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Do Patients Without a Terminal Illness Have the Right to Die?

Paula Ritchie wasn't dying, but under Canada's new rules, she qualified for a medically assisted death. Was that kindness or cruelty?

By Katie Engelhart

Katie Engelhart has been reporting about medicine and ethics for nearly a decade. For this article, she interviewed dozens of clinicians, ethicists, lawyers, advocates and patients.

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One of the doctors wanted to know why, despite everything, Paula Ritchie was still alive. “I’m just curious,” she said. “What has kept you from attempting suicide since August of 2023?”

“I’m not very good at it,” Paula said. “Obviously.” Then she started to cry. She said that everything was getting worse. She said she didn’t want to suffer anymore. “This is a more dignified way to go than suicide.”

Paula was lying in the big bed that she had pulled into the center of the living room, facing an old TV and a window that looked out on a row of garbage bins. The room’s brown linoleum floors were stained, and its walls were mostly unadorned. On a bookshelf, there was a small figurine of an angel, her arm raised in offering. At 52, Paula had a pale, unblemished face and a tangle of dark hair that fell around her waist. The day before the appointment, in January this year, she washed her hair for the first time in weeks, but then she was not able to lift herself out of the bathtub. When, after hours, she managed to get out, her pain and dizziness was so bad that she had to crawl across the floor.

Dr. Matt Wonnacott sat in a folding chair at the foot of the bed. He was there as Paula’s “primary assessor”: one of two independent physicians, along with Dr. Elspeth MacEwan, a psychiatrist, who drove through the snow to Smiths Falls, Ontario, to evaluate Paula's eligibility for Canada's Medical Assistance in Dying (MAID) program — what critics call physician-assisted suicide.

"You're a difficult case," Wonnacott admitted. Another clinician had already assessed Paula and determined that she was ineligible — but there was no limit to how many assessments a patient could undergo, and Paula had called the region's MAID coordination service every day, sometimes every hour, demanding to be assessed again, until the nurse on the other line had practically begged Wonnacott and his colleagues to take Paula off her roster.

Wonnacott had met Paula once before, and he found her to be a fairly accurate narrator of her own medical history. They had spoken about how, precisely, Paula suffered and why she wanted to die. For the last few months, Wonnacott had been reading through her medical records, which were copious, and thinking about her case. "I just sort of let it percolate," he said. "I have to sit with this for a little while. It's kind of a gestalt thing."

Paula started thinking about MAID in the spring of 2023, after suffering a head injury. In the days following, she had vertigo and a migraine that wouldn't go away. Her muscles jerked, and her legs buckled underneath her when she tried to walk. At night, she couldn't sleep. Same for the next night and the next one. Physicians in the local emergency department did a CT scan and later an M.R.I. but could not find an obvious cause for her symptoms. Based on Paula's presentation, several diagnosed her with a concussion — and then, when the symptoms didn't go away, and when Paula kept returning to the hospital in tears, with post-concussion syndrome. Others told Paula that her symptoms were caused by depression and anxiety. "Go home," they said, after running a few tests and referring her to county mental-health services.

When Paula was alone at her apartment, her symptoms grew worse. She was dizzy. She vomited all the time. Paula said it was like the world was spinning. Like she was on a "roller-coaster ride at full warped speed." Her body hurt, too. Like the blood in her veins had been replaced with burning gasoline. Like her brain was going to blow. She couldn't focus. She couldn't cook or do laundry. She couldn't cut her toenails; they grew inches long, yellowing and curling in on themselves, before breaking off at the base.

The pain was worse than anything she had ever felt, and Paula had always been in pain. Over the years, she had collected varied and sometimes competing diagnoses: fibromyalgia, chronic fatigue syndrome, chronic pain, chronic migraine. Also bipolar disorder, borderline personality disorder, post-traumatic stress disorder, depression, anxiety, substance-use disorder (marijuana). Paula told a friend that a veterinarian would put a dog down for feeling better than she did.

In the months after the concussion, she took Percocet, for joint pain, and Lyrica, for nerve pain, and Ativan, for anxiety. She took pills for vertigo and insomnia, and she tried a drug called Lamotrigine: an anti-epileptic that is also used as a mood stabilizer. When that didn't work, she spent money that she didn't really have on chiropractors and acupuncturists and reiki energy healers. Everything just made her dizzier, and nothing touched the pain.

Once, after being sent home from the hospital, Paula tried to take her own life, using two plastic grocery bags. She passed out but did not suffocate, and when she woke up, gasping and tearing at the plastic, everything was worse again. Her vocal cords were damaged from the pressure on her neck, and her smooth, low voice had turned into a permanent high-pitched squeak.

In June 2023, Paula went to Brockville General Hospital, a 45-minute drive from her home, to see if its E.R. doctors could help her. There, she was involuntarily admitted and put on a weeklong psychiatric hold. Two months later, Paula took a taxi to a different hospital, in Ottawa. She asked, "Do you guys do MAID?" Again she was placed on a psychiatric hold, this time for three weeks.

By then, MAID was in the air. That year, 15,343 Canadians — one out of 20 who died — received a physician-assisted death, making Canada the No. 1 provider of assisted dying in the world, when measured in total figures. This, just seven years after the procedure was legalized in Canada. In one province, Quebec, there were more MAID deaths per capita than anywhere else. Paula, who watched TV all day long, had seen lots of stories about MAID on the news.

Some of the coverage was about a recent expansion to the legislation. While MAID was initially restricted to patients with terminal conditions, the law in Canada was amended, in 2021, to include people who were suffering but who weren't actually dying: people like Paula, who might have years or decades of life ahead of them.

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Dr. Matt Wonnacott served as Paula's "primary assessor" for the MAID program. Credit...Oliver Farshi for The New York Times

Wonnacott already believed that Paula met most of the criteria for MAID, on the basis of her neurological disorder and lingering symptoms. Still, he wondered if there was anything he could do to make her life better, or at least good enough that she wouldn't want to die. In particular, Wonnacott wanted to know if Paula would consider seeing a neuropsychiatrist, a specialist who worked at the intersection of chronic pain and brain injury.

"I don't want to seem difficult if I say no," Paula said hesitantly. She had been called "difficult" before. The thing was, she knew that it could take months to get a specialist appointment in Ontario, as in the rest of Canada. And even then, it might not help. Paula had already seen a neurologist, who told her that "there is no magic wand."

"That's a thing that people say a lot," Wonnacott said. "And it comes off as pretty callous." What the neurologist probably meant, he suggested, was that there was nothing any individual doctor could do to make Paula instantly and all-the-way better. "I think it's possible, theoretically possible, that months to years of sustained work over many visits could make you marginally better. So I want you to just think about a hypothetical here: What if there was a magic wand that would make you *mostly* better, five years from now? Would you wait the five years?"

"I cannot get through a day," Paula said. "It's physical torture." She wanted to know at what point she was allowed to refuse more treatment.

"That's a great question," Wonnacott said. The answer was: at any point she wanted. There wasn't a specific number of treatments she was required to undergo before she could get MAID, or some specific period of time she had to suffer before she was deemed, under the law, to have suffered enough. Paula was allowed to say no. To say enough is enough.

"It's not my role to force you to do anything, even if I genuinely think it would really help you," Wonnacott said. In the doctor's opinion, Paula's understanding of her injury was not perfect, but it was not distorted by her mental illness either. Her MAID request didn't seem to be a cry for help, or a lashing out, or a manipulation. She had tried to get better, after all. She seemed to be thoughtful about the costs and benefits of dying. "I think you have capacity," he told her.

"That sounds like you are saying that you find Paula eligible," said MacEwan, who was sitting on a chair on the other side of the bed.

"Yeah, I will go ahead," Wonnacott said. "You?"

"Yes," she answered. And Paula started to weep.

"It's really a question of my schedule," Wonnacott said. "I can probably do next week."

When Canada's first MAID law, Bill C-14, passed in 2016, it was reserved for those who were over 18, eligible for health care and mentally competent to consent to death. They needed to have a "serious and incurable illness, disease or disability"; be in an "advanced state of irreversible decline in capability”; and have “enduring physical or psychological suffering” that was “intolerable.” Their natural deaths also had to be “reasonably foreseeable.” In other words, they had to be dying.

The early paradigmatic cases were people in their 70s and 80s with terminal cancer: educated, affluent men and women who didn’t want to die slowly, perhaps in pain, perhaps slipping in and out of consciousness for hours or days. In one poll, an overwhelming 86 percent of Canadians were found to support MAID’s legalization.

But clinicians who agreed to assess dying patients were visited by other kinds of patients too: people with chronic pain or spinal-cord injuries or slow-moving, early-stage neurological disorders, like Parkinson’s and multiple sclerosis — people who were suffering terribly but who weren’t dying of their conditions in any immediate way. MAID assessors would have to tell these patients that they didn’t qualify.

At the same time, Canadian newspapers were publishing stories about people who were denied MAID and then went on to take their own lives, alone or fearful. One was Cecilia Bernadette Chmura, a 59-year-old with chronic pain who killed herself with a handful of hoarded pills, crushed in a coffee grinder, and whose husband was taken into custody after her death. Her husband had insisted that his wife die in her own bed, in his arms, instead of alone in a motel room, as she initially suggested to protect him from prosecution. (He was not charged.)

In 2017, Bill C-14 was challenged, in a Quebec court, as being too restrictive. One plaintiff was Jean Truchon, a 51-year-old who had suffered from spastic cerebral palsy from birth. Truchon was almost completely immobile; he had movement only in his left arm. Still, he could function with assistance and, in adulthood, even live with some independence in a supervised apartment. Then, in 2012, Truchon lost sensation in his left arm. He was moved into an assisted-living facility, where he experienced constant pain and muscle spasms and monotony.

Jean Truchon was a plaintiff in the lawsuit that led to the expansion of Canada’s MAID program. Credit...Ivanoh Demers

His days were a wash: hours spent being moved from his bed, to an armchair, to a bathroom for a scheduled bowel-movement break at 1 p.m., to a common room, then back to bed to watch hours of television. "That's basically my life," he explained in a summary to the court. "My poor life." Truchon told lawyers that he had considered maneuvering his wheelchair in front of a truck or a bus, but that he didn't want to traumatize the driver. He had also considered starvation, but he thought he might suffer too much. His evaluating psychiatrist testified that Truchon was, as the judge later summarized, "not suicidal, despite his wish to die." He just couldn't see the point in living anymore.

Truchon was granted a legal exemption and allowed to die by MAID. As a result of the lawsuit, in 2021, the Canadian government passed Bill C-7, which removed the requirement that a patient's death be "reasonably foreseeable." Now Canada's law resembled the liberal legislation that was already in place in a few small European countries: the Netherlands, Belgium, Luxembourg. Now a Canadian who was chronically sick or disabled could receive MAID from a doctor or a nurse practitioner. Within Canada, this new kind of MAID came to be known as Track 2.

Technically, this second track was also open to people who did not have any physical condition at all, who were applying because of mental illness. But in response to an outcry from some Canadian psychiatrists who argued that the mental-health-care system was wholly unprepared for the change — and who worried about psychiatry's ability to know, with any certainty, whether any given patient was incurable — MAID for "mental illness as the sole underlying condition" was delayed for a period of two years, and then delayed again and again. (It is now set to begin in 2027.) Track 2 came into effect with a mental-health exclusion and remained relatively rare; in 2023, there were 14,721 Track 1 deaths and 622 deaths from Track 2.

Still, Track 2 quickly became a subject of national contention and even obsession. To supporters, the passage of Bill C-7 was an act of profound political empathy: a recognition that human suffering knows no temporal bounds, and an extension of mercy to people who might otherwise be driven to suicides that were painful or violent. For critics, Track 2 was a moral stain on a nation that believed itself to be a bulwark of decency. It was proof of the slippery slope. Dr. K. Sonu Gaind, chief of psychiatry at Toronto's Sunnybrook Health Sciences Centre, told The National Post that "we have gone so far over the line with Track 2 that people cannot even see the line that we've crossed."

How we reported this article:
Katie Engelhart spent hours interviewing Paula Ritchie about her life and medical history, as well as reviewing her medical records, legal documents and personal diaries. Paula granted permission for the reporter to be present for critical appointments and for herself and her home to be photographed by Oliver Farshi. Paula agreed to have her story shared by The New York Times; as she told the reporter, "I'm an open book."

From the start, some clinicians wanted nothing to do with Track 2. "There are whole regions of the country where doctors are just saying, 'Well, we don't do that,'" Dr. Stefanie

Green, a prominent MAID provider in British Columbia and the founding president of the Canadian Association of MAID Assessors and Providers, told me. Others tried but then stopped, after seeing how complicated and onerous a Track 2 assessment could be. This was nothing like evaluating a Track 1 patient with, say, pancreatic cancer, one Alberta provider told me. An evaluation like that could take 15 minutes. "The janitor could do the assessment," the provider said. "No disrespect to janitors."

While a Track 1 patient could technically apply for and receive MAID within a day, the process for Track 2 was slower; there had to be at least 90 days from the start of the assessment to the patient's death. Each patient was assessed by two independent clinicians, and if neither of the assessing clinicians had expertise in the patient's medical condition, they had to consult with a clinician who did. The patient requesting assisted death also had to be informed of "the reasonable and available means" to relieve the suffering — and to give "serious consideration" to those means.

By law, a MAID patient had to be suffering in some way. The suffering could come either directly from the medical condition or indirectly from the condition's follow-on effects. It could be either physical or psychological, as long as it was "enduring." The law did not define exactly what it meant to suffer, or exactly how a medical professional was meant to evaluate the suffering. It was up to individual clinicians to figure out, in conversation with their patients. In a "Model Practice Standard" published by Health Canada, the country's federal health regulator, MAID assessors were instructed to "respect the subjectivity of suffering."

For other clinicians, the concern about Track 2 was more philosophical. Dr. Madeline Li, a cancer psychiatrist who developed the MAID program for Toronto's University Health Network and who has personally overseen hundreds of Track 1 patients, told me that she was hesitant to involve herself in Track 2 because it didn't fit with her larger understanding of medicine and its purpose. "If you want to allow people to end their lives when they want to, then put suicide kits in hardware stores, right?" Li told me. It was not "assistance in dying" if the patient was not actually dying.

But Wonnacott, Paula's MAID assessor, started seeing Track 2 patients right away. He believed that bodily autonomy and patient choice should be the guiding tenets of his practice, and that many doctors didn't respect these things enough. Every week or so, he would receive an email from the regional case-coordination service with a list of prospective patients, and when he had the time, he would take a few names from the bottom of the list: the people who had been waiting the longest for an assessment — sometimes because they were difficult cases.

The straightforward Track 2 patients were those with a clear diagnosis and a trail of paperwork. They were people who had, over the years, tried very hard to get better or at least to tolerate their conditions. An Alberta man in his mid-30s who had been having multiple seizures a day since he was a child, and who said he was tired of living in the drugged-out, half-sedation that his medication induced. A 39-year-old Nova Scotia woman with a progressive spinal condition that caused relentless pain. Other cases were less obvious. Clinicians debated what to do with patients who wanted assisted death for conditions that affected large numbers of people, many of whom seemed to be coping all right: diabetes, back pain, blindness.

Rick Martins, a retired electrical contractor in St. George, Ontario, was 67 when he lost almost all the vision in his left eye. It went over the course of a few days: the peripheral vision first, and then the rest. He was told that he had giant cell arteritis. At the time, Martins's wife was sick with congenital heart disease and was in the hospital, and Martins visited her for 169 days. When she died in 2024, he found himself overwhelmed with grief — and then he lost vision in his right eye. That day, Martins decided that he wanted MAID. "It was too much all at once," he told me. He was approved several months later.

In the meantime, Martins tried to adjust to things. He got an audio player so that he could listen to books. He continued to have coffee with a grieving widow he met at a support group. He allowed his two adult sons to care for him. But ultimately, Martins decided that, at nearly 70, he did not want to learn to live as a blind man. During Martins's assessment, a psychiatrist asked him whether he would still want to die if his wife were alive. Probably not, Martins said; if she were alive, he would find a way to live. But she was not alive.

Other clinicians insisted that patients slow down — that, after a dramatic loss, they try to acclimate to their new bodies before requesting to die. Dr. Donna Stewart, a psychiatrist at Toronto General Hospital, told me about a patient in his late 20s who "took magic mushrooms, thought he could fly, found out he couldn't and sadly crushed and broke his neck and ended up quadriplegic." Almost immediately, he applied for MAID. Stewart consulted with rehabilitation experts. "And boy, I really got an earful," she said.

Some pointed to research showing that over time, usually years, patients with spinal-cord injuries adjusted to things and then were glad to be alive. Others believed that it wasn't the job of a MAID assessor to force people to stay alive for years in the hope that they might one day be grateful for it. Stewart reviewed the literature on long-term well-being after paralysis, and it gave her pause. "I said: 'You know, I can't go along with this. Let's revisit in a year.'" The young man agreed to go to rehab. A year later, he asked for MAID again, and Stewart approved him. She believes that she was justified in asking him to wait. Others would have made him wait longer. But then again, Stewart thought, he had suffered for a year longer than he wanted to.

Often, Track 2 patients had suffering that was caused by social forces — and often, clinicians had to disentangle how much *that* kind of suffering was contributing to a MAID request. Many would-be Track 2 patients had been sick for years or decades and had, in that time, slipped out of the work force and into poverty. About half reported that they were lonely. About half perceived themselves to be a burden on loved ones. Stefanie Green, the co-founder of the Canadian Association of MAID Assessors and Providers, told me about assessing a sick patient who had been homeless, on and off, for years. "And obviously his fluctuating housing status could not be ignored," Green said. "Why are you coming to see me? Because you’ve lost your room, you have nowhere to go? What is really driving this?”

And then there were the Track 2 patients whose suffering couldn’t be pinned down at all. They had chronic aches, or mysterious fevers, or fatigue that no amount of sleep would resolve. They had “functional disorders” that couldn’t be picked up on any blood test or body scan, that had no obvious medical explanation — disorders that are poorly understood within medicine, and disputed within medicine, and that some clinicians believe have a significant psychological component. Fibromyalgia, chronic fatigue, irritable-bowel syndrome, some kinds of chronic headaches, many types of chronic pain. Whether a clinician found such a patient eligible depended, in part, on how comfortable he or she was with ambiguity. The law itself did not require diagnostic certainty.

Some assessors refused to see patients with functional disorders. They argued that MAID for these conditions was, in effect, MAID for mental illness. Other clinicians assessed and approved them. Under Bill C-7, mental illness was not disqualifying as long as it existed alongside a physical condition. Many of these assessors argued that they were capable of deciphering exactly what was motivating a request to die.

Friends arranged a collection of belongings on Paula’s bedside table. Credit…Oliver Farshi for The New York Times

In the beginning, Wonnacott said, he could get hung up on a patient’s complexity — even distracted by it. He would try to map out the contours of a request: the shape and scope of different kinds of suffering. He learned to stop doing that. It was an impossible exercise that produced meaningless conclusions. Also, it didn’t matter. “The phrase I find myself saying a lot is, ‘I’m not going to judge people for why they’re suffering,’” he told me. “In some jurisdictions, you have to meet specific criteria for suffering, and I think it’s good that in Canada, you don’t. I don’t particularly care why you’re suffering. If you tell me that you’re suffering, who am I to question that?”

Paula said she had suffered from the day she was born. She was an unhappy baby, and then an unhappy child. She grew up in Perth, Ontario, in a motel that her parents owned, left to play all day in the lobby and the hallways. It was in that motel, Paula recalled, that her father abused her, in every way that a father can abuse a daughter. “He was a brutal monster,” she said. When her father was away, Paula could be vibrant and playful, but she also cried all the time. At night, she prayed for him to die: “God, please take him.”

When her father died in a car crash, Paula was 16, and she was left to wonder if her prayers had anything to do with it. She started getting terrible headaches and sometimes blacking out. She was always tired.

Paula went to college, to study sociology — she took a class on how to care for abused children — but she had to drop out because she was always in pain. Eventually, she was diagnosed with endometriosis and had a hysterectomy. Even then, the surgery didn’t take the ache away. It stayed there, deep in her hips and pelvis. Paula saw different doctors who proposed new diagnoses, like fibromyalgia. She went through bottles of Ibuprofen and prescription opioids.

Over the years, she tried to take her life several times: once with pills; once in a river, with weights in her pockets — like Virginia Woolf, except that Paula came up coughing and swam back to shore. Several times, beginning when she was 24, she was admitted to inpatient psychiatric units. Different doctors had different theories about why she was unwell and prescribed different things: antidepressants, antipsychotics, benzodiazepines. Sometimes she stayed on a particular drug for many years, but other times she decided that the drugs weren’t working, or that their side effects were too debilitating, or that they were making her fat, and she stopped them.

At home, Paula was treated by psychiatrists and caseworkers at Lanark County Mental Health, which provides publicly funded care. She was also seen, on and off, by a private therapist, whom she loved and who agreed to work with her for free because she couldn’t afford the help. Paula would attend appointments regularly for months, but then she would inevitably disappear, until she reappeared a few months later. “Paula is responsible and desires tremendously to carry her own weight in the world,” the therapist wrote in a letter of support. “Although Paula still has a long way to go, I fully expect Paula to become a happy and successful member of society.”

With friends, Paula could be sweet one minute and vicious the next. “You had to kind of tread carefully with her,” David Robinson told me. At one of her apartment buildings, Paula befriended David, who was three decades her senior. David was drawn to Paula’s big energy: the way she radiated it when she smoked a bit of weed and then went walking through town with her ponytail swinging, saying, “Hey, doll!” to everyone she came across. To David, everything about Paula was loud and excessive. Her voice. Her strut. The way she used a half a bottle of shampoo every time she washed her hair. Early in their friendship, Paula showed up at his door and told him that she was weaning herself off oxycodone — and could she lie on his bed for a while, so she wasn’t alone? She just lay there, in front of his window, sweating and talking, looking thin and beautiful. Sometimes David found himself thinking that if he had been born three decades later, he would have been all over Paula — but he never said it.

There were stretches of stability, of Paula feeling OK in her body. For a few years, she worked in group homes for people with disabilities. Some of her patients had Down syndrome and autism. Another, a young girl, was deaf and blind, and she just sat in a corner, alone, making buzzing sounds and sometimes hitting herself. “It drove people nuts,” Paula said. “But I loved her.” Paula would talk to the girl: close enough that she could feel the vibration of Paula’s voice. In the evenings, she would sit in bed with her.

But when Paula was 30, her mother died of stomach cancer, and everything fell apart. She felt abandoned. She struggled to take care of herself. Soon she was broke and had to sell her car. She started walking everywhere: up to 18 miles around town in a single day. She moved into a motel and then another. When, after years on the affordable-housing wait list, a unit finally opened up, it was not in Perth but in neighboring Smiths Falls, where Paula knew nobody. Paula did not want to move, but she had nowhere else to go.

Paula (left) and her mother, who died of stomach cancer when Paula was 30. Credit...Oliver Farshi for The New York Times

“She just went downhill really fast,” her aunt Dorothy Zoppa told me. Paula stopped seeing her therapists and her social workers. She stopped seeing a family doctor because she couldn’t find one. She stopped taking mood stabilizers. She didn’t have a cellphone or a computer, and she spent hours a day just talking on an old black landline phone to people back in Perth. Still, Paula said, she was managing things — she was holding it together — until the concussion.

In Paula’s telling, she was followed into town one day in March 2023 by two women: one, the daughter of someone who lived in her affordable-housing complex and whom Paula had been feuding with. The women punched Paula in the left side of the head until she blacked out. And when she awoke, “I’m like, I’m in trouble.”

Paula eventually found a family doctor who prescribed a variety of drugs and wrote a referral to a neurologist. But then she started calling the doctor's office all the time, demanding more referrals and yelling at the staff. She made appointments and then did not show up: because she couldn't find anyone to drive her the 45 minutes it took to get to the doctor's office, or because she felt too sick to get in the car. After a year, the doctor sent Paula a letter saying that she had "decided to discontinue providing medical care for you at this time. … Please understand that this decision is in no way a reflection of your personal worth." Later, a brain-injury clinic agreed to examine Paula, but she did not show up to her intake appointment.

Paula stopped leaving her apartment. She stopped bathing. She gained 30 pounds. Once, when David came to visit, he was stunned to see that Paula now resembled an old woman: soft and trembling, barely able to walk.

In May 2024, more than a year after the concussion, and months after she started asking doctors about MAID, Paula went to see a neurologist who diagnosed her with post-traumatic headaches. During the examination, the doctor observed "an on/off postural tremor" in both of Paula's arms but found that it was "distractible" — as in, if Paula were distracted, by a task or in conversation, the tremors ceased. Paula was also observed to have "giveaway weakness in all muscles." When the doctor pushed against a limb, Paula would initially be able to resist the touch at normal strength, before her muscles would suddenly buckle and give way. This suggested that the buckling was due to psychological causes or a lack of effort.

"Her neurological examination is normal," the doctor wrote, indicating that her symptoms might be linked to depression and anxiety, perhaps triggered by the concussion. She recommended that, in addition to taking medication for migraines, Paula go to therapy and start an S.S.R.I.; she noted that Paula refused to try any of it. "I don't think that she has permanent brain damage," the neurology report concluded. "I have already told her that none of these diagnoses would qualify for her MAID at this time."

Paula panicked. She started calling MAID coordinators in other regions. She called radio stations and newspapers and nonprofit organizations and the mayor, trying to plead her case. She called police stations too, asking if someone could administer a polygraph test, so that she could prove to everyone that her wanting MAID had nothing to do with mental illness but was instead about her brain damage. That if she seemed mad, it was only because the injury had driven her to the point of madness.

When Paula finally met Wonnacott and he told her that she had the capacity to consent to MAID, she decided that he must be an angel sent by God. By the grace of God, she said, the doctor had believed her.

The opponents said they knew all along that Bill C-7 would be dangerous. That when Canada severed the act of MAID from the condition of dying, the remaining law would be so expansive as to allow death for any manner of "suffering." And that the first casualties would be the poor and the marginalized and the disabled and the mentally ill.

These people, whose medical problems were so obviously made worse by their material conditions, would end up applying for MAID because of suffering that was, effectively, imposed on them by the system. They would be judged "incurable" and "irremediable" because they had not been provided with the means to become well. MAID, a procedure initially meant to help dying patients avoid painful deaths, would now be used to help nondying patients shortcut their painful lives. For the system, this would be less expensive too. A report released by the Parliamentary budget officer estimated that Bill C-7 would save the provincial governments an estimated $149 million annually in net health care costs.

Even some MAID defenders acknowledged that social and economic factors could confuse a MAID assessment. One 2023 academic paper, titled "Are Unmet Needs Driving Requests for Medical Assistance in Dying?" collected testimony from 20 MAID providers who had together done over 3,700 assessments. The clinicians told researchers that unmet needs were rare, but that some patients were impoverished and lonely, and that this led to an "ethical dilemma," because providers knew "that some of their suffering was due to society's failure to provide for them." The paper noted that "many evidence-based treatments that ameliorate quality of life" for people with chronic conditions were not covered by public health insurance.

Critics pointed to federal data from 2023 showing that Track 2 patients were more likely than the average Canadian to live in the lowest-income neighborhoods. (This is also true of Canadians who are chronically sick or disabled and who do not choose MAID.) For critics, this was further evidence that the supportive fabric of Canadian society was just not strong enough — or stretched widely enough — to allow an ethical practice of Track 2 MAID. Gaind, the Toronto physician, wrote an article suggesting Canada was committing "social murder."

But it was all legal. "That's why it's so complicated," said Li, the cancer psychiatrist. In her opinion, the problem was in what the law left space for. "If a patient meets eligibility criteria — and because the laws are kind of vague, it's actually not that hard to meet eligibility criteria — then you can provide the MAID. But that doesn't mean that, clinically, you *should* provide the MAID." Especially without putting up a fight. "It's odd to me. There's no other branch of medicine where we just do what a patient wants without asking, 'Is this the right decision?'"

Other countries had constructed their laws differently. In the Netherlands, for instance, where assisted dying for nonterminal patients is also legal, the law required the physician and patient to agree that all potentially effective means of alleviating suffering had been tried before the patient was approved. By contrast, in Canada, according to a 2018 paper in The Canadian Journal of Public Health, there was an "emphasis on the absolute right of patients to decide to die."

“I do think there is a swing toward, you know, *autonomy über alles*,” said Ed Weiss, a family physician in Toronto. In this view, Bill C-7 had created a bureaucracy, even an aesthetics, of medical care, when all that some MAID assessors were really doing was letting patients do whatever they wanted.

By February 2023, a poll by the Angus Reid Institute, a nonprofit research foundation, showed that “more than half of Canadians (55 percent) say they worry about MAID taking the place of improvements in social service.” At academic conferences in the United States and South Africa, and in debates about assisted dying in Britain and Ireland, Canada was presented as a warning and a threat: Pass any MAID law, however narrow, and the law would expand, and the practice would degrade. In Canada, critics argued, MAID had stopped being a “last resort.” Now it was just another way to relieve suffering.

The most organized critique of Canada’s law came from disability rights advocates. In September 2024, two people with disabilities and several nonprofit organizations announced a legal challenge to Bill C-7. Their case argues that, by definition, all Track 2 MAID patients are disabled — people with medical conditions that limit daily functioning — and thus, that the law is discriminatory. If a nondisabled person is suffering and wants to die, her desire will be understood as pathological, and she will be offered suicide prevention. If a disabled person is suffering and wants to die, her doctor will hand her the proverbial gun.

According to legal filings, one party in the case, a 40-year-old woman named Kathrin Mentler, went to Vancouver General Hospital in 2023 after experiencing an “acute mental-health crisis.” There, in the throes of her calamity, “a clinician advised her on MAID and discussed MAID in positive terms, even though she was seeking help to live and did not ask for information about how to die.”

As it was, people with disabilities said they were used to having to beg for not much of anything. They were used to having to apologize for their existence and their needs. In every Canadian province and territory, disability benefits fall below the poverty line. “In some places in our country, it is easier to access MAID than it is to get a wheelchair,” Carla Qualtrough, then the minister in charge of Canada’s “disability inclusion,” acknowledged in 2020.

Many advocates referred to the case of a 66-year-old Quebec man named Normand Meunier, who died with MAID in 2024. Meunier was a truck driver until a 2022 spinal-cord injury left his arms and legs paralyzed. In January, his partner took him to the emergency room because he had a respiratory infection. She explained that Meunier had quadriplegia and that he required a special mattress that shifted pressure points on his body, so that he wouldn’t develop bedsores. Meunier was not given a special mattress, or any bed at all, and instead spent four days on a stretcher. He developed a serious pressure sore on his buttocks, a few centimeters in diameter, that worsened until bone and muscle were exposed. Doctors told Meunier that, at best, it would take months for the sore to heal. At worst, the sore wouldn't heal at all and would instead lead to infection, sepsis, death.

Normand Meunier was approved for MAID on the basis of a serious pressure sore he developed during a hospital stay. Credit…Ivanoh Demers

Meunier requested MAID and was approved quickly on the basis of the pressure sore. "I don't want to be a burden," he told Radio-Canada, shortly before he died from MAID at this home. Later, the regional health authority confirmed that it had 145 alternating pressure mattresses available upon request. "I don't understand how this can happen," Meunier's partner said. "A mattress is the most basic thing."

"I'm certainly not going to argue that the system is in good shape," Wonnacott said. He tended to receive criticism of MAID with equanimity. Of course the system was broken. Of course people ended up on the wrong side of it. And of course the government should work urgently to improve it. But then again, it was the system. There was no other system on offer. "And to force people to continue suffering as we wait an indefinite amount of time to fix it is unfair." Sure, in any given MAID assessment, Wonnacott could allow himself to get caught up in the past conditional of what *should have* been done, what *could have* been. But there was the suffering patient sitting in front of him, here and now, wanting an answer.

Wonnacott also disagreed with the solution that the critics offered: to shut it all down. Fundamentally, he didn't think the best way to protect poor and marginalized patients was to force them to stay alive, because in some counterfactual version of events, in which the world was a better and more just place, they might have chosen differently. That wasn't how anything in medicine worked; a doctor always treated the patient as she was. How could it be otherwise? If only those who were rich or well connected were recognized to have autonomy and allowed to choose?

To defenders of Track 2, this was just the same old clinical paternalism, recast as concern for the downtrodden. Critics of MAID had grouped patients together, based on a few crude socioeconomic or medical characteristics, declared them collectively “vulnerable” and were now trying to deny them a legal right on the basis of that vulnerability. If a patient was assumed to be vulnerable, and viewed as incapable because of it, there was no limit to what her doctor might decide she could not do.

Even if resources were bountiful, patients would not always be healed. Modern medicine was especially bad at treating Track 2 conditions like chronic pain that lacked a clear structural etiology. Clinicians also struggled to treat chronic psychological symptoms like depression. Even the best palliative-care doctors — physicians whose entire careers were devoted to pain management — came up against symptoms they could not beat: because some physical pain clings to a body; because some patients get acclimated to the strongest drugs; because some kinds of human suffering are resistant to medical intervention. Denying eligible patients Track 2, on the grounds that they could be cured with more and more treatment, was allowing them to be held hostage to an unfounded belief in total recovery.

The critics seemed to imply that a few hundred Track 2 deaths each year were, together, taking the pressure off government officials to improve the system. And that, inversely, if enough people who wanted to die were instead forced to live, their suffering would create the moral imperative for a wide-reaching social-welfare revolution. Wonnacott and his colleagues thought this seemed unlikely. As it was, Canada had more publicly funded health care than many other countries.

For Wonnacott, it wasn’t that hard to approve Paula. If he was troubled about her case, it had more to do with what happened before he even met her. “If I could go back in time to the Paula of two years ago, when she still had the energy to go to emergency and ask for help, I think, in theory, this could have taken a different route and turned out differently,” he said. He could have tried her on one or two other medications. He could have referred her to a concussion clinic or a pain clinic, or maybe even an inpatient rehab unit.

“I think she could have been quite a lot better. But that’s too hypothetical.” If Wonnacott referred Paula to a specialty clinic now, it could be months or years before she even had an intake interview. (According to a 2023 survey, nearly one in 10 Canadians who need a medical specialist wait more than a year to see one.) In the meantime, Paula would grow more fearful, stop doing more things, become more depressed. Lose abilities. Lose resilience. Come to see herself, fundamentally and unshakably, as a person with chronic pain.

Wonnacott had to deal with the patient in front of him. The question was:
Would *this* Paula get better? Not some other patient who was open to different theories about her suffering. Who had the stamina to work hard at therapy. Who, at a basic level, was capable of showing up to medical appointments and taking her drugs on schedule. Wonnacott thought the answer to that question was no.
He had read the report from Paula’s neurologist, which said that Paula did not have permanent brain damage and was not eligible for MAID. But he thought the specialist,

who was not a MAID provider herself, misunderstood the eligibility criteria. There was nothing in the law that said that Paula's neurological condition had to be tied to actual, physical damage to the brain. Paula's pain was real either way. She felt it the same either way.

Wonnacott's doctor's bag. In Canada, almost all MAID patients die by lethal injection. Credit…Oliver Farshi for The New York Times

In recent years, some ethicists have argued that Canada should make its MAID law even more liberal — notably, by doing away with the "suffering" criteria altogether. They argue that the suffering requirement is redundant; of course a person who wants to die is suffering. And also, that a patient shouldn't have to be suffering in a way that is legible to her medical providers for her to be found worthy of death. It should be enough for her to decide, autonomously, that her life is not worth living.

For these advocates, the idea that MAID in Canada was no longer a last resort was not, itself, suggestive of anything being wrong. If a person did not have a religious objection to assisted death — if she didn't think that earthly suffering was noble or important or redemptive, if she didn't think she owed it to anybody else to stay alive — then why did she need to suffer through any number of "reasonable" treatments before she asked for MAID? Why did she need to suffer at all?

The plan had been for Paula's friend to arrive early with her "last meal": a McChicken with pickles and an iced tea. But that morning, on the day of her scheduled death, Paula called to say she wasn't hungry.

When her handful of friends arrived, Paula was lying in bed in blue and white pajamas. By then, her apartment was nearly empty; she had spent the previous week giving everything away. On the wall in the living room, behind the bookshelf, there was a scattering of nails where pictures used to hang. Beside the bed, there was a round table with a small alarm clock on it. Paula had asked for the alarm clock because she wanted to keep track of how much time she had left.

Those close to Paula gathered at her bedside. Credit…Oliver Farshi for The New York Times

The doctor was due in a few hours, and Paula was still preoccupied with logistics: where her belongings would go, who would manage everything with the bank. Everyone had told her not to spend her final hours worrying about that, but Paula said she didn't want to leave a mess behind.

She wrote out a list of instructions in a notebook. The TV and the small corner shelf were to go to her Aunt Dorothy. The microwave could be thrown out, as could the fan. There were two bananas and an apple in the kitchen that David could take, assuming they weren't rotten.

"Are you comfy enough?" Nancy Maynard, Paula's childhood friend asked. "I can tuck you in."

"How am I going to say goodbye to you?" Paula started crying again, her face pinched and anguished. "I just pray to God that the Lord is going to take me."

"I have no doubt," said Valerie Oldfield, a death doula Paula met a few months earlier.

"You're safe now, baby," Nancy said.

"Then why am I so terrified?"

Valerie shrugged. "It's human nature."

Then the minister walked in. Paula had spent days calling religious leaders and asking if they would come sit with her while she died. Some said they would not but that they would pray for her. Others wouldn't even do that. But then, finally, someone agreed to come. She introduced herself as the Rev. Takouhi Demirdjian-Petro, from the United Church of Canada, and she was tall and sturdy, in a pink clerical blouse. She looked down at Paula and took stock of the tearful situation. “You’re in the hands of the everlasting love of God,” she said firmly.

Paula started to cry harder, until she was nearly convulsing. “God have mercy on my soul.”

“God is with you,” the minister said. “And he is guiding you.”

“What if I get lost?” Paula asked. “My mind doesn’t have a very good GPS. I’m scared of getting lost.”

Paula and her friend David Robinson said goodbye. Credit...Oliver Farshi for The New York Times

“You won’t. I promise you, honey.” The minister told Paula that she had a vision of Paula’s mother waiting for her, like a mother might wait for her daughter at the airport. “And I’m not B.S.ing you. So just let go of this empty, empty world.”

Paula stopped crying and turned to the nurse coordinator who had worked on her MAID request. “Do you need to put sheets underneath me, in case — ”

“Nope,” the nurse said.

“Do you know? Do your bowels release?”

The nurse shook her head. “Don’t worry about that.”

When Dr. Wonnacott came in, he was carrying a black leather doctor’s bag. He told Paula that he hadn’t scheduled anything else for the rest of the day, and that things could go as quickly or as slowly as she needed them to. Paula wanted to know how long it would take for her to die. “From the time the meds are in until you’re gone, five or 10 minutes,” Wonnacott said. “But from your perspective: a minute.”

In the American states where assisted dying is legal, patients are required to die by drinking a cocktail of lethal drugs. In Canada, almost all MAID patients die by lethal injection. “It feels like falling asleep for surgery,” Wonnacott told her. “You’re going to get really relaxed, and you’re going to fall asleep.”

Wonnacott asked everyone but Paula to step into the kitchen, in the back of the apartment. He wanted to speak with his patient alone, so that he could get her final consent, as the law required. Once, an elderly woman changed her mind right before Wonnacott administered her drugs. He had literally been doing a silent countdown in his head before squeezing the syringe — “five, four, three … ” — when the woman told him to stop. Paula told Wonnacott she wanted to proceed.

“I’m going to take Paula’s hand now,” Wonnacott said softly. Credit...Oliver Farshi for The New York Times

After a few minutes, Wonnacott joined the small crowd in the kitchen. “I want to let people know what to expect,” he said. “This is fast enough that it can be unsettling.” Paula was going to lose consciousness very quickly, and once her eyes closed, she wouldn’t be able to feel anything. Sometimes, when people died, they looked as if they were in pain, but they weren’t really; that was just an involuntary muscle reaction.

When everyone entered the living room again, the lights were dim, and Paula was lying with a beige blanket pulled around her chest. She said she was ready.

“I’m going to take Paula’s hand now,” Wonnacott said softly.

“Now?”

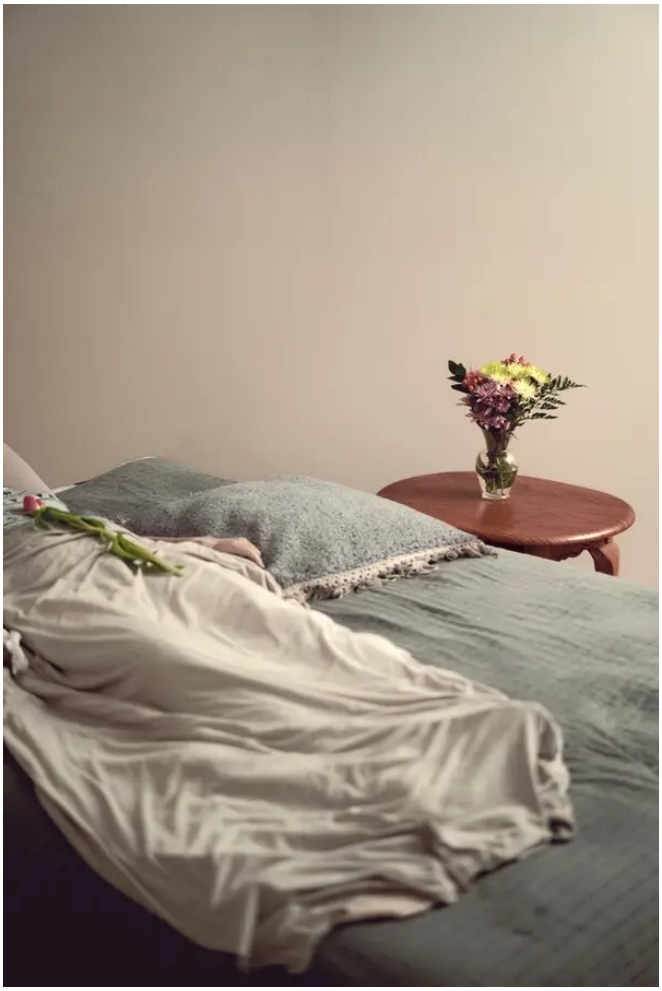
“Now.”

For days, Paula had worried that, at the final moment, she would waver, as she did when she tried to take her life before: pick up the pills, put them down, pick them up again; wade into the river, swim back, over and over. She imagined that when Wonnacott reached for the syringe, she would flinch. But Paula was calm and still as the drugs went in. “I don’t feel anything,” she whispered.

“You will.”

“Oh, wow,” she said. “This is horrible. I’m just so sorry.” Paula coughed as if she might vomit. Deep, guttural hacks. After a few moments, her body relaxed. A wet tissue fell from her hands. Her skin slowly turned a pale white.

Wonnacott pressed his stethoscope to Paula’s chest. “It’s over.”



Two friends stayed with Paula’s body until it was removed. Credit...Oliver Farshi for The New York Times

https://www.nytimes.com/2025/06/01/magazine/maid-medical-assistance-dying-canada.html