



MEDICAL ASSISTANCE IN DYING IN CANADA

ABSTRACT

In 2016, Medical Assistance in Dying (MAiD) became the legalized form of euthanasia in Canada after the Supreme Court struck down its prohibition on encouraging, aiding or counselling a person to die by suicide¹. Since then, patients who foresee a “grievous, irremediable death” have been allowed to seek MAiD. Current legislation even foregoes a waiting period with recent changes allowing for “Track 2” patients to request it, even if their death is not imminent². The law and professional standards, while created to regulate the provision of MAiD, have not provided uniform practice standards for MAiD providers across Canada (physicians and nurse practitioners)³. This has led to variations in practice patterns and regulatory expectations across the country, for a medical intervention that counteracts all other interventions normally aimed at preserving life. As of 2025, Canada has some of the highest rates of euthanasia in the world at 5% of all deaths. The province of Quebec has surpassed every country (including the Netherlands and Belgium, who have legalized euthanasia since the early 2000s) as being the jurisdiction with the highest euthanasia rate in the world at 7.2% of all deaths⁴. In a country where 15% of patients do not have a family doctor, increasing numbers of patients euthanized are a huge cause for concern.⁵ Alarming, in 2025, the United Nations Committee on the Rights of Persons with Disabilities has suggested outright cancellation of the 2021 expansion of MAiD eligibility beyond patients imminently approaching their death due to concerning cases of MAiD provisions, including documented “same day” and “next day” provisions⁶. Canadian Muslims are deeply concerned at how these changes chisel away at the core Islamic principle of the sacredness of all human life and the inherent dignity life deserves⁷. Active palliation continues to serve as a robust, well-studied medical alternative to alleviate suffering for those nearing the end of life.⁸ In this context, we present an updated guidance document from the Canadian Council of Imams and the Muslim Medical Association of Canada.

MEDICOLEGAL CONSIDERATIONS & PERSPECTIVES

MAiD legislation has undergone several additions over the years, most notably in 2021, with the introduction of “Track 2”, which allows for MAiD applications to be processed even when death is not immediately foreseeable. Several conditions for its provision still remain. Upon its introduction to Canadian law, MAiD legislation explicitly included the words “grievous” and “irremediable” along with additional stipulations that the patient be doing this voluntarily (not as a result of external pressure), that they be above 18 years old and capable of making decisions for their health, and have given informed consent after being informed of the means available to relieve their suffering.⁹

Several guides across the provinces have worked towards educating practitioners of the legal requirements and safeguards identified in the legislation. However, guidance documents from regulatory colleges largely outline the law

¹ <https://laws-lois.justice.gc.ca/eng/acts/c-46/section-241.2.html>

² [Model Practice Standard for Medical Assistance in Dying \(MAiD\) - Canada.ca](https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html)

<https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html>

³ Close, Eliana, et al. “Medical assistance in dying in Canada: A review of regulatory practice standards and guidance documents for physicians.” *Palliative Care and Social Practice* 19 (2025): 26323524251338859.

⁴ Lemmens, Trudo. “Euthanasia as Medical Therapy in Canada.” *Hastings Center Report* 55.4 (2025): 1-1.

⁵ Primary Care Needs OurCare - Unity Health

https://issuu.com/dfcm/docs/primary_care_needs_ourcare_the_final_report_of_the?fr=xKAE9_zU1NQ

⁶ Lemmens, Trudo. “Euthanasia as Medical Therapy in Canada.” *Hastings Center Report* 55.4 (2025): 1-1.

⁷ https://sencanada.ca/content/sen/committee/432/LCIC/Reports/LCIC_Pre-studyReportC-7_e.pdf

⁸ Elzayat, Rami and Khan, Nazir “Sedation and Psychoactive medications in Islamic jurisprudence and bioethics” 19th Annual Imams Conference

<https://www.amjaonline.org/wp-content/uploads/2023/10/Sedation-and-Psychoactive-medications-in-Islamic-jurisprudence-and-bioethics-AMJA-2023-Dr.-Rami-Elzayat-Nazir-Khan.pdf>

⁹ <https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html>



without detailed guidance on how to apply the law. Additionally, differing expectations are present in terms of what actions constitute disciplining of physicians¹⁰.

The year 2025 presents a stark reality in Canadian healthcare where 6.5 million (15%) Canadians remain without access to a family doctor¹¹ and the United Nations Committee on the Rights of Persons with Disabilities notes an alarming rise in the provisions of MAiD. The dominant view remains that ethics and intentionality are starkly different between palliative sedation and euthanasia¹², in that the types of medications and dosing differ greatly between them. While palliative sedation is meant to specifically address refractory symptoms (and doses are accordingly used for such a purpose), the intent of MAiD provision is to intend the death of the person, beyond merely providing comfort. As mentioned above, this would Islamically be tantamount to murder. In the case of palliative sedation, increasing doses may lead to further sedation of the patient, and although it has been suggested that this may hasten death, this is not based on strong evidence to-date.¹³ Since hastening death is not the primary purpose, this may even be Islamically acceptable based on existing Islamic legal maxims¹⁴.

What is more concerning is that there is a paucity of individual-level data looking into MAiD provisions across the country, with concerns from legal scholars that as few as 336 MAiD providers may be responsible for a majority of MAiD provisions across Canada¹⁵. There are also concerning reports of some of the most vulnerable Canadians seeking MAiD as a solution to their societal problems, including but not limited to social isolation, homelessness, imprisonment, suboptimally treated mental and/or physical health disorders or addictions, or a lack of support services especially for individuals with disabilities. As Canadians, this reflects a huge variation in practice that is wrought with inconsistencies at best, is certainly being misused as a solution to social problems that require systemic solutions, and promotes egregious violations against the sanctity of human life at worst.

A BALANCED AND COMPASSIONATE APPROACH TO PHYSICIAN-ASSISTED DYING OR MAID

The Canadian Council of Imams issued much of the following brief back in 2016 to share the concerns of imams regarding physician-assisted dying and to offer concrete solutions. In the Islamic faith tradition, neither euthanasia nor MAiD are allowed, supported or encouraged. However, since the Supreme Court has already decided on the matter, our concerns and recommendations regarding the legalization of physician-assisted dying centre around the vulnerability of patients, conscience protection for faith-based health care providers and institutions, and the quality of life for patients.

Most Canadians would agree that life is sacred and an effort should be made, in most if not all circumstances, to preserve it. The Quran highlights the importance of saving a life: **“Whoever saves (a life) – it is as if they had saved humanity entirely.”** (Quran – 5:32)

We understand that in some cases, patients experiencing extreme levels of pain and suffering, and those expecting the same in the future, may desire an end to their life. We empathize with them, and as we draw from our faith, we are instructed to pray for them to gain relief from their suffering and to try our best to make them comfortable by providing the best possible care.

¹⁰ Close, Eliana, et al. “Medical assistance in dying in Canada: A review of regulatory practice standards and guidance documents for physicians.” *Palliative Care and Social Practice* 19 (2025): 26323524251338859.

¹¹ Primary Care Needs OurCare - Unity Health

https://issuu.com/dfcm/docs/primary_care_needs_ourcare_the_final_report_of_the?fr=xKAE9_zUINQ

¹² Ten Have, Henk, and Jos VM Welie. “Palliative sedation versus euthanasia: an ethical assessment.” *Journal of pain and symptom management* 47.1 (2014): 123-136.

¹³ Elzayat, Rami and Khan, Nazir “Sedation and Psychoactive medications in Islamic jurisprudence and bioethics” 19th Annual Imams Conference

<https://www.amjaonline.org/wp-content/uploads/2023/10/Sedation-and-Psychoactive-medications-in-Islamic-jurisprudence-and-bioethics-AMJA-2023-Dr.-Rami-Elzayat-Nazir-Khan.pdf>

¹⁴ Ibid

¹⁵ Lyon, Christopher, et al. “Canadian Medical Assistance in Dying: Provider Concentration, Policy Capture, and Need for Reform.” *The American Journal of Bioethics*, vol. 25, no. 5, Jan. 2025, pp. 6–25. <https://doi.org/10.1080/15265161.2024.2441695>.



1. Safeguards for Patients

The availability of the option to die with the assistance of another individual may, in some cases, be subject to the interests of others rather than the patient, leading to direct or indirect encouragement and promotion of physician-assisted dying. We believe that there must be robust safeguards in place to ensure that this option is exercised only by those who voluntarily and independently choose physician-assisted dying after going through an informed decision-making process. We do note that the Office of the Chief Coroner brought these issues to light showing that although safeguards have been proposed¹⁶, they have at times been waived in the interest of same-day provisions¹⁷.

Recommendations

We propose that any requests for MAiD be considered and evaluated by an "end-of-life care team", consisting of four members:

1. A physician, ideally one who is familiar with the medical history of the patient and is involved in treating the patient;
2. A second physician (palliative care specialist, oncologist, nephrologist, psychiatrist or psychologist) who has rapport with the patient and understands the mental state of the patient and the reasons for their decision;
3. A social worker who can inform the patient about care options available to them and discuss potential impacts of their choices, upon themselves and on their family members;
4. A spiritual care provider representing the faith tradition of the patient who can offer spiritual counsel and advice, if the patient wishes to avail of their services.

This team shall ensure that:

- All care options available to the patient have been clearly explained without bias;
- The patient has made the decision voluntarily and without duress or encouragement from another party;
- The patient understands the impact of their decision;
- The patient's immediate family members are informed, if possible, about this process and counseling is offered to them, unless explicitly requested otherwise by the patient.

Furthermore, we recommend that section 241 (a) of the Criminal Code of Canada be amended to ensure that encouragement to commit suicide, including physician-assisted death, remains a criminal offence.

In light of the Supreme Court decision in *Carter vs. Canada*, we recommend that a patient be able to seek the assistance of a physician to end their life only if they meet ALL of the following criteria:

- Be above the age of majority in their jurisdiction;
- Be incapable of personal care;
- Be at the end-of-life;
- Be suffering from a grievous and irremediable medical condition;
- Be in an advanced state of irreversible decline in capability;
- Experience regular and unbearable physical suffering that cannot be relieved in a manner the patient deems tolerable.

The patient should be required to sign a request form or, in the case of a disability, express their wish clearly in unambiguous terms through any other means.

We recommend the process and procedures to be as follows:

¹⁶ <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s2>

¹⁷ https://macdonaldlaurier.ca/wp-content/uploads/2025/09/MDRC-Report-2025.2_Dementia_Final.pdf



1. The patient informs the care provider of their request.
2. The end-of-life care team visits the patient to assess eligibility and inform them about their choices.
3. The team contacts family members, informs them about requests and offers them support (unless requested otherwise by the patient).
4. The team makes a follow-up visit to the patient.
5. If the patient chooses physician-assisted dying, the team has them sign appropriate forms.
6. The request is submitted to the health care provider.
7. The health care provider arranges for the time, location and a physician who is willing to assist the patient in dying.
8. Details are shared with immediate family members (unless requested otherwise by the patient).
9. Before the procedure, the end-of-life care team once again confirms the decision with the patient (if the patient is still able to communicate).
10. If the response is in the affirmative, the physician assists the patient in ending their life.
11. The death is reported to a central, provincial and federal registry.

2. Conscience-Protection for Physicians and Faith-Based Care Facilities

Physicians and faith-based care facilities should not be compelled to participate in physician-assisted dying if their conscience, faith or personal values do not allow for the taking of human life. While some Muslim doctors may not want to facilitate physician-assisted dying in any way, having the ability to refer such requests to another physician without participating in the procedure should be sufficient to reconcile the rights of physicians with the rights of patients. Muslim health-care facilities will likely not want to facilitate or participate in physician-assisted dying in any way. In the case of a Muslim physician hinting or swaying a patient towards MAiD, or completing their Clinician Aid forms for an assessment, this, in the eyes of our faith, is the same as one doing the provision. An existing model is that of allowing independent pager extensions or phone numbers set up by the hospital system for interested patients to call and get effective MAiD referrals.

Recommendations

The level of disengagement from physician-assisted dying should be at the discretion of individuals and faith-based care facilities. All health care facilities should be required to disclose their policy on physician-assisted dying during the admission process in order to assist patients and their families in making informed decisions on the matter. If a patient chooses physician-assisted dying while admitted in a faith-based care facility that does not perform the procedure, the facility should provide any reasonable assistance necessary to transfer the patient to another facility that can facilitate their request. Information on facilities offering physician-assisted dying should be made publicly available, particularly for those patients whose physicians do not wish to make referrals for physician-assisted dying.

3. Quality of Life

We would like to highlight the Canadian Institute for Health Information's report on Access to Palliative Care in Canada's quote in their introduction¹⁸:

"Canadians are living longer and, as we do, the number of people living with life-limiting illnesses, such as cancer or kidney disease, is growing. These factors increase the demand for palliative care, which focuses on relieving suffering and improving the quality of life of patients and their loved ones during life-limiting illness. Supporting and improving access to palliative care is a goal of Canada's health systems."

We also echo their call for sufficient funding to ensure that all Canadians have access to palliative care that meets national standards and the needs of each community. The research behind palliative care has shown it to be effective and

¹⁸ <https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf>



has even led to increased longevity¹⁹, underscoring the robust research and work that goes behind such an approach. A multimodal approach that relies on evidence-based strategies and clinical guidelines to use opioids, neuropathic agents and patient-controlled analgesia (PCA) has a plethora of data exploring its approach²⁰. As mentioned previously, a decision to initiate palliative sedation despite side effects is judged based on what is intended by the physician and what is reasonably expected as a side effect from such an approach²¹.

Furthermore, the teachings of our faith lead us to believe that every disease has a cure. Human beings just have to strive to find them.

Recommendations

As a priority, a strategy should be developed and sufficient funding should be made available to ensure that all Canadians have access to quality palliative care that meets national standards.

A greater emphasis should be put on medical research towards finding cures and better pain management methods, particularly through increased funding and reversal of cuts to programs such as combined MD/PhD programs, for which funding was withdrawn in June 2015.

Summary

The Canadian Council of Imams recommends that:

- An end-of-life care team be required to meet all patients requesting physician-assisted dying to inform them about care options available to them, without bias, and to ensure that the patient has made the decision voluntarily and without duress, or encouragement from another party;
- Encouragement to seek physician-assisted dying be made a criminal offence;
- Physicians and faith-based care facilities be allowed to disengage themselves from physician-assisted dying, to the extent they feel is necessary to them, without infringing upon the rights of patients;
- Development of a strategy to offer quality palliative care to all Canadians;
- Greater funding for medical research towards finding cures and improving pain management methods.

CONCLUSION

We would like to reiterate that neither euthanasia nor MAiD are supported or encouraged in the Islamic faith tradition. We believe there is a need and an opportunity to protect the vulnerable, improve quality of life for patients and balance the rights of patients and physicians.

In a publication in the American Journal of Bioethics, Dr. Lyons et al. have said that “the story of MAiD in Canada has been one of apparently relentless, rapid expansion.”²² As Muslims, we have significant concerns regarding its implications to Canadians as a whole. We welcome the request from the United Nations Committee on the Rights of Persons with Disabilities in 2025 to outright cancel the 2021 expansion of MAiD eligibility to patients not imminently approaching their death. We also hope that our government continues to reflect on the implications for MAiD for a sole underlying mental disorder (MD-SUMC) until rediscussion in March 2027.

¹⁹ Sullivan, Donald R., et al. “Association of Early Palliative Care Use With Survival and Place of Death Among Patients With Advanced Lung Cancer Receiving Care in the Veterans Health Administration.” *JAMA Oncology*, vol. 5, no. 12, Dec. 2019, p. 1702. Crossref, <https://doi.org/10.1001/jamaoncol.2019.3105>.

²⁰ <https://bc-cpc.ca/wp-content/uploads/2019/10/2-BCPC-Clinical-Best-Practices-colour-Pain.pdf>

²¹ Elzayat, Rami and Khan, Nazir “Sedation and Psychoactive medications in Islamic jurisprudence and bioethics” 19th Annual Imams Conference

<https://www.amjaonline.org/wp-content/uploads/2023/10/Sedation-and-Psychoactive-medications-in-Islamic-jurisprudence-and-bioethics-AMJA-2023-Dr.-Rami-Elzayat-Nazir-Khan.pdf>

²² Lyon, Christopher, et al. “Canadian Medical Assistance in Dying: Provider Concentration, Policy Capture, and Need for Reform.” *The American Journal of Bioethics*, vol. 25, no. 5, Jan. 2025, pp. 6–25. <https://doi.org/10.1080/15265161.2024.2441695>.



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Our patients are some of the most vulnerable in society and need to be heavily advocated for. It is no surprise to any Canadian that our national approach towards primary care access alone has fallen to a low standard. We hope to build on a foundation that prioritizes access to primary care as well as palliative care. We hope our suggestions are useful in developing legislation that is balanced and compassionate.



بسم الله الرحمن الرحيم

الحمد لله والصلاة والسلام على رسول الله وآله وصحبه ومن والاه

**In the name of Allah, the Most Gracious and the most Merciful
May Allah's Blessings and Peace be showered
on His Prophet Muhammad, his family and those who follow his path.**

STATEMENT ON EUTHANASIA AND MEDICAL ASSISTANCE IN DYING (MAiD)*

On Wednesday, the 17th of December 2025, the undersigned scholars formally approved this document prepared collaboratively by physicians of the Muslim Medical Association of Canada, together with scholars from the Canadian Council of Imams and the Fiqh Council of Canada, addressing the ethical, legal, and religious dimensions of Euthanasia and Medical Assistance in Dying (MAiD).

The following points are hereby affirmed:

1. Legal and Ethical Ruling on Euthanasia and Physician-Assisted Suicide

Euthanasia and Physician-Assisted Suicide (PAS), commonly referred to as Medical Assistance in Dying (MAiD), are categorically prohibited (ḥarām) according to the principles of Islamic jurisprudence (fiqh) and the higher objectives of Islamic law (maqāṣid al-sharīah). Although the two practices differ procedurally—wherein euthanasia involves the direct administration of a lethal substance by a physician, and PAS involves the patient's self-administration of prescribed medication—their legal ruling remains identical due to their shared intent and outcome: the deliberate termination of human life.

In Islamic theology and law, human life is a sacred trust (amānah) bestowed by Allah, not a personal possession subject to voluntary termination. The intentional taking of life, even under the pretext of alleviating suffering, is explicitly forbidden, as affirmed by the Qur'anic injunction: **"Do not take life which Allah has made sacred, except by right"** (Qur'an 6:152). The entirety of Islamic legal and ethical teachings is oriented toward the preservation, protection, and sanctity of life; thus, intentional life termination constitutes a major sin (kabīrah) and a violation of divine sovereignty. Even for Physicians, or people with authority, it would be considered a major violation when they make a decision to end someone's life whether with the patient's consent or not. Thus, we strongly recommend that Physicians who refuse to be involved in anything related to these procedures to be exempted and not held liable for anything.

2. Juristic Distinction Between Hastening Death and Allowing Natural Death

Islamic jurisprudence clearly differentiates between actively causing death and permitting the natural process of dying to occur. The withdrawal or withholding of futile or extraordinary life-sustaining treatment is permissible when death is deemed medically inevitable and all reasonable measures to preserve life have been exhausted. Such an action does not constitute the causation of death but rather allows death to occur naturally, and therefore does not fall under the prohibition of killing.



3. Theological Perspective on Suffering and the Obligation of Care

From an Islamic theological perspective, suffering and illness may serve as a means of spiritual purification and expiation of sins prior to meeting Allah. Consequently, making a conscious decision to end one's life to escape suffering is impermissible. The Islamic tradition affirms that patients who endure illness with patience (ṣabr) and perseverance are promised immense reward in the Hereafter.

As life and death fall exclusively within divine authority, Islamic ethics mandates the pursuit of compassionate, comprehensive, and ethically sound palliative care. High-quality palliative care aims to alleviate pain, preserve human dignity, and provide holistic physical, emotional, and spiritual support, thereby fulfilling the moral obligation to care without transgressing the sanctity of life.

4. Societal and Ethical Implications

Scholars and Muslim medical professionals express grave concern regarding the broader ethical ramifications of MAiD, including the risk of a “slippery slope” whereby vulnerable populations—such as the elderly, persons with disabilities, and those experiencing psychological distress—may feel implicit or explicit pressure to choose death. Such practices risk undermining the foundational ethical duty of healthcare systems to heal, protect, and care for human life.

Conclusion

In conclusion, Islamic law unequivocally rejects the intentional termination of human life, including in cases of terminal illness. It instead upholds patience, faith, human dignity, and the provision of robust palliative care as the morally and legally sound response to suffering at the end of life.

Signed on behalf of the FMC present Scholars: _____

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(*) The MMAC statement was prepared by Dr. Obaidullah Khan and the CCI statement was prepared by scholars from CCI and reviewed by Dr. Hamid Slimi and Dr. Abdul Hai Patel.

The FMC statement was prepared by Dr. Hamid Slimi in collaboration with FMC members, CCI and MMAC.