What Factors Explain the Growing Use of Medical Assistance in Dying in Quebec? Protocol of an Interdisciplinary, Mixed and Multi Methods Study

Marie-Ève Bouthillier, Isabelle Marcoux, Catherine Perron, Bruno Gagnon, David Lussier, Ghislaine Rouly, Mathieu Moreau, Michel Dorval, Sabrina Lessard, Dominique Girard, Gina Bravo, Maude Hébert, Michelle Giroux, Simon Lemyre, Alexandra Beaudin, Claude Julie Bourque, Maryse Soulières, Maude Lévesque, Mona Gupta, Valérie Bourgeois-Guérin, David Lavoie, Bertrand Lavoie, Ariane Plaisance, Louise Bernier

Submitted to: JMIR Research Protocols
on: September 05, 2025

Table of Contents

What Factors Explain the Growing Use of Medical Assistance in Dying in Quebec? Protocol of an Interdisciplinary, Mixed and Multi Methods Study

Marie-Ève Bouthillier[1, 2] PhD; Isabelle Marcoux[3] PhD; Catherine Perron[4] PhD; Bruno Gagnon[5] MD, MSc; David Lussier[6] MD; Ghislaine Rouly[1]; Mathieu Moreau[2] MD, MSc; Michel Dorval[7, 8] PhD; Sabrina Lessard[9, 10] PhD; Dominique Girard[11] PhD; Gina Bravo[12] PhD; Maude Hébert[13] inf. PhD; Michelle Giroux[14] LLL, MA; Simon Lemyre[6] MA, PhD candidate; Alexandra Beaudin[3] PhD candidate; Claude Julie Bourque[2] PhD; Maryse Soulières[15] PhD; Maude Lévesque[10, 16] PhD; Mona Gupta[17] MD, PhD; Valérie Bourgeois-Guérin[18] PhD; David Lavoie[6] PhD; Bertrand Lavoie[19] LLD, MA; Ariane Plaisance[20] PhD; Louise Bernier[19] LLM, LLD

[1] Research Center Centre Hospitalier de l'Université de Montréal Montreal CA
[2] Department of Family Medicine and Emergency Medicine Université de Montréal Montréal CA
[3] School of Interdisciplinary Health Sciences University of Ottawa Ottawa CA
[4]School of Social Work Faculty of Arts and Humanities Université de Sherbrooke Sherbrooke CA
[5]Department of Family Medicine and Emergency Medicine Centre de Recherche du CHU de Québec Université de Laval Québec CA
[6]Department of Medicine Faculty of Medicine Université de Montréal Montréal CA
[7] Faculty of Pharmacy Université de Laval Québec CA
[8] Centre de recherche du CHU de Québec Université de Laval Québec CA
[9]Department of Anthropology Faculty of Arts and Sciences Université de Montréal Montréal CA
[10] Centre for Research and Expertise in Social Gerontology Montréal CA
[11] Department of Health Sciences Université du Québec à Rimouski Rimouski CA
[12]Department of Community Health Sciences Faculty of Medicine and Health Sciences Université de Sherbrooke Sherbrooke CA
[13] Department of Nursing Université du Québec à Trois-Rivières Trois-Rivières CA
[14]Civil Law Section Law Faculty University of Ottawa Ottawa CA
[15] School of Social Work Université de Montréal Montréal CA
[16] School of Social Work Université du Québec à Montréal Montréal CA
[17]Department of Psychiatry and Addiction Medicine Faculty of Medicine Université de Montréal Montréal CA
[18] Department of Psychology Université du Québec à Montréal Montréal CA
[19] Law Faculty Université de Sherbrooke Sherbrooke CA
[20] Qulysis Québec CA

Corresponding Author:
Marie-Ève Bouthillier PhD

Department of Family Medicine and Emergency Medicine
Université de Montréal
C.P. 6128, succursale Centre-ville
Montréal
CA

Abstract

Background: Medical Assistance in Dying (MAiD) became a legal end-of-life option on December 10th, 2015 in Quebec, and on June 17th, 2016 in the rest of Canada. Since its legalization, there has been a steady increase in the number of MAiD requests and provisions. Across permissive jurisdictions, Quebec now has the highest rate of assisted death.

Objective: The objective of this paper is to present the protocol developed by CIRAMM (in French: Consortium interdisciplinaire de recherche sur l'aide médicale à mourir), an interdisciplinary research consortium, including an International Advisory Committee, set up to better understand the growing use of MAiD in the Canadian province of Quebec.

Methods: The design of this protocol is multimethods and convergent mixed-methods, including 1) an international cross-thematical approach with four main research methods (a scoping review, key informant interviews, focus groups with healthcare professionals and a population-based survey) chosen to partially answer research questions across the entire study and to compare with other jurisdictions, and 2) theme-specific methods (including community forums, media coverage analysis,

comparative legal analyses, case studies of triads, individual interviews, system mapping) to enrich and complement findings from the cross-thematical approach.

Results: In July 2024, several research methods not requiring ethics committee approval were initiated. By Summer 2025, interviews with key informants and analyses were completed. Concurrently, other sub-teams are getting ready to seek ethics approval for their protocols and data collection processes.

Conclusions: Findings from the international cross-thematical approach and theme-specific methods will provide a comprehensive understanding of the factors influencing the use of MAiD in Quebec. This study has strengths, including the use of a specific theoretical framework, a variety of complementary methods, and an integrated knowledge mobilization strategy. As for its limitations, we foresee challenges with comparison of jurisdictions in terms of language, culture and legal systems, as well as access to data about MAiD cases since reporting systems may differ between jurisdictions.

(JMIR Preprints 05/09/2025:83549)
DOI: https://doi.org/10.2196/preprints.83549

Preprint Settings

1) Would you like to publish your submitted manuscript as preprint?

✓ **Please make my preprint PDF available to anyone at any time (recommended).**
Please make my preprint PDF available only to logged-in users; I understand that my title and abstract will remain visible to all users.
Only make the preprint title and abstract visible.
No, I do not wish to publish my submitted manuscript as a preprint.

2) If accepted for publication in a JMIR journal, would you like the PDF to be visible to the public?

✓ **Yes, please make my accepted manuscript PDF available to anyone at any time (Recommended).**
Yes, but please make my accepted manuscript PDF available only to logged-in users; I understand that the title and abstract will remain v
Yes, but only make the title and abstract visible (see Important note, above). I understand that if I later pay to participate in <a href="http
No. Please do not make my accepted manuscript PDF available to anyone. I understand that if I later pay to participate in <a href="https:/

Original Manuscript

Original Paper

Marie-Ève Bouthillier, PhD, Associate Professor[3,4]
Isabelle Marcoux, PhD, Associate Professor[14]
Catherine Perron, PhD, Assistant Professor[19]
Bruno Gagnon, MD, MSc, Associate Professor[1]
David Lussier, MD, Clinical Associate Professor[2]
Ghislaine Rouly, Patient Partner[3]
Mathieu Moreau, MD, MSc, Clinical Professor[4]
Michel Dorval, PhD, Full Professor[5,6]
Sabrina Lessard, PhD, Associate Professor [7,8]
Dominique Girard, PhD, Professor[9]
Gina Bravo, PhD, Associate Professor[10]
Maude Hébert, inf. PhD, Associate Professor[11]
Michelle Giroux, LL. L, MA, Full Professor[12]
Simon Lemyre, Doctoral Candidate[2]
Alexandra Beaudin, Doctoral Candidate[14]
Claude Julie Bourque, PhD, Associate Professor[4]
Maryse Soulières, PhD, Associate Professor [15]
Maude Lévesque, PhD, Professor[8,16]
Mona Gupta, MD, PhD, Full Professor[17]
Valérie Bourgeois-Guérin, PhD, Professor[18]
David Lavoie, PhD[2]
Bertrand Lavoie, MA, PhD (LLD), Assistant Professor[20]
Ariane Plaisance, PhD[21]
Louise Bernier, LL. M., PhD (LLD), Full Professor[20]

Affiliations
[3] Research Center, Centre Hospitalier de l'Université de Montréal, Montréal, QC, Canada
[4] Department of Family Medicine and Emergency Medicine, Université de Montréal, Montréal, QC, Canada
[14] School of Interdisciplinary Health Sciences, University of Ottawa, Ottawa, ON, Canada
[19] School of Social Work, Faculty of Arts and Humanities, Université de Sherbrooke, Sherbrooke, QC, Canada
[1] Department of Family Medicine and Emergency Medicine, Centre de Recherche du CHU de Québec, Université de Laval, Québec, QC, Canada
[2] Department of Medicine, Faculty of Medicine, Université de Montréal, Montréal, QC, Canada
[5] Faculty of Pharmacy, Université de Laval, Québec, QC, Canada
[6] Centre de recherche du CHU de Québec, Université de Laval, Québec, QC, Canada
[7] Department of Anthropology, Faculty of Arts and Sciences, Université de Montréal, Montréal, QC, Canada
[8] Centre for Research and Expertise in Social Gerontology, Montréal, QC, Canada
[9] Department of Health Sciences, Université du Québec à Rimouski
[10] Department of Community Health Sciences, Faculty of Medicine and Health Sciences, Université de Sherbrooke
[11] Department of Nursing, Université du Québec à Trois-Rivières, Trois-Rivières, QC, Canada
[12] Civil Law Section, Law Faculty, University of Ottawa, Ottawa, ON, Canada
[15] School of Social Work, Université de Montréal, Montréal, QC, Canada
[16] School of Social Work, Université du Québec à Montréal, Montréal, QC, Canada

[17] Department of Psychiatry and Addiction Medicine, Faculty of Medicine, Université de Montréal, Montréal, QC, Canada
[18] Department of Psychology, Université du Québec à Montréal, Montréal, QC, Canada
[20] Law Faculty, Université de Sherbrooke, Sherbrooke, QC, Canada
[21] Qulysis, QC, Canada

Correspondence information: Marie-Eve Bouthillier, Ph.D., Associate Professor
marie-eve.bouthillier@umontreal.ca
Department of Family Medicine and Emergency Medicine, Université de Montréal, Montréal, QC, Canada

What Factors Explain the Growing Use of Medical Assistance in Dying in Quebec? Protocol of an Interdisciplinary, Mixed and Multi Methods Study

Abstract

Background: Medical Assistance in Dying (MAiD) became a legal end-of-life option on December 10th, 2015 in Quebec, and on June 17th, 2016 in the rest of Canada. Since its legalization, there has been a steady increase in the number of MAiD requests and provisions. Across permissive jurisdictions, Quebec now has the highest rate of assisted death.

Objective: The objective of this paper is to present the protocol developed by CIRAMM (in French: Consortium interdisciplinaire de recherche sur l'aide médicale à mourir), an interdisciplinary research consortium, including an International Advisory Committee, set up to better understand the growing use of MAiD in the Canadian province of Quebec.

Methods: The design of this protocol is multimethods and convergent mixed-methods, including 1) an international cross-thematical approach with four main research methods (a scoping review, key informant interviews, focus groups with healthcare professionals and a population-based survey) chosen to partially answer research questions across the entire study and to compare with other jurisdictions, and 2) theme-specific methods (including community forums, media coverage analysis, comparative legal analyses, case studies of triads, individual interviews, system mapping) to enrich and complement findings from the cross-thematical approach.

Results: In July 2024, several research methods not requiring ethics committee approval were initiated. By Summer 2025, interviews with key informants and analyses were completed. Concurrently, other sub-teams are getting ready to seek ethics approval for their protocols and data collection processes.

Conclusions: Findings from the international cross-thematical approach and theme-specific methods will provide a comprehensive understanding of the factors influencing the use of MAiD in Quebec. This study has strengths, including the use of a specific theoretical framework, a variety of complementary methods, and an integrated knowledge mobilization strategy. As for its limitations, we foresee challenges with comparison of jurisdictions in terms of language, culture and legal systems, as well as access to data about MAiD cases since reporting systems may differ between jurisdictions.

Keywords: Medical Assistance in Dying; Evolution of assisted dying practices; Protocol; Mixed and Multi Methods Study; Growing use of MAiD; Factors explaining use of MAiD; Assisted Dying Related Factors; Euthanasia; End-of-life Care; Quebec, Canada

Introduction

In the province of Quebec, Medical Assistance in Dying (MAiD) has been permitted, as of December 2015, for individuals who meet the eligibility criteria specified in the Act respecting end-of-life care [1].This legislation sets out a framework for 'end-of-life care', which includes palliative care, continuous palliative sedation, as well as euthanasia (referred to in the Act and in this paper as

MAiD) [1]. In Quebec, MAiD consists ‘in the administration by a competent professional of medications or substances to a patient, at the patient’s request, in order to relieve their suffering by hastening death.’ [2, Para. 14]. Unlike the Canadian law, Quebec legislation excludes assisted suicide or self-administered MAiD [3].

Since 2015, there has been steady, year over year increase in the global number of requests and provisions of assisted dying [4]. In fact, Quebec now ranks first in the world in terms of the proportion of MAiD deaths, ahead of other Canadian provinces, and even of countries where this practice has been permitted for decades [5], [6]. In the fall of 2023, at the request of the Quebec Ministry of Health and Social Services, a call for proposals was launched by Quebec's main funding agency (Fonds de recherche du Québec (FRQ)), to fund a research team willing to investigate the factors explaining this rise in MAiD incidence [7]. The study proposed by our consortium (Interdisciplinary research consortium on medical assistance in dying (in French : Consortium interdisciplinaire de recherche sur l’aide médicale à mourir (hereafter CIRAMM) was successful in securing three years of financial support [8]. The objectives of this paper are the following: 1) to briefly summarize current knowledge on the factors explaining the use of MAiD in Quebec, 2) to specify the research objectives that led to the development of the CIRAMM to carry out this vast study, 3) to present the study’s theoretical framework, 4) to describe its methodology, and 5) to discuss its strengths and limitations.

Factors Explaining the Use of MAiD

Studies on the evolution of the use of MAiD and potential explanatory factors remain sparse. Few authors propose hypotheses concerning the increase in MAiD practices at the international level. Boer describes the development of medically assisted death in the Netherlands from 1968 onwards, and reports that the number of euthanasia tripled between 2007 and 2021; a period during which eligibility criteria would have been interpreted more broadly and mobile teams performing euthanasia without a prior doctor-patient relationship were set up [9]. Still in the Netherlands, a study conducted by Groenewould et al. revealed that age, church attendance, political orientation, income, health and volunteer availability were associated with the geographical variation in the incidence of euthanasia over time (2013-2017) [10].

Byram and Reiner tested 10 hypotheses that could explain why the rates of deaths by MAiD is 15 times higher in Canada than by assisted suicide in California, despite having adopted their respective laws in 2016 [11].Three of them were confirmed: limited public awareness, fewer MAiD practitioners per capita, and sparse support by healthcare institutions in California in comparison to Canada. On the other hand, Pullman suggests, as possible hypotheses for the higher rate of MAiD in Canada, that the eligibility criteria are more ambiguous, their interpretation more flexible and the method used (mainly injection in Canada rather than prescription of lethal drugs in California) implies more active participation of providers, who (even if that's not their intention), have tacit ascendancy over patients in vulnerable positions [12]. According to Khakzedeh, other factors associated with the legislation and its implementation should be taken into account [13]. For example, in jurisdictions like the United States, Switzerland and Austria, assisted suicide is neither a care nor a right, and involves greater mobilization on the part of individuals regarding medical consultations, the purchase of medication or notarial deeds [13].

In the Canadian context, recent analyses and opinion pieces on what triggers requests for MAiD bring divergent and controversial elements to the conversation. Coelhlo et al. link MAiD requests to suffering and lack of medical, psychosocial and rehabilitation support (disability support) due in part to structural problems [14]. The lack of access to palliative care and housing alternatives are often cited in the media to explain the use of MAiD [15], [16], [17], [18], [19]. Alternatively, according to

Downar et al., available evidence showed that people who died by MAiD had higher socioeconomic status, and most of them benefited from the involvement of palliative care providers [20]. In Quebec, the idealization of “a good death”, social secularization, and the wide-spread emphasis on self-determination have been proposed to explain the increase in the use of MAiD [21], [22]. The “quest for autonomy” and the reappropriation of power in the intimate sphere could be explained by the retreat (or rejection) of the argument of authority [22] and, in Quebec in particular, the decline of religion [23]. Even with “increasing social acceptance of this care” [24, p. 35] in Quebec, as elsewhere, studies highlight the lack of public knowledge of MAiD in relation to other end-of-life practices [25], [26]. Overall, the practice of euthanasia and assisted suicide is still recent in Canada. Studies are needed to better understand the use of these means to end one’s life.

Research Objectives

The call for proposals issued by the FRQ aimed at better understanding the use of MAiD in the Quebec context. It included a series of stated objectives reproduced in Table 1.

Table 1. Research themes and objectives

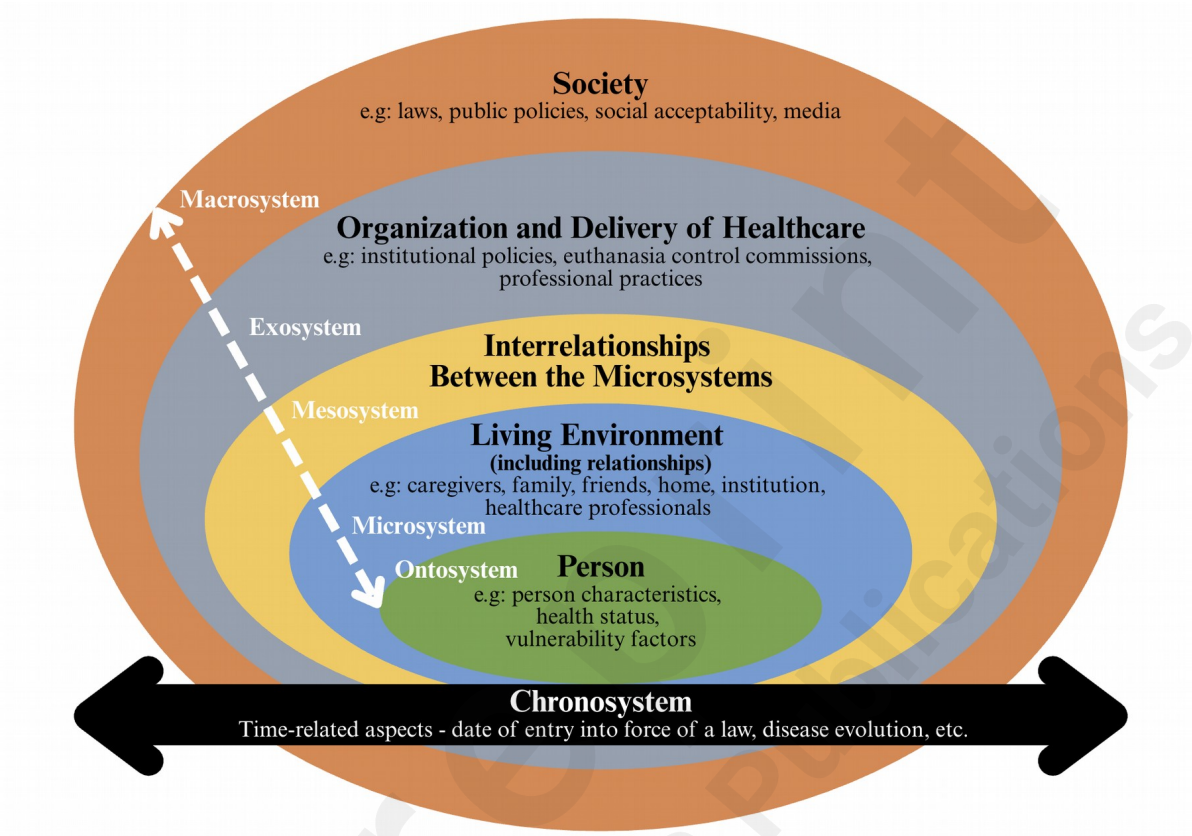
Themes	Objectives
1. Personal characteristics	Identify the characteristics of people who request MAiD; Identify how social determinants of health influence the personal experience of MAiD; Investigate the influence of vulnerability factors on personal experience; Investigate the relationship between the nature of suffering and one's desire to obtain MAiD; Investigate how personal experiences of support throughout the MAiD process influence one's motivation to consider MAiD.
2. Organization and delivery of healthcare in Quebec	Demonstrate how Quebec's end-of-life care legislative provisions that pertain to the organization of healthcare are associated with the increased use of MAiD; Explain how differences in the availability of end-of-life care in different regions and institutions influence the use of MAiD; Describe the relationship between professional practice in MAiD and the evolution of requests for MAiD in Quebec.
3. Societal dimensions	Determine whether socio-legal factors explain the growing use of MAiD; Examine whether the patient (family)/professional relationship has an impact on MAiD requests and administration; Explore the factors influencing the social acceptability of MAiD; Understand local and regional disparities in MAiD with respect to their socio-demographic characteristics.
4. Practices, legislation, and public policies	Compare and contrast Quebec's MAiD legislation and public policies with those of other jurisdictions; Examine how MAiD numbers in Quebec compare to those in other jurisdictions; Explore how Quebec's context can explain differences in MAiD use.
5. Regulation of Advance Requests for MAiD	Compare the provisions for advance MAiD requests set out in Quebec's Act respecting end-of-life-care with those in effect in jurisdictions that already allow MAiD for incompetent persons; Document experiences and practices related to advance MAiD requests in these other jurisdictions.

Theoretical Framework

The Bronfenbrenner's ecological systems theory [27] serves as the theoretical framework for this protocol (see Figure 1). This theory aims to better understand a phenomenon (namely, the use of MAiD) by situating the individual in relation to the various proximal and distal environments that

exert a direct or indirect influence on them. This will enable us to take into account all the specific objectives related to the five themes (in Table 1), each being linked to one or more systems. Figure 1 illustrates how the Bronfenbrenner's ecological systems theory will be applied to better understand the use of MAiD in the Quebec context.

Figure 1. Bronfenbrenner's ecological systems theory to better understand the use of MAiD in the Quebec context



First, the Ontosystem refers to a person's internal characteristics, states, strengths, and vulnerabilities. A better understanding of what characterizes people who use MAiD will enable us to address the objectives of Theme 1 relating to personal characteristics (e.g. health status, social determinants of health, vulnerability factors, personal values, conception of quality of life, relationship to suffering).

Second, the Microsystem is characterized by the person's immediate environment, and includes the individuals with whom the person has a direct relationship (e.g. relatives, healthcare professionals), as well as their immediate living environment, including the care setting (private dwelling, nursing home, hospital, palliative care home). The contribution of this system to the explanation of the phenomenon will be addressed by exploring, for example, the influence of social determinants of health (e.g. social support) (Theme 1) and patient and healthcare professionnals relationship on MAiD requests or administration (Theme 3).

Third, the Exosystem encompasses all the environments that have an indirect influence on the person. This will enable us to better understand the disparities in the use of MAiD, while considering factors associated with the organization of care and services, such as characteristics of the end-of-life care offer, depending on facilities and regions (Theme 2).

Fourth, the Macrosystem corresponds to society's cultural matrix (e.g. beliefs, values, norms, ideologies) and includes the laws, rules and policies that govern a society. A better understanding of

the use of MAiD as a function of the Macrosystem will be addressed through several themes' objectives, such as: Theme 3 (e.g. Quebec societal and legal factors; social acceptability; evolution of roles in decision-making), Theme 4 (e.g. comparative analysis of laws and public policies; factors associated with the evolution of the use of MAiD in different jurisdictions), and Theme 5 (international experiences with advance requests for MAiD).

Fifth, the Chronosystem allows considering the temporal elements that mark the evolution of MAiD use, depending on different factors, such as the changes in the course of the disease, the changes in institutional policies, the date of coming into force of MAiD legislation and relevant amendments.

Finally, the dotted line running through the systems represents the bidirectional influence- upward or downward - between society, its systems and its individuals, thus demonstrating their interdependence.

Methods

Study Design

The diversity of research objectives calls for the use of multimethods and convergent mixed methods design. Two complementary approaches were adopted to address the reseach objectives: 1) an international cross-thematical approach comprised of four research methods, and 2) theme-specific methods devoted to each theme. An overview of the research methods developed for this study (n=15) is provided in Table 2 and briefly described in the next section. The different methods will be deployed in such a way that the preliminary results will inform the development of data collection tools for subsequent theme-specific methods.

Table 2. Overview of the methods according to each theme

Themes	Methods (n=15)
All themes	Cross-thematical Methods Jurisdictions: Canada, Belgium, Switzerland, the Netherlands, United States (California), Australia (Victoria). Scoping Review Population-based Survey Key Informant Interviews Focus Groups with healthcare professionals
1. Personal characteristics	Theme-specific methods Individual Interviews Case Studies of Triads Retrospective Qualitative Chart Review
2. Organization and delivery of healthcare in Quebec	Theme-specific methods Document Analysis System Mapping
3. Societal dimensions	Theme-specific methods Media Coverage Analysis Community Forums
4. Practices, legislation, and public policies	Theme-Specific methods Comparative Legal Analysis on Assisted Dying Realist Synthesis

5. Regulation of advance requests for MAiD	Theme-specific methods Comparative Legal Analysis on Advance Requests for MAiD Mixed-literature systematic review

Cross-Thematical Methods

Scoping Review

Study Design: The scoping review will be conducted following the Joanna Briggs Institute methodology for scoping reviews and reported in accordance with the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) guidelines [28], [29]. The scoping review will follow these steps: 1) translating the overarching objective of the study, which is to better understand the use of MAiD in Quebec, into an operationalized research question,formulated to make the Population, Concept and Context (PCC) explicit; 2) specifying inclusion and exclusion criteria; 3) in collaboration with a librarian, developing the strategy to identify relevant literature, with adaptation for 10 databases (e.g. MEDLINE, CINAHL, EMBASE, PsycINFO, Web of Sciences and grey literature; 4) conducting the selection and extraction through Covidence [30] by two independent reviewers; 5) presenting the findings in a narrative format, and mapping them in tables and graphs to address the review objectives; and 6) drafting recommendations and implications for research and practice in a language adapted to different target audiences (general population, decision-makers, practitioners), and identifying future research needs.

Population-Based Survey

Study Design: A cross-sectional population-based survey on the social acceptability of MAiD in Quebec, two other Canadian provinces and five international jurisdictions (the Netherlands, Belgium, Switzerland, California (US) and Victoria (Australia)) will be conducted. In Canada, British Columbia and Ontario were selected for their demographic significance, as together with Quebec, these provinces accounted for 75% of the national population in 2024 [31]. In British Colombia, the MAiD death rate ranked second after Quebec, while Ontario’s rate was below the national average [6]. For their part, international jurisdictions were selected for having (1) at least five years of assisted dying legal permissibility (as of 2024) since a sufficiently long period is required to analyze potential explanatory factors in its growing use, and (2) different forms of assisted dying (euthanasia and physician assisted suicide) for comparability purpose. Participants. The survey will be conducted among the adult population (18 years old), in the official languages of the selected jurisdictions (either French, English, Dutch, German or Italian). The target sample size is calculated according to the following parameters: a 95% confidence interval, a maximum proportion of 0.50, a margin of error of +/- 5%, multiplied by the number of jurisdictions (n=8). A larger sample of respondents will be selected for Quebec to allow regional comparisons (expected total n of 3580).

Data Collection: The questionnaire, based on and adapted from questionnaires designed by CIRAMM members [25], [32], [33], [34] will include: acceptability and knowledge of MAiD, palliative care and continuous palliative sedation; previous experiences with MAiD and with other end-of-life care; social determinants of health; and sociodemographic characteristics. Special consideration will be given to tailoring the level of language and MAiD-related terminology to the specific context of each jurisdiction, while preserving thematic consistency across all settings. The survey will be conducted online via a web panel designed by the chosen polling firm (to be

determined).

Data Analysis: Data will be weighted according to socio-demographic characteristics to adjust results to represent the target population. Usual descriptive statistics will be used to summarize the factors associated with the acceptability of MAiD and with the use of MAiD for the selected jurisdictions. Multivariable regressions will be conducted to identify which factors (knowledge, previous experiences, social determinants of health, sociodemographic characteristics) are associated with acceptability of MAiD and contribute to the differences in use of MAiD across juridictions.

Key Informant Interviews

Study Design: To complement the results of the scoping review with data specific to the Quebec and each aboved-mentionned jurisdictions, a qualitative descriptive study will be carried out on the factors associated with growing use of MAiD. Participants. Fifty key informants will be selected for their expertise and experience in the field of MAiD in the above-mentioned jurisdictions. We will include: members of MAiD regulatory authorities (e.g. member of an oversight body) or people actively involved in MAiD practice (e.g. MAiD program manager or experienced provider). Selection will be done by non-probabilistic maximum variation purposive sampling method, to obtain rich and meaningful information, as well as to capture the breadth of different experiences and perspectives [35].
Data Collection: We will conduct semi-structured interviews with participants in order to gain insight into potential explaining factors to the use of MAiD. The interview guide, available in French and English, will be pre-tested and adapted in an evolving and iterative process throughout the data collection process [36]. Recruitment in Quebec will take place through networks already established by CIRAMM members (i.e. communities of practic of Quebec MAiD providers and support structures for MAiD, among others) [37], [38], [39], [40], [41], [42]. In other provinces of Canada and internationally, we will use a snowball approach [43] and mobilize our many Canadian and international networks: medical associations and federations, professional regulatory bodies, etc. [44], [45], [46], [47]. Interviews will be conducted by trained interviewers via the online Microsoft Teams platform. They will be recorded, and research notes will be taken by the interviewers to synthesize important ideas.

Data Analysis: The transcription process will leverage Teams' automatic transcription system, followed by editing by the interviewers. A descriptive thematic analysis will be conducted on the transcripts and research notes [48], with an iterative review process to refine codes based on the interview guide. Coding disagreements will be discussed between coders until a consensus is reached. The QDA Miner software [49] will support the coding process, allowing for the identification of recurring themes across participants' discourse. The criteria of rigor and consistency will be considered to ensure data quality (as for all the qualitative analyses included in this protocol) [50].

Focus Groups with Professionals Involved in MAiD

Study Design: We will explore with focus groups the viewpoints of professionals involved in MAiD in the same jurisdictions as the population-based survey and interviews with key informants.

Participants: Physicians and nurse practitioners involved in assessing, providing or supporting families accessing MAiD will be recruited (nurses, social workers, spiritual care workers, ethicists, etc.). Professionals must have participated in at least ten MAiD cases, or have been involved in

MAiD for at least two years. We will recruit the professionals using a non-probabilistic purposive sampling to obtain maximum variation (gender, age, experience, location and type of practice, etc.) [35].

Data Collection: A total of 18 online focus groups, each comprising of 6 to 8 participants, and lasting about two hours, will be organized as follows: four groups in Quebec (physicians and nurse practitioners (n=2); other professionals (n=2)); four groups in the rest of Canada (physicians and nurse practitioners (n=2); other professionals (n=2)); two groups in each international jurisdiction (Netherlands (n=2), Belgium (n=2), Switzerland (n=2), California (n=2) and Victoria (n=2)). The international focus groups will be comprised of only physicians because of the limited involvement of other healthcare professionals in MAiD. We will construct the facilitation guide (with the help of the International Advisory Committee for jurisdictions other than Quebec) based on information extracted from the key informant interviews. The facilitation guide will be pre-tested with a group of four people familiar with the reality of MAiD, but not approached as potential participants. For recruitment, we will use the same methods as for the key informant interviews. Focus groups will be conducted virtually, recorded and transcribed via Microsoft Teams.

Data Analysis: Analysis of the qualitative data from the focus groups will follow the same procedure as for the key informant interviews.

Theme-Specific Methods

In this section, we will present the five themes that structure the call for proposals and their associated specific methods. For the sake of consistency, we have chosen to present them in accordance with the Bronfenbrenner's ecological systems theory, from the microsystem (e.g. personal characteristics) to the macrosystem (e.g. practices, legislations and public policies) as presented in Figure 1.

Theme 1: Personal Characteristics

This theme focuses on the personal characteristics of people who have requested MAiD, using qualitative methods to help understand the process that led to their request.

Study Design: Three complementary methods will be used: 1) individual interviews with persons requesting MAiD; 2) case studies of triads involving interviews with persons requesting MAiD, one of their close-ones and a member of their caregiving staff; and 3) a retrospective retrospective chart review.

Individual Interviews

Participants: We will conduct interviews inspired by narrative approaches of the "life story" [51], [52], [53], [54] with approximatively 30 people who have requested MAiD, diversifying the choice of participants according to their personal characteristics (age, gender, identity, cultural or ethnic origin, diagnoses, disability status, socioeconomic situation).

Data Collection: A semi-directive approach will be used to focus on the stories collected, while directing them towards the central themes, encouraging the emergence of new reflections. One or two interviews will be conducted with each participant (varying in length from 30 to 60 minutes, depending on the participant's health and ability to participate). The interviews will be recorded and

transcribed integrally. Interviewers will keep a diary in order to note their impressions following each interview and use this information to enrich their analysis (emotional state of the participant, non-verbal cues during the interview, general context of the interview, etc.). Recruitment will be based on the CIRAMM's contacts across the province (MAiD interdisciplinary support groups (ISGs), hospice care organizations, patient associations, etc.) with the aim of reaching participants in different regions of Quebec (urban, semi-urban and rural). During recruitment, we will explore the possibility of involving one of the participant's close-ones, as well as one of their care providers in order to conduct a triadic case study (see "Case studies of triads" below).

Data Analysis: A thematic analysis of the data [55], [56] will be conducted according to these steps: 1) interview verbatims and diaries will be read, 2) a sample of three transcripts will be randomly chosen and analyzed to produce a list of themes, and 3) the content of the remaining interviews and diaries will be classified from this list of themes using NVivo 14 software, released 2023 (Lumivero). The quality of the codification process will be ensured by an inter-judge agreement process in accordance with validity and quality criteria in qualitative research [57].

Case Studies of Triads

Many studies [58], [59] focus on the individual perspectives of people who want to receive assistance in dying, their relatives or caregiving staff. This approach does not reveal the relational dynamics at play within a request, the contrasts between different individual perspectives, and the way these factors influence each individual's perspectives.

Participants and Data Collection: To overcome the shortcomings identified in current literature, we will carry out 10 triadic case studies, each comprising of "contextualized narrative" interviews with the person requesting MAiD, one of their close-ones, and one of their care providers (doctor, nurse, allied health clinicians, care assistant, etc.). This method was tested in another study conducted in the Netherlands by a co-leader of this theme and her colleagues [60]. A different interview guide will be used for each sub-group, aimed at gaining a better understanding of the personal factors that motivate people to request MAID from the perspective of the three sub-groups. Each person will be interviewed individually.

Data Analysis: An analysis anchored in phenomenology, combining a longitudinal and multiperspective framework [61], as well as different aspects of reflective lifeworld research [62] will be used [61], [63], [64].The whole process will be iterative and guided by multiple discussions between the members of our research team [65].

Retrospective Qualitative Chart Review

The researchers will also undertake a retrospective chart review of MAiD requesters in a single institution in Montreal. The purpose of this study is to better understand the role of economic disadvantage (which is defined as dependence on social assistance as one's sole form of revenue) on these individuals' MAiD requests particularly for those requesters whose natural death is not reasonably foreseeable (Track 2) for it is this group where public debate about the impact of ecnonomic disadvantage on requests has arisen. This part of the protocol draws upon similar methods used in two studies currently being carried out by CIRAMM researchers, the first involving a population of requesters in which the assessment required a psychiatric consultation [66], the second involving people with amyotrophic lateral sclerosis (ALS) [67].

Data collection and analysis: We aim to review the charts of all Track 2 requesters from 2021-2025 who are experiencing economic disadvantage. We will obtain a list of all requesters at the identified institution. We will then do a preliminary review to determine the economic situation of each requester, identifying those in a situation of economic disadvantage. The charts of this subgroup will be subject to a complete chart review. First, we will extract data relating to each individual's sociodemographic profile: age, gender, social circumstance, diagnoses, stated reason for requesting MAiD, and whether MAiD was ultimately received. Second, we will review all notes pertaining to the person's request for an assisted death. We will extract all segments that refer to the person's statements about assisted dying as well as the writer's views about those statements, if any. We will be particularly attentive for any notes relating to the person's economic situation and its potential impact on the experience of their disease, access to care and suffering. In our analysis we will focus on the manifest content of the extracted text. We will identify meaning units from the extracted segments, grouping them together in categories. Ultimately, we will seek pattern that link the categories, which describe and explain the role of a person's economic circumstances in their request for an assisted death, with their sociodemographic profiles, recognizing that a plurality of such narratives may emerge from these records [68].

Theme 2: Healthcare Organization and Delivery in Quebec

For this theme, we adopt a systematic comparison approach between Quebec regions to examine the relationships between gaps in the use of MAiD and differences in sociodemographic profiles, in health services structures, practices and perceptions. Quebec regions will be further broken into territories corresponding to each of the 30 MAiD ISGs.

Study Design: A mixed methods approach will be implemented including a document analysis and system mapping. Qualitative discourse analysis will be used to summarize government reports on MAiD (provincial and regional) and information documents available to the public, to explain how MAiD is presented and how ressources are promoted in each region. Correlational analysis from MAiD reports and regional sociodemographics will be used to explore the strength and directions of links between regional MAiD rates and the social profile of the population. Both qualitative and quantitative results will be mobilized for a system mapping analysis to show possible causal loops between different categories of items.

Document Analysis

Document analysis is a systematic procedure for reviewing and synthetizing various sources (printed or digital) including their format dimensions (institutional authors, aims, availability), and their discourse (themes, perspective, posture, legitimation).

Data Collection: We will first create a mixed database of organizational documents, records and reports produced by the ISGs on cases of refused, accepted, abandoned and administered MAiD requests for the period 2019-2025 (case profiles including age of individuals, status of request, trajectory characteristics, access to alternative, curative, palliative and psychosocial care and services). Data gathered by the Quebec End-of-life Commission (Control Commission) will be considered, as well as socio-demographic data by region (population, age, socio-economic profile, disease incidence, deaths and causes of death, including rates of unassisted suicide). Other documents from gray literature will also be analyzed (local reports and registers of care and services from the ISGs, the End-of-life Commission and the Ministry of Health andf Social services,

information and training documents, etc.).

Data Analysis: In order to produce a general portrait of the evolution and current state of structures, resources and practices in each region, the qualitative data will be subject to a documentary analysis using the READ method (read, extract, analyze, distill) [69]. Quantitative data will be the subject of descriptive and comparative statistical analyses of regional realities and their evolution (averages, frequencies, standard deviations), population representativeness of cases, as well as correlation analyses between the explanatory variables and the rate of increase in MAID use. The analysis of the proportionality of the variables for each region will be used, among other things, to determine the associations and the relative weight of population ageing in the use of MAID, which is the main assumption made in the CSFV report [4].

System Mapping

Data Collection: Qualitative and quantitative analyses will be synthesized into a system mapping model, an approach for integrating systems analysis into the implementation of public and community health programs, care and services using visual representations [70], [71].

Data Analysis: This method has the advantage of facilitating the detailed description of complex systems by interested parties and producing a rigorous evaluation of the concrete impacts of an intervention, policy or program and their local variations [72]. Systems mapping allows the description and comparison of systems and organization models to produce conceptual maps, diagrams and causal loops reflecting complex decision-making and accessibility processes [73]. All these analyses will enable us to meet our objectives by modelling the organization of care and services for each region, creating detailed statistical reports as well as typologies of practice models and individual pathways [74].

Theme 3: Societal Dimensions

Study Design: This theme encompasses two methods. First, media coverage analysis can provide access to the discursive and symbolic predominance of MAiD and, in so doing, shed light on how content contributes to ways of thinking, feeling and acting about MAiD, and how we integrate it into our "own social value systems" [75, p. 20]. Second, Community Forums (CF) favor an open, participatory approach with citizens and take the pulse of the community's concerns, knowledge and resources [76], [77]. In addition to stimulating the exchange of ideas, this dynamic method brings together people from various backgrounds, in a given region, to hear and gather their opinions on a subject that concerns them, such as the use of MAiD.

Media Coverage Analysis

Data Collection: The main French- and English-language media published in each of the studied regions of Quebec will be analyzed (Journal de Québec, Journal de Montréal, The Gazette, La Presse, Le Devoir, Hebdo Rive-Nord, Journal de Joliette, le Laurentien, le Soleil, Le Nouvelliste et le Nord-Côtier) from 2014 (the year the Act respecting end-of-life care was adopted in Quebec) to the present. A systematic search on Eureka will be carried out with the help of a librarian, by combining corollary terms referring to MAiD. All journalistic articles on on MAiD will be included. Two people will select the texts and extract the data using Covidence [30].

Data Analysis: The qualitative discourse will be triangulated through an inductive thematic analysis using NVivo 14 software [78], and a lexicographic analysis [79] conducted with IRaMuTeQ [80]. Media texts, in the form of a textual corpus, will be statistically contrasted in the light of meaningful lexical categories derived from the software's statistical calculations (i.e. correspondence factor analysis and top-down hierarchical classification method). This quantitative input will validate and/or complement the discourse analysis initially carried out.

Community Forums

Participants: Adult citizens of a given region will be invited to participate in CFs. The team will use a variety of means to encourage diversity in the participants' sociodemographic profile (gender, sex, age, sexual orientation, ethnic group, socioeconomic status, level of education, religious practices, beliefs and spirituality, (dis)ability). For each CF, we set no maximum number of participants, but anticipate a minimum of 20 representatives per region. The six CFs will be organized in virtual or in-person in the 3 regions with the highest annual proportion of MAiD deaths (Lanaudière, Bas-Saint-Laurent, Capitale-Nationale), and the 3 regions with the lowest proportion of MAiD deaths (Montréal, Mauricie-Centre-du-Québec, Côte-Nord) [4]. These regions also represent urban, semi-urban and rural environments. In order to represent and understand the indigenous perspective on palliative care and MAiD, we plan to consult Nunavik citizens, in co-construction with community representatives.

Data Collection: The facilitation guide will be elaborated on the basis of the results of the cross-thematical methods and in co-construction with our partner organizations, patients and relatives. Recruitment will be based on a call for applications via social media, healthcare associations, distribution lists of community, associative and organizational partners, etc. Individuals will be able to register using an online form. Questions about their socio-demographic profile will enable us to assess the number and diversity of people attending, and to adjust ourselves accordingly. CFs will be conducted online via Microsoft Teams or face-to-face, and moderated by the researchers. Discussions will be recorded and automatically transcribed by Microsoft Teams, with subsequent verification. Observation notes will be taken by research assistants, and a logbook kept by each of the facilitating researchers will help contextualize the data.

Data Analysis: The data collected will be analyzed using an inductive thematic approach for each region. This qualitative analysis will then be compared with a quantitative content analysis under the same methodology as the media coverage analysis (i.e. triangulated through IRaMuTeQ with a lexicographic analysis of the discussion transcriptions).

Theme 4: Comparison of practices, legislations and public policies

Comparative legal analysis on Assisted Dying

Legal databases (e.g. SOQUIJ, CAIJ and La reference for Quebec; CANLII for the rest of Canada; Lexis, Westlaw, Heinonline for selected international jurisdictions) will be searched to identify legal documents associated with MAiD legislation for the jurisdictions selected. The comparative positivist legal analysis (legislation, case law, and doctrine) carried out by our team of legal experts will enable us to identify the differences and similarities between laws and the scope of legislative criteria, and to grasp the appropriateness of their interpretation by contrasting them with the findings emerging from the scoping review. This work will be complemented by a comparative analysis of

Quebec public policies promoting the quality of life of sick people and their families (e.g., home care [81] and informal care [82]), as well as of the various legal mechanisms contained in the Quebec legislation (MAiD, advance directives, palliative care, and continous palliative sedation), while considering recent updates to the law. In addition, by compiling (and critically comparing) data from 2 complementary sources [83], we will be able to address objective 4.2, which is to examine how MAiD numbers in Quebec compare to those in others jurisdictions: 1) the annual reports of the Control Commissions of the selected jurisdictions based on official MAiD declarations, and 2) independent surveys conducted in certain jurisdictions and aimed at documenting the frequency of MAiD practices, in addition to other types of end-of-life medical practices [84], [85].

Realist synthesis

The final objective of Theme 4 (see Table 1 - 4.3 Explore how Quebec's context can explain differences in MAiD use) represents one of the overarching goals of the project, requiring the consideration of all results generated across themes, through both cross-thematic and theme-specific methods. To this end, we will draw on the realist synthesis method developed by Pawson et al. [86]. The realist synthesis method addresses questions concerning what works for whom, in what circumstances, in what respects, and how a complex social intervention operates, such as a public policy, a healthcare system, or even a law [86], [87], [88].
Realistic synthesis is characterized by 1) the use of a conceptual framework, and 2) the involvement of an advisory committee at various stages of the process. The conceptual framework chosen will combine the Bronfenbrenner's ecological systems theory and that of the Health System Performance Measurement [89]. It will be adapted to the phenomenon under study (use of MAiD) and will provide a global understanding of the explanatory factors and the underlying mechanisms. In particular, the framework will consider: a) the characteristics and inputs of the legislation (macrosystem) and its operational functioning; b) the characteristics and social determinants of health related to individuals (microsystem) who use MAiD; c) the outputs of the system (exosystem), which include access to and provision of MAiD and associated services; and d) the results obtained (the use of MAiD in terms of requests and provisions). We will add the historical context (chronosystem) as a potential explanatory factor for the differences observed in the evolution of the use of MAiD (e.g. legislative change initiated by whom and how).

A bipartite Advisory Committee will be set up, made up of: a) members of an International Advisory Committee; b) representatives of the stakeholders (patients and their families, physicians, nurse practitioners and other healthcare professionals, managers and decision-makers) involved in MAiD in Quebec. The involvement of the bipartite Advisory Committee will be particularly decisive in adapting the conceptual framework to the specific characteristics of the MAiD study, as well as in interpreting the results. The comparison of our data, based on the conceptual framework, will enable us to identify the contributing factors for which data already exist, as well as those for which further studies are required.

Theme 5: Regulation of Advance Requests for MAiD

On June 7, 2023, Quebec's Act respecting end-of-life care was modified to allow advance requests for MAiD (AR-MAiD) from people diagnosed with a disease leading to decisional incapacity [2]. Legal dispositions related to AR-MAiD came into effect on October 30th, 2024. AR-MAiD may lead to further increases in the use of MAiD, given its widespread acceptability in Quebec [26], [33], [90]. On the other hand, providing MAiD to patients who are no longer competent, based on their advance

requests, can be challenging to implement. To inform the implementation of the AR-MAiD regime in Quebec, a comparative analysis of the legal regimes of jurisdictions that already allow such requests, and a systematic review of implementation challenges, will be conducted.

Comparative Legal Analysis on Advance Requests for MAiD

A comparative portrait specific to AR-MAiD will be drawn from the legal analysis conducted under Theme 4. Results will highlight processes that led to AR-MAiD legalization in permissive jurisdictions and reasons underlying different legislative choices pertaining to eligibility criteria, procedural safeguards, as well as the assessment of suffering. Professional standards established by medical associations, learned societies and regulatory bodies will complement our legal interpretation work [91]. Legal analysis specific to this theme will be anchored in a recent review of Dutch and Belgian AR-MAiD legislation [91], that we will extend to include Luxembourg, Colombia, Spain and Quebec.

Mixed-Literature Systematic Review

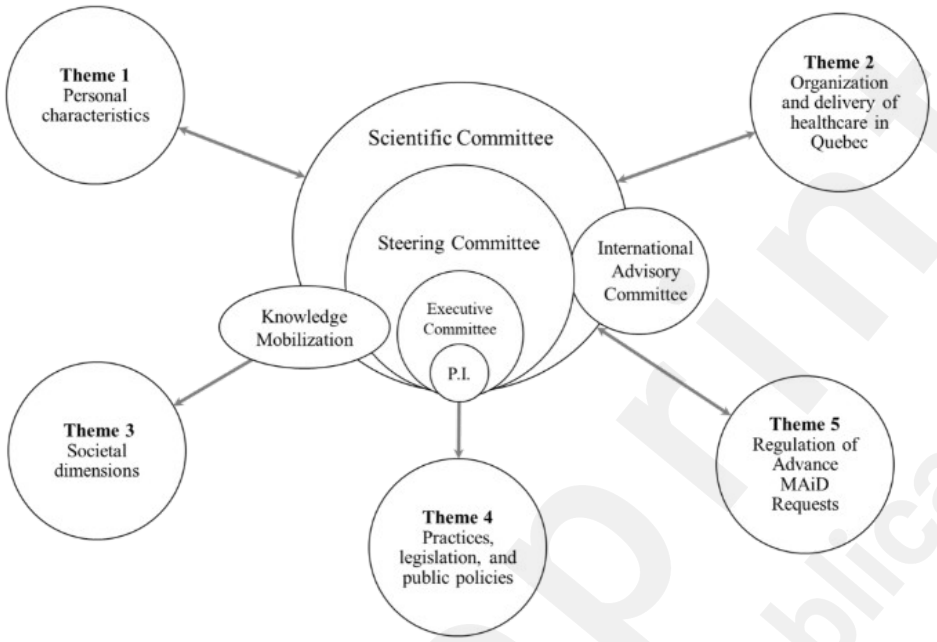
We aim to provide a comprehensive overview of the international literature on the barriers and facilitators (both anticipated and experienced) related to AR-MAiD. Perspectives from patients, their relatives, healthcare professionals, legal experts and scholars will be sought. Primary studies (qualitative, quantitative and mixed-methods studies), theoretical work, as well as relevant documents from grey literature (e.g., theses, Control Commissions' reports) will be considered for inclusion. Peer-reviewed studies published after 2002 will be searched by a librarian in 10 electronic databases, with no restriction on language or origin of the authors. Screening of retrieved citations, assessment of the methodological quality of included studies and data extraction will be conducted independently by pairs of researchers, supported by the software Covidence [30]. A preliminary search for publications on AR-MAiD revealed a predominance of qualitative studies, with a few surveys and mixed-method studies [92], [93], [94]. Hence, to enable synthesis and integration, quantitative data will be transformed into themes and sub-themes in a convergent integrated approach. Identified barriers and facilitators to implementing AR-MAID will be summarized following a content analysis of included documents, examined in light of the Quebec regime, and contrasted according to i) whether they are anticipated or truly experienced; ii) the perspective from which they originate (e.g., that of healthcare professionals or relatives); iii) when they might arise along the MAiD process (request drafting, eligibility assessment or MAiD provision); and iv) prevailing legislation and codes of practice. We expect our legal analysis and systematic review to highlight significant challenges to implementing AR-MAiD in Quebec and also possible ways to overcome them.

Governance and Methods Sequence

To meet the challenge of this mixed and multi method study, CIRAMM rallied leading forces in the field of end-of-life care: 46 co-researchers (Quebec, Canada and international), 14 clinicians, 5 partner organizations, and 10 postdoctoral fellows and graduate students. Researchers are drawn from over 15 disciplines and work in various university departments, programs and faculties: medicine (palliative care, family medicine, geriatrics, neurology, psychiatry, emergency medicine, pediatrics), nursing, law, psychology, clinical ethics, epidemiology, social work, occupational therapy, pharmacy, philosophy, anthropology, religious sciences and theology, sociology and population health. We developed a governance structure to support CIRAMM members, enabling us to successfully coordinate the various research sub-teams (see Figure 2). We set up an Executive

Committee responsible for the operationalization and general coordination of CIRAMM. A Steering Committee made up of clinicians, researchers and patient partners supports the Executive Committee in general decisions and orientations. A Scientific Committee brings together all researchers in charge of the specific themes, whose sub-teams will meet as projects progress. We also set up an International Advisory Committee made up of ten collaborators (Canadian and international researchers) with expertise in euthanasia, assisted suicide and end-of-life care.

Figure 2. CIRAMM's governance structure



Each theme has a sub-team responsible for its theme-specific methods. The sequence in which the methods are deployed has been designed to ensure that data from the cross-thematic methods can inform the development of the theme-specific methods. Coordination tools for the deployment sequence of methods are put in place to structure and adapt the activities of the study as it evolves.

Knowledge Mobilization

Inspired by Graham et al.'s Knowledge to Action Framework [95], we aim not only to produce appropriate knowledge adapted to the target audiences, but also to produce this knowledge by, for and with them. The strategy put forward for this study is intended to be inclusive and collaborative, at all stages of the research. To carry out this mission, we put together a Knowledge Mobilization Committee, including patients, their close-ones and key stakeholders, to play an anchoring role and to : 1) support the sub-team in the production of knowledge transfer (KT) tools; 2) plan the project's mobilization and KT activities with partners and users; 3) coordinate deliverables with pre-identified milestones; 4) coordinate a unified plan for disseminating and promoting KT activities among partners; and 5) provide feedback on the activities developed, assessing whether the strategy's objectives have been met, while making adjustments where necessary.

Ethics Approval

The ethics approval of the study will be done in stages given the planned sequence of the various methods. So far, we received ethical approval from the Scientific and Research Ethics Committee of the CISSS de Laval (MP-35-2025-1112) and the Research Ethics Committee on Health Science at the University of Montreal - CERES (MP-35-2025-1112) for the cross-sectional methods of interviews with key informants and focus groups with professionals.

Results

The study was funded in April 2024. In July 2024, we initiated projects that do not require the approval of an ethics committee: scoping review, realist synthesis, both comparative legal analyses, mixed-literature systematic review, media coverage analysis and document analysis. In Spring 2025, we completed the interviews with the key informants and will start the analysis. All other sub-teams are preparing for ethics approval (protocol, data collection tools, consent forms, etc.).

Discussion

A Better Understanding of the Use of MAiD

This study is the first to comprehensivly examine the use of MAiD in Quebec. It builds on existing evidence and attempts to fill knowledge gaps. The results will provide a global understanding of the factors explaining the use of MAID, both by cross-thematical methods and by theme-specific methods. While focusing on explaining the high uptake of MAiD in Quebec, findings could also provide insight into reasons for a decline in demand (if any) or lower rates of deaths by MAiD observed in other jurisdictions [83]. Several hypotheses exist to explain the increase in the use of MAiD, but much still needs to be done to understand this choice made by thousands of people every year.

Strengths and Limitations

This strengths of this study include: The use of a variety of methodologies, allowing for methodological triangulation that promotes reliability of the results; The breadth of this interdisciplinary team with its combined set of skills and an International Scientific Committee ensuring the feasibility of the project; The creation of the Knowledge Mobilization Committee disseminating the results to various target audiences; and the diversity of activities proposed in the study to train the next generation of students in end-of-life research.

Among the limitations, two of the selected jurisdictions (Belgium and Switzerland) are multilingual (other than French and English) and, within their respective linguistic communities, the rates of assisted suicide or euthanasia are quite different. It will be very challenging to compare the data given linguistic and cultural differences. Also, the evolution of MAiD rates is perceptible in some countries while not in others. Alternative explanations would need to be taken into consideration. For example, the number of cases reported to the authorities may differ from the actual number of cases. It will also be necessary to consider the evolution of alternatives to MAiD, particularly continuous palliative sedation, which is experiencing an important growth in some countries notably in the Netherlands and Switzerland [96]. Finally, large and comparative population surveys in different jurisdictions present several scientific and practical challenges that will require rigor and attention to detail from our research team.

Acknowledgments

On behalf of Consortium interdisciplinaire de recherche sur l’aide médicale à mourir (the authors of this papers and other members: Omid Hosseini, Émilie Allard, Elaine Champagne, Josée Chénard, Marc Dumas, Isabelle Dumont, Nicolas Dupré, Sylvie Fortin, Nathalie Gaucher, Claire Godard-Sebillotte, Diane Guay, Manon Guay, Johanne Hébert, Philippe Laperle, Sylvie Lapierre, Jérôme Leclerc-Loiselle, Marianne Olivier-d’Avignon, Antoine Payot, Chantale Simard, Diane Tapp, Deborah Ummel, Bilkis Vissandjee, Carl Bromwich, Andréanne Côté, Thania Crnich-Côté, Dominique Dion, Geneviève Lamothe, Marie-Hélène Marchand, Guy Morissette, Olivia Nguyen, Élodie Petit, Justin Sanders, Jacinthe Dupuis, Patrick Durivage, Sandra Smele, Emilie Richard-Frève, Jean-Thomas Chouinard, Marie-Alexandra Gagné, France Lacharité, Isabelle Martineau,

Marta Martisella, Antoine Bé dard, Francine Carmichael, Eliana Close, Luc Deliens, James Downar, Jocelyn Downie, Andrea Frolic, Ralf Jox, Thaddeus Pope, Agnes Van der Heide), we acknowledge the contribution of Vanessa Finley-Roy, clinical ethics manager at the Centre Hospitalier Universitaire Sainte-Justine, in Montreal, for revising the English version of this manuscript.

Funding Statement

The study is funded by the Fonds de recherche du Québec, Action concertée Mieux comprendre le recours à l'aide médicale à mourir en contexte québécois (Grant #2025-0AMMR-355830). This study is also possible thanks to additional funds from: Réseau québécois de recherche en soins palliatifs et soins de fin de vie (RQSPAL), Pôle de recherche sur la transformations des pratiques cliniques et organisationnelles du CISSS de Laval and Chaire de la Famille Blanchard. We are also grateful to our partners who support the CIRAMM with in-kind contributions: Centre de recherche et d'expertise en gérontologie sociale (CREGES), the CISSS de Laval and the RQSPAL.

Conflicts of Interest

None declared.

Data Availability

Not applicable.

Authors' Contributions

IM, CP et MEB are the leaders of the project. All authors of this article are a part of the CIRAMM scientific committee, and have made substantial contributions to : (1) the conception and design of the study protocol and grant application to the FRQ; (2) drafting the article or revising it critically for important intellectual content; and (3) approval of the final version.

References

[1] LégisQuébec, *Loi concernant les soins de fin de vie*. Canada, 2025. Accessed: Aug. 27, 2025. [Online]. Available: https://www.legisquebec.gouv.qc.ca/fr/document/lc/s-32.0001

[2] LégisQuébec, *Act respecting end-of-life care*. 2025. Accessed: Aug. 27, 2025. [Online]. Available: https://www.legisquebec.gouv.qc.ca/en/document/cs/s-32.0001

[3] Government of Canada, *An Act to amend the Criminal Code (medical assistance in dying)*. Canada, 2021. Accessed: Aug. 27, 2025. [Online]. Available: https://laws-lois.justice.gc.ca/PDF/2021_2.pdf

[4] Commission sur les soins de fin de vie, "Rapport annuel d'activités: Du 1er avril 2022 au 31 mars 2023," 2023. Accessed: Aug. 27, 2025. [Online]. Available: https://csfv.gouv.qc.ca/fileadmin/docs/rapports_annuels/rapport_annuel_dactivites_2022-2023.pdf

[5] "Les soins de fin de vie au Québec : où en sommes-nous?," *Collège des médecins du Québec*, Oct. 10, 2023. Accessed: Aug. 27, 2025. [Online]. Available: https://www.cmq.org/fr/actualites/les-soins-de-fin-de-vie-au-quebec-ou-en-sommes-nous

[6] Health Canada, "Fourth annual report on Medical Assistance in Dying in Canada 2022," 2023. Accessed: Aug. 26, 2025. [Online]. Available: https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html#table_3.1

[7] Fonds de recherche du Québec, "Action concertée : Mieux comprendre le recours à l'aide médicale à mourir en contexte québécois." Accessed: Sep. 03, 2025. [Online]. Available: https://frq.gouv.qc.ca/programme/action-concertee-mieux-comprendre-le-recours-a-laide-medicale-a-mourir-en-contexte-quebecois/

[8] The Canadian Press, "Quebec funds a project to better understand the use of medical assistance in dying," *CityNews*, Mar. 27, 2024. Accessed: Aug. 26, 2025. [Online]. Available: https://montreal.citynews.ca/2024/03/27/quebec-funds-project-medical-assistance-dying/

[9] T. A. Boer, "Assisted Dying in the Netherlands: Recent Legal and Religious Considerations," *Revista Derecho y Religion*, vol. 17, pp. 185–198, 2022.

[10] A. S. Groenewoud, F. Atsma, M. Arvin, G. P. Westert, and T. A. Boer, "Euthanasia in the Netherlands: a claims data cross-sectional study of geographical variation," *BMJ Support Palliat Care*, p. bmjspcare-2020-002573, Jan. 2021, doi: 10.1136/bmjspcare-2020-002573.

[11] A. C. Byram and P. B. Reiner, "Disparities in public awareness, practitioner availability, and institutional support contribute to differential rates of MAiD utilization: a natural experiment comparing California and Canada," *Mortality*, vol. 30, no. 1, pp. 252–272, Jan. 2025, doi: 10.1080/13576275.2024.2328627.

[12] D. Pullman, "Slowing the Slide Down the Slippery Slope of Medical Assistance in Dying: Mutual Learnings for Canada and the US," *The American Journal of Bioethics*, vol. 23, no. 11, pp. 64–72, Nov. 2023, doi: 10.1080/15265161.2023.2201190.

[13] L. Khakzedeh, "Assisted Suicide in Austria – the new legal framework," *BioLaw Journal rivista di BioDiritto*, vol. 1, no. 22, 2022, doi: https://doi.org/10.15168/2284-4503-2242.

[14] R. Coelho, J. Maher, K. S. Gaind, and T. Lemmens, "The realities of Medical Assistance in Dying in Canada.," *Palliat Support Care*, vol. 21, no. 5, pp. 871–878, Oct. 2023, doi: 10.1017/S1478951523001025.

[15] D. Gentile, "Choisir l'aide médicale à mourir faute de soins palliatifs appropriés?," *Radio-Canada*, May 31, 2018. Accessed: Aug. 26, 2025. [Online]. Available: https://ici.radio-canada.ca/nouvelle/1104152/aide-medicale-mourir-soins-palliatifs-college-medecins-penurie

[16] M. Noël, "«Mourir plutôt que de vivre en CHSLD»," *laTribune*, Dec. 03, 2019. Accessed: Aug. 26, 2025. [Online]. Available: https://www.latribune.ca/2019/12/04/mourir-plutot-que-de-vivre-en-chsld-3a78fb227bc5f02e96f6ab60a664ad5f/

[17] J. A. Morais, P. J. Durand, and F. Pageau, “Notre inquiétude face à l’aide médicale à mourir,” *Le Devoir*, Feb. 26, 2021. Accessed: Aug. 26, 2025. [Online]. Available: https://www.ledevoir.com/opinion/idees/595951/notre-inquietude-face-a-l-aide-medicale-a-mourir

[18] L. Vigneault, “Nous voulons une aide à vivre, pas à mourir,” *leSoleil*, Jan. 27, 2020. Accessed: Aug. 26, 2025. [Online]. Available: https://www.lesoleil.com/2020/01/28/nous-voulons-une-aide-a-vivre-pas-a-mourir-faeffda3ba4fe8dbbc9fec2c67a25081/

[19] D. Lessard, “Mort d’Andrée Simard : Dans la douleur et la détresse,” *La Presse*, Jan. 20, 2023. Accessed: Aug. 26, 2025. [Online]. Available: https://www.lapresse.ca/actualites/sante/2023-01-20/mort-d-andree-simard/dans-la-douleur-et-la-detresse.php

[20] J. Downar, S. MacDonald, and S. Buchman, “What drives requests for MAiD?,” *Can Med Assoc J*, vol. 195, no. 40, pp. E1385–E1387, Oct. 2023, doi: 10.1503/cmaj.230259.

[21] L. Des Aulniers and B. J. Lapointe, *Le choix de l’heure: Ruser avec la mort?* Somme Toute, 2018.

[22] J. Roy, A. Stylios, and É. Pilote, “Tendances sociétales sur le plan de l’évolution des valeurs et aide médicale à mourir. Des enjeux pour la pratique,” *Intervention*, no. 156, pp. 69–83, Mar. 2023, doi: 10.7202/1097407ar.

[23] P. J. Fournier, “Les Québécois peu portés sur le religieux, les Canadiens un peu plus,” *L’actualité*, Dec. 08, 2022. Accessed: Aug. 26, 2025. [Online]. Available: https://lactualite.com/politique/les-quebecois-peu-portes-sur-le-religieux-les-canadiens-un-peu-plus/

[24] Commission sur les soins de fin de vie, “Rapport annuel d’activités 2021-2022,” 2022. Accessed: Aug. 26, 2025. [Online]. Available: https://csfv.gouv.qc.ca/fileadmin/docs/rapports_annuels/csfv_rapport_activites_2021-2022.pdf

[25] A. Bérubé *et al.*, “Do Socioeconomic Factors Influence Knowledge, Attitudes, and Representations of End-of-Life Practices? A Cross-Sectional Study,” *J Palliat Care*, vol. 40, no. 2, pp. 152–161, Apr. 2025, doi: 10.1177/08258597221131658.

[26] A. Plaisance, B. L. Mishara, J. Masella, G. Bravo, V. Couture, and D. Tapp, “Quebec population highly supportive of extending Medical Aid in Dying to incapacitated persons and people suffering only from a mental illness: Content analysis of attitudes and representations,” *Ethics Med Public Health*, vol. 21, p. 100759, Apr. 2022, doi: 10.1016/j.jemep.2022.100759.

[27] U. Bronfenbrenner, *The Ecology of Human Development*. Harvard University Press, 1981. doi: 10.2307/j.ctv26071r6.

[28] M. D. Peters, C. Godfrey, P. McInerney, Z. Munn, A. C. Tricco, and H. Khalil, “Scoping reviews,” in *JBI Manual for Evidence Synthesis*, JBI, 2024. doi: 10.46658/JBIMES-24-09.

[29] A. C. Tricco *et al.*, “PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation,” *Ann Intern Med*, vol. 169, no. 7, pp. 467–473, Oct. 2018, doi: 10.7326/M18-0850.

[30] Veritas Health Innovation, “Covidence systematic review software,” *Melbourne*. Accessed: Aug. 26, 2025. [Online]. Available: www.covidence.org

[31] Statistics Canada, “Population estimates, quarterly. Table: 17-10-0009-01 (formerly CANSIM 051-0005),” Jun. 2025. Accessed: Aug. 27, 2025. [Online]. Available: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000901&request_locale=en

[32] I. Marcoux, B. L. Mishara, and C. Durand, “Confusion Between Euthanasia and Other End-of-Life Decisions,” *Canadian Journal of Public Health*, vol. 98, no. 3, pp. 235–239, May 2007, doi: 10.1007/BF03403719.

[33] G. Bravo *et al.*, “Comparing the attitudes of four groups of stakeholders from Quebec, Canada, toward extending medical aid in dying to incompetent patients with dementia,” *Int J Geriatr Psychiatry*, vol. 34, no. 7, pp. 1078–1086, Jul. 2019, doi: 10.1002/gps.5111.

[34] L. Plourde *et al.*, “Social acceptability of psilocybin-assisted therapy for existential distress at

the end of life: A population-based survey," *Palliat Med*, vol. 38, no. 2, pp. 272–278, Feb. 2024, doi: 10.1177/02692163231222430.

[35] M.-F. Fortin and J. Gagnon, *Fondements et étapes du processus de recherche*. Chenelière Éducation, 2022.

[36] D. L. Driscoll, A. Appiah-Yeboah, P. Salib, and D. J. Rupert, "Merging Qualitative and Quantitative Data in Mixed Methods Research: How To and Why Not," *Ecological and Environmental Anthropology*, vol. 3, no. 1, pp. 19–28, 2007, Accessed: Aug. 26, 2025. [Online]. Available: https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1012&context=icwdmeea

[37] Alliance des maisons de soins palliatifs du Québec, "À propos." Accessed: Aug. 28, 2025. [Online]. Available: https://www.alliancemspq.com

[38] Gouvernement du Québec, "Aide médicale à mourir." Accessed: Aug. 28, 2025. [Online]. Available: https://www.quebec.ca/sante/systeme-et-services-de-sante/soins-de-fin-de-vie/aide-medicale-a-mourir

[39] Fédération des médecins spécialistes du Québec, "Specialists for you." Accessed: Aug. 28, 2025. [Online]. Available: https://fmsq.org/en

[40] Fédération des médecins omnipracticiens du Québec, "Médecins de famille. Prendre soin de votre vie donne un sens à la nôtre." Accessed: Aug. 28, 2025. [Online]. Available: https://www.fmoq.org/

[41] Collège des médecins du Québec, "Protecting the public by ensuring quality medical care." Accessed: Aug. 28, 2025. [Online]. Available: https://www.cmq.org/en

[42] Commission sur les soins de fin de vie, "La Commission sur les soins de fin de vie." Accessed: Aug. 28, 2025. [Online]. Available: https://csfv.gouv.qc.ca/en/

[43] A. Geddes, C. Parker, and S. Scott, "When the snowball fails to roll and the use of 'horizontal' networking in qualitative social research," *Int J Soc Res Methodol*, vol. 21, no. 3, pp. 347–358, May 2018, doi: 10.1080/13645579.2017.1406219.

[44] "Canadian Association of MAiD Assessors and Providers." Accessed: Aug. 25, 2025. [Online]. Available: https://camapcanada.ca/

[45] Artsenfederatie KNMG, "Over SCEN." Accessed: Aug. 25, 2025. [Online]. Available: https://www.knmg.nl/ik-ben-arts/scen/over-scen

[46] "LevensEinde InformatieForum." Accessed: Aug. 25, 2025. [Online]. Available: https://leif.be/home/

[47] "Academy of Aid-in-Dying Medicine." Accessed: Aug. 26, 2025. [Online]. Available: ttps://www.acamaid.org/

[48] V. Braun and V. Clarke, "Using thematic analysis in psychology," *Qual Res Psychol*, vol. 3, no. 2, pp. 77–101, Jan. 2006, doi: 10.1191/1478088706qp063oa.

[49] Provalis Research, "QDA Miner," 2025. Accessed: Aug. 18, 2025. [Online]. Available: https://provalisresearch.com/products/qualitative-data-analysis-software/

[50] S. J. Tracy, "Qualitative Quality: Eight 'Big-Tent' Criteria for Excellent Qualitative Research," *Qualitative Inquiry*, vol. 16, no. 10, pp. 837–851, Dec. 2010, doi: 10.1177/1077800410383121.

[51] P. Dawson and M. Mäkelä, *The Routledge Companion to Narrative Theory*. New York: Routledge, 2022. doi: 10.4324/9781003100157.

[52] K. Puckett, *Narrative Theory*. Cambridge University Press, 2016. doi: 10.1017/CBO9781139522502.

[53] L. Webster and P. Mertova, *Using Narrative Inquiry as a Research Method*. Routledge, 2007. doi: 10.4324/9780203946268.

[54] S. Trahar, Ed., *Contextualising Narrative Inquiry*. Routledge, 2013. doi: 10.4324/9780203071700.

[55] P. Paillé and A. Mucchielli, *L'analyse qualitative en sciences humaines et sociales*. Armand

Colin, 2012. doi: 10.3917/arco.paill.2012.01.
[56] V. Braun and V. Clarke, “Thematic analysis.,” in *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological.*, Washington: American Psychological Association, 2012, pp. 57–71. doi: 10.1037/13620-004.
[57] S. L. Morrow, “Qualitative Research in Counseling Psychology,” *Couns Psychol*, vol. 35, no. 2, pp. 209–235, Mar. 2007, doi: 10.1177/0011000006286990.
[58] R. Goldberg, R. Nissim, E. An, and S. Hales, “Impact of medical assistance in dying (MAiD) on family caregivers,” *BMJ Support Palliat Care*, vol. 11, no. 1, pp. 107–114, Mar. 2021, doi: 10.1136/bmjspcare-2018-001686.
[59] V. A. Jackson *et al.*, “A Qualitative Study of Oncologists’ Approaches to End-of-Life Care,” *J Palliat Med*, vol. 11, no. 6, pp. 893–906, Jul. 2008, doi: 10.1089/jpm.2007.2480.
[60] D. Girard, “Vers une meilleure compréhension de l’expérience de la souffrance dans le contexte de l’aide médicale à mourir : une étude longitudinale alliant la perspective des patients, des proches et des médecins.”
[61] S. Vogl, U. Zartler, E.-M. Schmidt, and I. Rieder, “Developing an analytical framework for multiple perspective, qualitative longitudinal interviews (MPQLI),” *Int J Soc Res Methodol*, vol. 21, no. 2, pp. 177–190, Mar. 2018, doi: 10.1080/13645579.2017.1345149.
[62] K. Dahlberg, H. Dahlberg, and P. Moodley, *Reflective Life-World Research*, 2nd ed. Studentlitteratur, 2008.
[63] M. F. Antonides and E. van Wijngaarden, “‘It’s like crystal gazing’: The Lived Experience of Anticipating End-of-Life Choices in Older Adults and Their Close Ones,” *Gerontologist*, vol. 64, no. 7, Jul. 2024, doi: 10.1093/geront/gnae061.
[64] M. F. Antonides, T. Tholking, D. Girard, and E. Van Wijngaarden, “Bridging multiperspective and longitudinal research with a phenomenological approach: a novel analytical framework (submitted).”
[65] S. B. Merriam, *Qualitative Research: A Guide to Design and Implementation*. John Wiley & Sons, 2009.
[66] M. Gupta, “Le service de consultation psychiatrique pour l’AMM et les troubles mentaux : un projet pilote,” 2022.
[67] N. Dupré, “SLA/AMM : Les patients atteints de sclérose latérale amyotrophique qui demandent l’aide médicale à mourir diffèrent-ils des patients qui décèdent directement de la maladie? .”
[68] U. H. Graneheim and B. Lundman, “Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness,” *Nurse Educ Today*, vol. 24, no. 2, pp. 105–112, Feb. 2004, doi: 10.1016/j.nedt.2003.10.001.
[69] S. L. Dalglish, H. Khalid, and S. A. McMahon, “Document analysis in health policy research: the READ approach,” *Health Policy Plan*, vol. 35, no. 10, pp. 1424–1431, Feb. 2021, doi: 10.1093/heapol/czaa064.
[70] D. A. Luke, B. J. Powell, and A. Paniagua-Avila, “Bridges and Mechanisms: Integrating Systems Science Thinking into Implementation Research,” *Annu Rev Public Health*, vol. 45, no. 1, pp. 7–25, May 2024, doi: 10.1146/annurev-publhealth-060922-040205.
[71] M. Tran, K. Honarmand, R. Sibbald, F. Priestap, S. Oczkowski, and I. M. Ball, “Socioeconomic Status and Medical Assistance in Dying: A Regional Descriptive Study,” *J Palliat Care*, vol. 37, no. 3, pp. 359–365, Jul. 2022, doi: 10.1177/08258597211053088.
[72] E. McGill *et al.*, “Evaluation of public health interventions from a complex systems perspective: A research methods review,” *Soc Sci Med*, vol. 272, p. 113697, Mar. 2021, doi: 10.1016/j.socscimed.2021.113697.
[73] L. K. Brennan, N. S. Sabounchi, A. L. Kemner, and P. Hovmand, “Systems Thinking in 49 Communities Related to Healthy Eating, Active Living, and Childhood Obesity,” *Journal of*

Public Health Management and Practice, vol. 21, no. Supplement 3, pp. S55–S69, May 2015, doi: 10.1097/PHH.0000000000000248.

[74] E. Stapley, S. O'Keeffe, and N. Midgley, "Developing Typologies in Qualitative Research: The Use of Ideal-type Analysis," *Int J Qual Methods*, vol. 21, Apr. 2022, doi: 10.1177/16094069221100633.

[75] F. D. Ginsburg, L. Abu-Lughod, and B. Larkin, *Media worlds: Anthropology on new terrain*. University of California Press, 2002.

[76] S. Tétreault *et al.*, "Comment mobiliser la communauté grâce au forum communautaire ?," *Serv Soc Que*, vol. 59, no. 2, pp. 65–75, Oct. 2013, doi: 10.7202/1019110ar.

[77] É. Bolduc and E. Jean, "Organisation efficiente d'un forum citoyen: Un guide pratique appuyé sur les meilleures connaissances ," Jul. 2023. Accessed: Aug. 27, 2025. [Online]. Available: https://consortiuminters4.uqar.ca/wp-content/uploads/2023/08/20230803ForumCitoyen_GuideDePratique-InterS4-VF.pdf

[78] Lumivero, "NVivo 14," 2023.

[79] A. Mucchielli and P. Paillé, *L'Analyse qualitative en sciences humaines et sociales*, 5th ed. Armand Colin, 2021.

[80] J.-J. Salone, "Analyse textuelle avec IRaMuTeQ et interprétations référentielles des programmes officiels de mathématiques en quatrième," *Sciences-Croisées*, no. 13, pp. 1–13, 2014, Accessed: Aug. 27, 2025. [Online]. Available: http://jjsan.free.fr/JJSanMath/Recherche/2013%20SCIENCES%20CROISEES%20AnalyseStatRefBOS6Math4.pdf

[81] Ministère de la Santé et des Services sociaux, "Orientations en soutien à domicile - Actualisation de la Politique de soutien à domicile «Chez soi: le premier choix»," 2023. Accessed: Aug. 27, 2025. [Online]. Available: https://publications.msss.gouv.qc.ca/msss/fichiers/2023/23-704-01W.pdf

[82] Ministère de la Santé et des Services sociaux, "Politique nationale pour les personnes proches aidantes - Reconnaître et soutenir dans le respect des volontés et des capacités d'engagement," 2021. Accessed: Aug. 27, 2025. [Online]. Available: https://publications.msss.gouv.qc.ca/msss/fichiers/2021/21-835-01W.pdf

[83] S. Mroz, S. Dierickx, L. Deliens, J. Cohen, and K. Chambaere, "Assisted dying around the world: a status quaestionis," *Ann Palliat Med*, vol. 10, no. 3, pp. 3540–3553, Mar. 2021, doi: 10.21037/apm-20-637.

[84] A. Boivin *et al.*, "Comparing end-of-life practices in different policy contexts: a scoping review," *J Health Serv Res Policy*, vol. 20, no. 2, pp. 115–123, Apr. 2015, doi: 10.1177/1355819614567743.

[85] Y.-S. Chao *et al.*, "International changes in end-of-life practices over time: a systematic review," *BMC Health Serv Res*, vol. 16, no. 1, p. 539, Dec. 2016, doi: 10.1186/s12913-016-1749-z.

[86] R. Pawson, T. Greenhalgh, G. Harvey, and K. Walshe, "Realist review - a new method of systematic review designed for complex policy interventions," *J Health Serv Res Policy*, vol. 10, no. 1_suppl, pp. 21–34, Jul. 2005, doi: 10.1258/1355819054308530.

[87] G. Wong, R. Pawson, and L. Owen, "Policy guidance on threats to legislative interventions in public health: a realist synthesis," *BMC Public Health*, vol. 11, no. 1, p. 222, Dec. 2011, doi: 10.1186/1471-2458-11-222.

[88] É. V. Langlois, K. Daniels, and E. A. Akl, *Evidence Synthesis for Health Policy and Systems: A Methods Guide*. World Health Organization, 2018. Accessed: Aug. 27, 2025. [Online]. Available: https://www.ncbi.nlm.nih.gov/books/NBK569585/

[89] Institut canadien d'information sur la santé, "Cadre de mesure de la performance du système de santé," 2013. Accessed: Aug. 27, 2025. [Online]. Available: https://www.cihi.ca/fr/acceder-aux-donnees-et-aux-rapports/mesure-de-la-performance-du-systeme-de-sante/cadre-de-mesure-de-la-performance-du-systeme-de-sante

[90] G. Bravo, N. Delli-Colli, I. Dumont, M.-E. Bouthillier, M. Rochette, and L. Trottier, “Social Workers’ Attitudes Toward Medical Assistance in Dying for Persons With Dementia: Findings From a Survey Conducted in Quebec, Canada,” *J Soc Work End Life Palliat Care*, vol. 18, no. 3, pp. 273–292, Jul. 2022, doi: 10.1080/15524256.2022.2093314.

[91] R. M. Marijnissen, K. Chambaere, and R. C. Oude Voshaar, “Euthanasia in Dementia: A Narrative Review of Legislation and Practices in the Netherlands and Belgium,” *Front Psychiatry*, vol. 13, Jun. 2022, doi: 10.3389/fpsyt.2022.857131.

[92] J. Schuurmans, C. Crol, M. Olde Rikkert, and Y. Engels, “Dutch GPs’ experience of burden by euthanasia requests from people with dementia: a quantitative survey,” *BJGP Open*, vol. 5, no. 1, p. bjgpopen20X101123, Jan. 2021, doi: 10.3399/bjgpopen20X101123.

[93] J. Schuurmans, C. Crol, B. Chabot, M. Olde Rikkert, and Y. Engels, “Euthanasia in advanced dementia; the view of the general practitioners in the Netherlands on a vignette case along the juridical and ethical dispute,” *BMC Fam Pract*, vol. 22, no. 1, p. 232, Dec. 2021, doi: 10.1186/s12875-021-01580-z.

[94] P. S. Kouwenhoven *et al.*, “Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed methods approach,” *Palliat Med*, vol. 27, no. 3, pp. 273–280, Mar. 2013, doi: 10.1177/0269216312448507.

[95] I. D. Graham *et al.*, “Lost in knowledge translation: Time for a map?,” *Journal of Continuing Education in the Health Professions*, vol. 26, no. 1, pp. 13–24, 2006, doi: 10.1002/chp.47.

[96] M. T. Heijltjes, G. J. M. W. van Thiel, J. A. C. Rietjens, A. van der Heide, A. de Graeff, and J. J. M. van Delden, “Changing Practices in the Use of Continuous Sedation at the End of Life: A Systematic Review of the Literature,” *J Pain Symptom Manage*, vol. 60, no. 4, pp. 828-846.e3, Oct. 2020, doi: 10.1016/j.jpainsymman.2020.06.019.

Supplementary Files

Figures

Bronfenbrenner's ecological systems theory to better understand the use of MAiD in the Quebec context.

CIRAMM's governance structure.