Canadian Psychology/Psychologie canadienne.* 2022 Feb;63(1):126-137. doi:10.1037/cap0000286
13. Health Canada. Sixth Annual Report on Medical Assistance in Dying in Canada. Ottawa: Health Canada; 2025 Nov. [updated 28 November 2025, cited 20 January 2026]. Available from: <https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2024.html>
14. Grant I, Benedet J, Sheehy E, Frazee C. A conversation on feminism, ableism, and medical assistance in dying. *Canadian Journal of Women and the Law.*

- 2024;35(1):31-72. Published 2024 Jun 1. doi:10.3138/CJWL\_2023\_Grant3, 10.3138/CJWL\_2023\_Grant3
15. Coelho R, Maher J, Gaiind KS, Lemmens T. The realities of medical assistance in dying in Canada. *Palliat Support Care*. 2023;21(5):871-878. doi:10.1017/S1478951523001025
  16. Berkman CS, Cavallo PF, Chesnut WC, Holland NJ. Attitudes toward physician-assisted suicide among persons with multiple sclerosis. *J Palliat Med*. 1999;2(1):51-63. doi:10.1089/jpm.1999.2.51
  17. Marrie RA, Salter A, Tyry T, Cutter GR, Cofield S, Fox RJ. High hypothetical interest in physician-assisted death in multiple sclerosis. *Neurology*. 2017;88(16):1528-1534. doi:10.1212/WNL.0000000000003831
  18. Teodoro IP, Rebouças VD, Thorne SE, de Souza NK, de Brito LS, Alencar AM. Interpretive description: a viable methodological approach for nursing research. *Escola Anna Nery*. 2018;22(03):e20170287. <https://doi.org/10.1590/2177-9465-EAN-2017-0287>
  19. Hobart J. The multiple sclerosis impact scale (MSIS-29). In: Jenkins C, Peers M, Bromberg MD, editors. *Quality of life measurement in neurodegenerative and related conditions*. Cambridge: Cambridge University Press; 2011 Feb 3. p. 24-40
  20. Ann Marrie R, McFadyen C, Yaeger L, Salter A. A systematic review of the validity and reliability of the patient-determined disease steps scale. *Int J MS Care*. 2023;25(1):20-25. doi:10.7224/1537-2073.2021-102
  21. Ganzini L, Goy ER, Dobscha SK. Why Oregon patients request assisted death: family members' views. *J Gen Intern Med*. 2008;23(2):154-157. doi:10.1007/s11606-007-0476-x
  22. Hendry M, Pasterfield D, Lewis R, Carter B, Hodgson D, Wilkinson C. Why do we want the right to die? A systematic review of the international literature on the views of patients, carers and the public on assisted dying. *Palliat Med*. 2013;27(1):13-26. doi:10.1177/0269216312463623
  23. Crumley ET, LeBlanc J, Henderson B, Jackson-Tarilton CS, Leck E. Canadian family members' experiences with guilt, judgment and secrecy during medical assistance in dying: a qualitative descriptive study. *CMAJ Open*. 2023;11(4):E782-E789. Published 2023 Aug 22. doi:10.9778/cmajo.20220140
  24. Serota KL. *Complex MAiD Bereavement Stories: A Critical Narrative Analysis of Family Members' Discordance, Pain, Dignity, and Wisdom*. Doctoral dissertation. University of Toronto; 2024. [accessed January 20, 2026] <https://utoronto.scholaris.ca/server/api/core/bitstreams/9e762429-dfee-4a31-8964-138bf8f81de8/content>
  25. Bowers SP, Chin M, O'Riordan M, Carduff E. The end of life experiences of people living with socio-economic deprivation in the developed world: an integrative review. *BMC Palliat Care*. 2022;21(1):193. Published 2022 Nov 5. doi:10.1186/s12904-022-01080-6
  26. Aker N, Griffiths S, Kupeli N, Frost R, Nair P, Walters K, et al. Experiences and access of palliative and end of life care for older people from minority ethnic groups: a scoping review. *BMC Palliat Care*. 2024;23(1):228. Published 2024 Sep 17. doi:10.1186/s12904-024-01555-8

# Join the Community That Sets the Standard

CAMAP members stand within a national community committed to ethical excellence, clinical integrity, and informed practice in MAiD.

As a CAMAP member, you gain access to:

- ✓ Exclusive educational offerings and professional development
- ✓ National collaboration and connection that shapes the future of MAiD practice in Canada
- ✓ Timely updates on legislation, safeguards, and practice guidance
- ✓ Priority conference rates and member-only resources

**BECOME A MEMBER AT**  
[www.camapcanada.ca](http://www.camapcanada.ca)

**CAMAP**  
Canadian Association  
Assessors and



*Julie Campbell*  
President, CAMAP