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Medical Aid in Dying: New Frontiers in Medicine, Law, and Culture

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Abstract

Medical aid in dying (MAID) has been a productive target for social scientific inquiry at the intersections of law and medicine over the past two decades. Insofar as MAID crystallizes and reflects personal and cultural understandings of key concepts such as individualism, dependency, dignity, and care, it is a rich site for social scientific theorizing. This article reviews and assesses the contributions of social scientific perspectives to research on MAID. We propose that social scientific research on MAID offers four distinctive contributions: its descriptive (rather than normative) orientation, its focus on cultural meanings, its insights into processes of knowledge production, and its comparative lens. The article's major sections describe (*a*) attitudes toward MAID, (*b*) MAID-related social movements, (*c*) legalization approaches, and (*d*) lived experiences of MAID in permissive jurisdictions. We conclude by reflecting on how MAID scholarship can inform social inquiry into other areas in which law and medicine converge.

INTRODUCTION

Since the turn of the twenty-first century, the legalization of medical aid in dying (MAID) has accelerated dramatically. In 11 countries worldwide, it is now legal for physicians to provide medical assistance to end a patient's life (Battin & Pope 2022) (see **Table 1**). The methods for doing so and requirements vary by setting. MAID remains relatively rare, accounting for 0.19% of all deaths in Oregon in the first 20 years of Oregon's Death with Dignity Act (Hedberg & New 2017) and, in 2021, 2.4% of all deaths in Belgium, the jurisdiction with the highest utilization rates (Fed. Public Health Food Chain Saf. Environ. 2021, Stat. Res. Dep. 2021). Nevertheless, this shifting global climate has had an important impact on the sociocultural landscape of end-of-life care and raised urgent social and ethical questions about the expansion, implementation, routinization, and regulation of assisted dying as a medicolegal practice.

A longstanding bioethics literature has considered—and contested—the legal and ethical permissibility of MAID (Battin et al. 1998, Foley & Hendin 2002, Pellegrino 2005, Quill & Battin 2004, Snyder & Sulmasy 2001). Many recent debates have centered on the permissibility of extending legalized MAID to people with psychiatric conditions and dementia (Bolt et al. 2015, Dembo et al. 2018, Kim 2021). A robust health services literature has also examined the frequency of requests for MAID (Back et al. 1996, Ganzini et al. 2000), physicians' strategies for responding

Table 1 Characteristics of jurisdictions with legalized medical aid in dying (MAID)[a]

Jurisdiction	Year authorized	Method of legalization	Method of MAID
Switzerland	1937	Penal code	Patient administered only
Netherlands	1994 2002	First legal review procedure Legislation	Both physician and patient administered
Colombia	1997 2015	Court ruling Guidelines published	Both physician and patient administered
Oregon, USA	1997	Voter referendum	Patient administered only
Belgium	2002	Legislation	Both physician and patient administered
Luxembourg	2009	Legislation	Both physician and patient administered
Washington, USA	2009	Voter referendum	Patient administered only
Montana, USA	2009	Court ruling	Patient administered only
Vermont, USA	2013	Legislation	Patient administered only
California, USA	2015	Legislation	Patient administered only
Canada	2016	Legislation	Both physician and patient administered
Colorado, USA	2016	Voter referendum	Patient administered only
Washington, DC, USA	2017	Legislation	Patient administered only
Victoria, Australia	2017	Legislation	Patient administered only
Hawaii, USA	2018	Legislation	Patient administered only
Maine, USA	2019	Legislation	Patient administered only
New Jersey, USA	2019	Legislation	Patient administered only
Germany	2020	Court ruling	Patient administered only
New Mexico, USA	2021	Legislation	Patient administered only
Western Australia, Australia	2021	Legislation	Patient administered only
Tasmania, Australia	2021	Legislation	Patient administered only
New Zealand	2021	Legislation	Patient administered only
Spain	2021	Legislation	Both physician and patient administered

[a] Table adapted from Emanuel et al. (2016).

to such requests (Back 2004, Dobscha et al. 2004, Quill et al. 2016), and patients' motives for pursuing such assistance (Ganzini et al. 2007, 2009). A systematic review found that dominant reasons for pursuing MAID include the loss of autonomy and dignity and a decreased capacity to engage in regular life activities, with fewer than 33% of patients reporting inadequate pain control as a primary motivation (Emanuel et al. 2016).

This article considers the distinctive contributions of social scientific perspectives to research on MAID. We propose that social scientific research on MAID offers four distinctive contributions. First, in contrast to the dominant approach in the bioethics and legal literature, social scientific research on MAID is primarily descriptive. Social science perspectives shift the focus from normative questions of whether assisted dying is right or wrong to broader descriptive questions about how various social actors engage with its relational, moral, and bureaucratic challenges, including in cases within which law and ethics are not neatly aligned (Heimer 2010). Second, whereas the health services literature has provided strong evidence on attitudes and practices regarding MAID, social science perspectives foreground the cultural meanings of these attitudes and practices. For example, social science research can explain how and why different religious, ethnic, and racial groups might respond differently to MAID, as well as the cultural values underlying a fear of loss of autonomy (Buchbinder 2018b, Cain & McCleskey 2019).

Third, social science perspectives offer insights into processes of knowledge production that accompany legalization, enhancing understandings of MAID as a new cultural and medicolegal object. Although for some clinicians MAID may seem contiguous with other forms of end-of-life care (Koksvik et al. 2022), from a legal and regulatory perspective it is categorically distinct. Social science perspectives can illuminate the epistemological processes through which understandings of end-of-life suffering are transformed (Karsoho et al. 2016) and MAID comes to be known as a new form of death. Finally, the comparative lens of social science can help to tease out contextual perspectives on how assisted dying regimes are operationalized in different cultural, national, and sociopolitical settings, as well as historical perspectives from jurisdictions at different points in the implementation trajectory.

MAID consists of multiple practices within specific medical, legal, political, and cultural contexts. Much remains controversial, unsettled, and evolving with respect to its implementation, including its nomenclature. Here, we use MAID as an umbrella term to encompass the range of legal options that exist in these jurisdictions, including physician-administered medication (usually intravenously, also known as active voluntary euthanasia) and patient-administered medication (also known as assisted suicide) (see **Table 1**). We recognize that stakeholders in different settings use different language to refer to similar practices. In some cases, we use the specific terminology used by the authors whose research we discuss. In general, however, we prefer to speak of MAID because advocates of the practice find the language of suicide offensive when someone very much wants to live yet is faced with a terminal diagnosis. For this reason, the American Association of Suicidology has issued a clear statement that suicide is distinct from medical assistance in dying (Am. Assoc. Suicidol. 2017). Similarly, we avoid the term euthanasia because of its negative associations with Nazi Germany (Kragh 2019).

This article is divided into four major sections. First, we review attitudes toward MAID among the general public and medical professionals. We then describe research on social movements in favor of, and in opposition to, MAID, highlighting discursive strategies for mobilizing public support on both sides. Next, we review the research on legalization approaches. Finally, we described lived experiences of MAID in permissive jurisdictions. We conclude by reflecting on how MAID scholarship can inform social inquiry into other areas in which law and medicine converge.

ATTITUDES ABOUT MAID

One of the most studied aspects of MAID is the attitudes of the general public. Studies in the United States generally find support for the practice, and that support has grown over time. The US Gallup poll currently includes two questions to assess attitudes about assisted dying. The first, which has been used since 1947, asks, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?" This is generally regarded as a question about physician-administered MAID, which is not currently legal in any US jurisdiction. Support for this form of assisted dying has gone up from 37% in 1947 to 72% in 2018 (Brenan 2018).

The second question measures attitudes about practices that more closely align with US laws: "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?" This question was added in the 1990s (corresponding with the passage of Oregon's Death with Dignity law) and has had support from the majority of Americans since then (52–61%). What distinguishes these questions is who is responsible for administering the life-ending medications: the doctor in the first case, or the patient in the second. Although this distinction is important, the lay public may not understand the difference or draw the lines about acceptability and unacceptability the same way (Hendry et al. 2013).

Researchers have examined whether attitudes vary by social group or social status. The primary demographic factor that seems to drive attitudes about MAID is religiosity. Church attendance of any kind is associated with lower levels of support for MAID (Brenan 2018). Regardless of religion, belief that a higher power should determine the timing of death is also associated with more negative views of MAID (Baeke et al. 2011). A nationally representative survey of Americans found that those who imagine a higher power as a "father, a master, and a king" have the most negative views of hastening death (Sharp 2017, p. 529). Additionally, experiences that are interpreted as miracles or miraculous healing are associated with negative attitudes toward MAID (Sharp 2019). As Western societies have increasingly secularized, support for MAID also seems to be growing, especially among those identifying as least religious (Danyliv & O'Neill 2015). As with other morally contested medical practices, some religious groups may engage in a form of "bricolage" to construct new meanings that are more accepting of MAID (Casson 2011).

Age is a weaker predictor of attitudes about MAID than religion. One might expect older adults to have considered their end-of-life wishes more seriously than younger adults and therefore to be more supportive of MAID. However, they may also feel vulnerable if they are subjected to others' judgments about the value of continuing their lives (Lamers & Williams 2016). If older adults feel like MAID is a duty as opposed to an option, they might have less positive attitudes toward it (Balch 2017). A qualitative study from the Netherlands illustrates that for some older adults, support for assisted dying was associated with loneliness, fear of not mattering, tiredness, fear of dependency, and an inability to communicate, which created a sense that life was complete and no longer worth living (van Wijngaarden et al. 2015). However, a systematic review of attitude studies conducted with older adults reported mixed findings for age; the stronger predictors for positive attitudes were higher education and income (Dransart et al. 2021).

Those facing a terminal diagnosis, regardless of age, might also have had the opportunity to seriously consider the balance between quality and quantity of life (Kaufman 2010). An interview study of people with cancer in Toronto, Canada, found that the desire to hasten death changed over the course of serious illness, with some seeing hastened death as a "hypothetical exit plan," others expressing despair through their desire to die, and some at the very end of life seeing it as "letting go" (Nissim et al. 2009, p. 168). The authors argue that this progression of attitudes partially explains why a larger number of people inquire about and request MAID than actually use it: Having an exit plan does not mean it will be followed, and the discussions may relieve fears and anxiety (Nissim et al. 2009).

Across a variety of contexts, those who desire control over the process of dying and express fear over pain, debility, indignities, and dependencies are most favorable to MAID (Chapple et al. 2006, Young et al. 2021). Although some have argued that MAID is not necessary if sufficient palliative care is available (Foley & Hendin 2002), the research evidence suggests that attitudes about MAID are not just a reflection of an unmet need for palliative support. In England, a survey of bereaved family members found that those whose loved ones had received hospice care were more likely to say that a hastened death would have been preferable (compared to those without hospice support) (Seale & Addington-Hall 1995). Furthermore, data from Oregon and Washington suggest that most people who use MAID are enrolled in hospice (Al Rabadi et al. 2019).

Gallup poll results do not show strong attitudinal differences by gender (Brenan 2018), nor have studies found support for racial or ethnic differences in attitudes about MAID (Periyakoil et al. 2016). Although MAID utilization is highest among non-Hispanic white people (Al Rabadi et al. 2019), it is not clear that such differences are driven by attitudes. Attitudes may represent only a surface-level reaction to MAID. A deeper analysis of how people construct meaning about death and dying shows that people from different racial and ethnic groups may have different ways of thinking about what constitutes a "good death" and whether MAID fits into that definition (Cain & McCleskey 2019). Historically racialized groups may also encounter barriers to accessing MAID (Buchbinder 2018a). Few surveys of attitudes have fine-grained data on respondents' incomes or social class standing, but qualitative studies show that people who join advocacy groups supporting the right to die are primarily affluent and white (Judd & Seale 2011). Data from Oregon also indicate that the vast majority of those who use MAID are white and highly educated and have health insurance (Public Health Div. Cent. Stat. 2021).

Physicians' attitudes toward MAID have been studied separately from those of the lay public. Professional objections to MAID include that the practice violates the professional obligation to "do no harm" and that MAID is not aligned with the physician's role as healer. Physicians have also expressed concerns about stigma, career obstacles, or threats to their safety as a result of participating (Cain 2016). Although the American Medical Association has historically opposed MAID, it shifted its position to one of neutrality in 2019, after extensive study and debate. The American Medical Association stopped short of offering support for MAID but indicated that MAID is not necessarily incompatible with high-quality end-of-life care (Am. Med. Assoc. 2019). Attitudes of individual physicians have followed a similar evolution. Early surveys of physicians showed that many were opposed to MAID, but physicians today are more neutral or even positive (Emanuel et al. 2016). However, attitudes may not map cleanly onto actual decisions physicians make in their encounters with patients. Even when physicians have favorable attitudes, ethical, legal, and practice questions and concerns may preclude them from participating in MAID (Sellars et al. 2022).

Overall, attitudes about MAID show social patterning, especially in terms of religion and familiarity with death and dying. One limitation of the literature is that it focuses primarily on the United States. Although MAID is spreading throughout the world, very little of the attitudinal research allows for comparison across societies. The legal availability of MAID and accompanying cultural meanings intersect with social statuses and religion in important ways. Additionally, attitudes are important but not necessarily predictive of behaviors (Lee 2010). Although most Americans support MAID, utilization is quite low (Brenan 2018) and is shaped by a range of situational factors, including diagnosis and disease trajectory, access to healthcare, and social support. Consequently, attitudinal research on MAID, although useful, may be most meaningful when complemented by other research methods—as with research on other social phenomena (Jerolmack & Khan 2014).

SOCIAL MOVEMENTS, ADVOCACY, AND SOCIOCULTURAL MEANINGS

As attitudes and legal status change, other cultural and social changes ripple out. Understandings of how to die well may shift as new options are advocated for and become available. As a case of something previously taboo undergoing a shift in public perception and a change in legal status, MAID is ripe for social scientific analysis. Studies of these processes of cultural change often focus on social movement actors, advocacy groups, and larger sociocultural meanings. Social movement actors, both in support of and in opposition to MAID, use a variety of tactics to frame the debate, push for legal and cultural changes, and shape public and policy-maker perceptions of MAID as well as other end-of-life options (Anspach 2010).

The right-to-die movement focuses on creating legal and sociocultural systems that permit self-determination in the timing and circumstances of death, reflecting a cultural emphasis in Western societies on autonomy and individuality and resisting state control (McInerney 2000). How social movement groups frame their goals in relation to broader cultural meanings is shaped by the institutions they must work within. For example, in North America, because MAID is strongly tied to institutionalized medicine (Karsoho et al. 2016), biomedical frames are emphasized, even though some activists would prefer control to move outside of medical institutions (Gandsman et al. 2016). A United Kingdom–based survey found that members of right-to-die societies were more likely to be women, be older than the general public, and have a high degree of social power and access to health care (Judd & Seale 2011). Likewise, a survey of a United States–based right-to-die organization characterized the majority of members as “elites,” with high income and education, and over 95% white (Kamahaki et al. 2001).

On the opponent side, one persistent concern is that legalizing MAID sends cultural messages that certain kinds of lives are not worth living. Disability rights advocates worry that such messages will deteriorate the quality of care and social supports for people with disabilities (Golden & Zoanni 2010, Mwaria 1996). A related concern is that groups who are already socially marginalized will be encouraged to hasten their deaths. This is framed most commonly as an issue for people with disabilities but is also a concern for older adults with or without serious health issues (Gandsman 2016). Some have extended this argument to raise the possibility that people of color or people with limited economic resources could be coerced to end their lives using MAID. There is no evidence for the idea that racial or class status makes one more vulnerable to such coercion (Battin et al. 2007). Instead, because the process of requesting and completing the legally required steps to access MAID benefits from cultural health capital (Shim 2010), the most disadvantaged groups are the least likely to get access (Buchbinder 2018a). Nevertheless, many opponents believe that it is a slippery slope from authorizing an option to creating pressure for that option to be pursued, which would further marginalize those who are already vulnerable (Balch 2017). It is noteworthy, however, that not all people who may be considered socially vulnerable agree with this opposition to MAID (see, for example, Shavelson et al. 2022).

As discussed in the previous section, religion and organized medicine are also powerful sources of opposition to MAID. The Catholic Church regularly produces statements and commentaries opposing practices that actively hasten death, claiming that the timing of death should be determined by a higher power (Hannig 2019). Similarly, medical professionals have argued against MAID, claiming that it harms the profession and patients’ trust in medicine (Sulmasy & Mueller 2017) or disregards medicine’s duty to tend to suffering (Bauchner & Fontanarosa 2016).

Beyond the question of whether MAID should be legal is a bigger debate about the medicalization of dying (Broom 2017; Karsoho et al. 2016, 2017). In most jurisdictions, MAID laws give a great deal of power and discretion to physicians and medical institutions, which further defines death as a medical problem. Insofar as the right-to-die movement reflects a crisis of faith in biomedicine as the lynchpin to end-of-life care, it exemplifies a broader trend of health social movements challenging biomedical authority (Archibald & Crabtree 2010, Banaszak-Holl et al. 2010, Brown & Zavestoski 2004). However, proponents of MAID face a central paradox: Although they reject the medicalization of death through technologies that prolong the process of dying, they nevertheless demand a medicalized form of hastened death (Richards 2015). Therefore, the MAID movement fails to fully recuperate cultural authority over death from medicine (Timmermans 2005). Questions about the changing purview of doctors are also relevant for several other health-related social issues, such as abortion (Buchbinder 2016, Krauss 2018, Mishtal 2009, Singer 2022) and gender-affirming care (shuster 2021). In each of these, doctors are in the crosshairs of larger societal debates about medicine, control, and bodily autonomy.

Media analyses have also been common in studies of MAID. Debates about control over the dying process cross different social boundaries and bring people into ethical and values-based discussions, generating a great deal of public and media interest (Lalancette et al. 2020). Additionally, reactions to MAID and other end-of-life issues are sensitive to framing effects (Rambotti 2017), and how death-related data are explained affects how people see hastened death (Seale 2010). Finally, studies of media and cultural products are more feasible than studies of direct experiences with MAID. Because it is a rarely used option, and the people who make this choice are very ill, gathering other types of data can be challenging—although not impossible, as we discuss further below.

Media studies on MAID tend to explore how different interest groups mobilize support for or opposition to MAID. High-profile media coverage can generate a great deal of public discussion and even change to laws and policy (Akabayashi 2002, Lauffer & Baker 2020, Leppert 2016). Media analyses seek to identify common cultural sentiments, even across different interest groups. For example, Behuniak (2011) analyzed materials from groups in favor of and opposed to MAID and found that both groups emphasized the concept of "dignity," even though they defined it differently. These points of cultural convergence may offer an opportunity to bridge divides. Another cross-cutting cultural meaning represented by both advocates and opponents is the importance of personal stories of suffering. Stories of suffering and failures of the current medical system have been used to mobilize support for MAID (Duckett 2020, Karsoho et al. 2016), although opponents have used similar stories of suffering and medical failure to warn of potential problems with MAID (Cain 2020). Across varying positions, media debates often focus on individualism, individuals' rights over their bodies, and potential harms to society (Booth & Blake 2022). This individualistic framing is consistent with a more general trend toward neoliberal concepts of autonomy and resistance to state control (Birenbaum-Carmeli et al. 2006).

Another source of cultural meanings about MAID comes from official documents produced by professional, advocacy, or other groups. A study of more than 100 declarations from advocacy organizations found that they established a range of goals, from defining quality end-of-life care, to describing experiences of dying, to sometimes demanding changes to laws or policies (Hamilton et al. 2020). Studies of the implementation of laws also sometimes use official documents or policies (Cain et al. 2020a,b; Campbell & Cox 2012), finding variation in how health care entities operationalize MAID policies. As official documents, these forms of data reveal how cultural meanings are transformed into guides for action. They also highlight how MAID bureaucratizes death, inviting new forms of bureaucratic management through documents that both reflect and construct ideologies, knowledge, and practices concerning this new medicolegal object.

LEGALIZING MAID

The legalization of MAID has proceeded along four distinct pathways in different jurisdictions: legislative, judicial, voter referendum, and penal code. Several jurisdictions have followed a hybrid approach, with different forms of legalization occurring over time (see **Table 1**). Since 1937, the Swiss penal code has considered assisted suicide a crime only if the person assisting has selfish motives, rendering assisted death without selfish motives legal by omission. In the last 10 years, some cantons have instituted laws to regulate the practice, including Vaud (in 2013), Neuchâtel (in 2014), and Geneva (in 2018) (Stavrianakis 2020). Similarly, in 2001, the Dutch Parliament legislatively authorized the practice of euthanasia, which had been legal since 1984 (Norwood 2009, Weyers 2006). In Oregon, a 1994 voter referendum was followed by an unsuccessful attempt to overturn the law via the judicial pathway, which was then followed by a second voter referendum process in 1997 (Ball 2012). These patterns highlight how legalization is not necessarily something that happens all at once. Instead, it may be a stepwise process, with increasing layers of regulation over time.

A distinguishing feature of social scientific work on the legalization of MAID is its descriptive orientation. Whereas the bioethics, medical, and legal literatures on MAID are often prescriptive, the primary purpose of the social science literature is to explain or understand the social, cultural, historical, and political factors that have fostered legalization in different settings. To do so, social scientists have employed a range of methods, including discourse analysis of expert testimony and judicial proceedings, media analysis, and analysis of policy frames.

Within this body of work, the discursive approach acknowledges that language not only reflects social reality but also helps to construct that reality (Duranti 1997, Potter 1996). This approach also recognizes that language matters immensely in debates about assisted death. Successful legalization strategies in the United States and Canada have explicitly rejected the language of suicide (Ball 2012, Hannig 2019, Karsoho et al. 2017) to underscore that the two types of death are distinct phenomena associated with different ethical registers and professional obligations for healthcare providers (Am. Assoc. Suicidol. 2017). Proponents emphasize that people pursuing medical assistance in dying do not want to die, yet death is inevitable due to terminal illness. Rhetorically differentiating MAID from ordinary suicide can be understood as a discursive strategy that serves to create a new object: a medically authorized form of hastened death.

In a series of publications, Karsoho and colleagues explore what they call "the 'constitutive' effects of a legal action" (Karsoho et al. 2017, p. 47; see also Greenhouse 2006, Mather 1998, Sharma 2013). This work illustrates how the legalization process creates new truths and cultural meanings, demonstrating the coproduction of law and society (Jasanoff 2006). Drawing on expert witness testimony from *Carter v. Canada* (2015), the Supreme Court case that decriminalized MAID in Canada in 2015, Karsoho et al. (2016) show how MAID proponents created conceptual linkages between suffering and medical intervention at the end of life. In doing so, they asserted that medicine had been inadequate to address suffering and that assisted death was the logical solution.

Further elaborating on this approach, Karsoho et al. (2017) examine how stakeholders on both sides of the debate marshaled evidence to create competing visions of the kind of person who might seek medical assistance in dying. The defense portrayed such people as irrationally motivated by depression or psychiatric conditions, whereas the plaintiffs portrayed them as thoughtful individuals making a deliberate choice to uphold lifelong values. By persuading the court to see assisted death in a new way, the plaintiffs produced new cultural scripts about death and dying. These cultural scripts are then redeployed by advocacy groups, lobbyists, and legislators, who use them as starting assumptions in drafting and revising laws.

A second dominant strand of social scientific work on the legalization of medically assisted death focuses on what legalization campaigns reveal about underlying cultural values. Whereas the discursive approach explores how legalization processes produce new cultural truths, the cultural approach sees such truths as a priori realities, to be exposed by mining legalization processes for cultural meanings. Richards (2015) analyzes the case of Debbie Purdy, a British woman with progressive multiple sclerosis who in 2008 mounted a high-profile legal challenge against Britain's prohibition on assisted suicide. The lawsuit specifically concerned the possibility that criminal law might be applied in cases where an individual asks for assistance from relatives in traveling abroad (i.e., to Switzerland) to die. The UK Suicide Act of 1961 prohibits assisting a suicide and subjects those who do so to up to 14 years in prison. Ms. Purdy requested clarification about the likelihood of her husband being prosecuted should he accompany her to Switzerland in the future—namely, what counts as "assistance"? And what factors might be considered in weighing whether to prosecute? Although the suit did not change the law, it did result in a 2010 policy statement clarifying the conditions under which the state might not prosecute someone under such circumstances.

For Richards (2015), the Purdy case reveals the intersubjective nature of MAID. Although the right-to-die movement casts assisted death as "purely a matter of individual choice and a desire for individual control" (p. 221), Ms. Purdy's autonomy was clearly limited by her refusal to criminally implicate her husband. In analyzing the case, Richards highlights the relational dimensions of assisted death that are so often obscured in advocacy rhetorics and media accounts, which emphasize individual autonomy. Richards's insightful analysis highlights how social scientific research on MAID can bring new perspectives to public narratives by showcasing previously hidden cultural meanings.

Finally, the third dominant approach to studying legalization uses policy analysis to explain the success or failure of legalization efforts. Ball (2012) analyzes the powerful forces shaping failed legalization attempts in multiple US states prior to their eventual successes. He shows how the Catholic Church formed a formidable opposition to MAID advocacy movements due to its financial strength. For example, in Washington State in 1990, the Catholic Church organized voter registration drives before the general election to increase votes against a ballot initiative (Hillyard & Dombrink 2001). Ball (2012) further shows how the legalization of MAID in the United States resulted from an interplay of local and national forces. Whereas battles have been fought on local state grounds, national organizations such as Compassion & Choices and Death with Dignity have helicoptered in to try to influence the political strategy. Ball attributes Oregon's success in being the first US state to legalize to its progressive political culture and secular population.

Duckett (2019) uses Kingdon's (1984) three streams of policy formulation framework to examine the legalization of medically assisted death in Australia, focusing on understanding why Victoria was successful and a similar effort in New South Wales was not. With respect to the first stream, the problem stream, Duckett suggests that proponents were successful in commanding public attention because they asked Legislative Council to consider the issue through a formal inquiry process that included solicitation of public feedback. Public submissions were persuasive in establishing the need for assisted dying as an end-of-life option. The policy stream refers to the soundness of the policy ideas. In Victoria, specialized committees developed highly technical protocols that had buy-in from organized medicine. Finally, political leaders played a strong role in scaffolding the federal government's positive response (the politics stream).

Weyers (2006) suggests that social control is an overlooked motivation for legalization and draws on the work of Selznick (1968) to argue that societies with strong social norms create pressure for laws that codify norms to protect vulnerable groups. In the Dutch case, values and norms favoring individualization and self-determination, trust, and the early erosion of societal death taboos alongside a well-developed welfare state paved the way for legalizing euthanasia.

Taken together, this body of research shows that the legalization of MAID reflects changing sociopolitical conditions and cultural norms. Yet law is not only a product of such social, cultural, and political shifts; it also helps to construct social life by establishing new meanings, discourses, and categories. Although this insight is not novel in sociolegal studies, its application to the study of macrolevel policy change has been relatively less explored (Levitsky 2013).

LIVING WITH MAID

Implementation and Regulation as Bureaucratic Practices

Once MAID is legalized, and ideally even before, society must contend with how to implement and regulate the emergent medicolegal practice. Social scientific scholarship on assisted death reveals the critical gaps between laws as text and laws as practiced (Greenhouse 2006). In the United States and Canada, judicial decisions and written statutes have offered limited guidance on the implementation and regulation of MAID, leaving many unanswered questions about how it would be socially organized and bureaucratically managed at the state and local levels. Laws have been silent on many aspects of prescribing, documentation, data and safety monitoring, pharmacy involvement, and institutional obligations. Consequently, it has been up to stakeholders on the ground to determine how to proceed, similarly to the implementation of new abortion laws (Buchbinder 2016).

Permissive jurisdictions have varied widely in the extent to which they have adopted formal implementation frameworks. In the United States alone, there is a broad spectrum of policy responses. At one pole is California, where stakeholders organized a conference two months after the End of Life Option Act passed in 2015 to help providers and health care facilities plan for implementation (Petrillo et al. 2017). At the other pole is Montana, which lacks a regulatory statute and any formal implementation processes (Neumann 2006). In Vermont, the Patient Choice and Control at End of Life Act was effective immediately upon being signed into law in 2013, and implementation initially occurred with minimal attention to regulatory policy (Buchbinder 2021). In Canada, the rollout was similarly decentralized despite a uniform federal legalization process, with provinces determining policies and procedures at the local level. Some jurisdictions, such as Alberta, have engaged stakeholders in formal implementation planning through deliberative democracy procedures (Silvius et al. 2019).

At the institutional level, hospitals and hospices have had to determine whether and how to participate in MAID. In Switzerland, where assisted dying has occurred only in right-to-die organizations until very recently (Bloom 2022, Gandsman 2018, Richards 2016), the role of organized medicine has shifted over time in an incremental move toward incorporating assisted death into medical institutions (Stavrianakis 2020). In a survey of 270 California hospitals conducted between September 2017 and May 2018 regarding their policies on the End of Life Option Act, Cain et al. (2020a) found that most (87%) had adopted formal policies on physicians' participation, whether or not they permitted it. Of these, 39% permitted staff physicians to write prescriptions, and 61% prohibited physicians from writing prescriptions. Consequently, access to MAID for California residents may depend on where one receives medical care. Hospitals permitting MAID were less likely to be religiously affiliated, more likely to be nonprofit, and more likely to offer palliative care. Among those hospitals that permitted MAID, almost half added supererogatory requirements onto the law's stipulations, which may lead to additional access barriers.

Hospices have faced similar questions regarding whether and how to engage with MAID. Campbell & Cox (2012) analyzed policy documents from 56 Oregon hospice organizations to understand the nature of their participation in the state's Death with Dignity law. Although nearly every document explicitly stated that the hospice would not provide, deliver, administer, or otherwise assist with medications, they contained a range of stances on sharing information with patients and permitting staff to be present at the time of ingestion. The authors' findings highlight numerous ethical tensions: between organizational commitments to patient choice and to not hasten death and between patient nonabandonment and hospice noninvolvement.

In a related study focused on Washington State hospices, Campbell & Black (2014) identified five types of hospice participation, including opposition (i.e., explicitly prohibiting participation or involvement), procedural nonparticipation (i.e., prohibiting involvement in the medicolegal process of receiving medication), nonparticipation in the act of ingestion, noninterference in the patient's choice for an assisted death (while not facilitating this choice in any way), and respect for patient choice (i.e., assuming responsibility for sharing information about MAID with patients). The authors suggest that these subtle distinctions reveal different ways of reconciling fundamental ethical tensions in organizational values and hospice philosophy more broadly. Campbell's studies suggest that the majority of medically assisted deaths in Oregon and Washington may occur without the presence of a hospice staff member, which may raise challenges should complications arise (Campbell & Cox 2010). Medicine may thus resist expansion of its professional jurisdiction (Cain 2020).

At the provider level, there is a massive learning curve to understanding the statutory provisions and restrictions once new laws are in place. Physicians play an important gatekeeping role, declining to participate if they do not think the patient meets the eligibility criteria (Buchbinder 2022, de Andrade Neves 2020, Pool 1995). Although stringent regulations reassure physicians that they are acting lawfully (Sellars et al. 2022), physicians must adjudicate eligibility with few formal training opportunities, and with many ambiguities in the legal protocol (Buchbinder et al. 2019, Byrnes et al. 2022, Cain et al. 2020a, Sellars et al. 2022, Winters et al. 2022). A study of psychiatrists in the Netherlands found that differentiating between suicidality and "rational death wishes" required a great deal of skill and that Dutch laws do not fully appreciate the nuances between different forms of suffering (Pronk et al. 2021). Participating in MAID also entails an emotional burden for physicians, with many expressing a desire for social and emotional support in addition to training in practical skills (Sellars et al. 2022, Winters et al. 2022). Studies of nurses, clergy, and social workers have been rare but generally find that those who assist in MAID report ambiguity surrounding their role in providing high-quality palliative care and assisting with the dying process (Brooks 2019, Fujioka et al. 2018, Wright et al. 2021).

A dearth of physicians willing to participate in MAID has created challenges for implementation (Buchbinder 2018a). Some hospitals have tried to create lists of willing prescribers, but not all physicians wanted to be named (Cain et al. 2020b). Moral ambivalence and religious opposition have complicated the implementation of MAID, with physicians and pharmacists often feeling as if they are participating in something illicit (Hannig 2022). Difficulty obtaining the required medication is a related challenge (Bryant 2016, Buchbinder 2018a, Cain et al. 2020a). Such access barriers thwart the search for control over dying, highlighting that MAID always depends on assistance from others (Buchbinder 2021).

Overall, social scientific research has demonstrated that the legalization of MAID does not guarantee access, and policies designed to protect vulnerable groups may exacerbate or reinforce existing healthcare inequalities (Buchbinder 2018a). Policies adopted by healthcare institutions such as hospitals, hospice agencies, and pharmacies (Chiarello 2013) can limit patients' access to medical services to which they may be legally entitled. Social scientists have been instrumental in illustrating how patients' hard-won legal rights may bump up against the rights of organizations and institutions, as well as those of individual healthcare providers. Such findings highlight the limits of legal rights for determining access to care, despite their rhetorical efficacy (Merry 2003).

MAID as Discourse

Once it enters the clinic, MAID first takes shape as a form of talk. A key finding from Norwood's (2009) pathbreaking ethnography of euthanasia in the Netherlands is that requests for euthanasia only rarely culminate in euthanasia death. The process is lengthy, requiring an initial request, consultation with family members, a written declaration by the person seeking euthanasia, a second opinion, and only then scheduling euthanasia. In practice, doctors may stretch out these steps to avoid reaching the end. The result, Norwood suggests, is that euthanasia is very unlikely to occur unless a patient is persistent and culturally savvy. Similarly, Stavrianakis (2020) characterizes narrative as an important component of access to assisted death in Switzerland: One must be able to tell one's story in a particular way to show that one is deserving of this type of death. Bloom (2022) echoes this point in her moving memoir of accompanying her husband to Switzerland to die following his dementia diagnosis.

Norwood (2009) argues that euthanasia is a social discourse grounded in cultural and historical norms as much as it is a social act. This discourse plays a significant palliative role in alleviating end-of-life worries and concerns, even if euthanasia never occurs. Research conducted in the United States has found that inquiries about medical assistance in dying are occasions to explore and address patients' fears, improve symptom control, and reassure patients that they would not be abandoned—whether or not MAID is ultimately pursued (Back et al. 2004). Such conversations are frequently tense and emotionally charged, reflecting both the sensitive nature of talk about dying and the fact that MAID remains controversial and stigmatized.

Most bioethics scholarship has assumed that conversations about MAID should always begin with a patient's inquiry. In Victoria, Australia, such views are codified into the state's assisted dying legislation, which explicitly prohibits physicians from initiating a discussion of MAID (Duckett 2019, Wilmott et al. 2020). These proscriptions are motivated primarily by the view that initiating such discussions could damage the patient–provider relationship by signaling a loss of hope or offend patients whose values do not support assisted death (Buchbinder 2017). On the other hand, waiting for patients to initiate such discussions may inadvertently privilege those with higher socioeconomic status, who are more likely to know enough about MAID to ask (Buchbinder 2018a). In general, physicians have noted that patients typically introduce the discussion of MAID, yet some physicians in Oregon, Vermont, and the Netherlands report initiating such conversations proactively so that patients are aware of all options.

Buchbinder (2019) argues that how we understand the moral stakes of physicians informing patients about MAID depends on local theories of linguistic performativity—what language can do in the social arena (Austin 1962). This understanding of language as social action may not be addressed by bioethical frames for informed consent and disclosure, which view the function of talk as primarily denotative—that is, to relay information. From this perspective, talk about MAID not only reflects the role of assisted death in the social arena but also helps to constitute social relations de novo.

The Experience of Assisted Death

Social scientific accounts of the experience of assisted death showcase stories and perspectives that have been largely left out of public and media accounts. Whereas much of the media discourse in the United States characterizes MAID as a matter of individual autonomy, anthropological perspectives highlight its relational dimensions. Norwood (2009) illustrates how the decision for euthanasia in the Netherlands is approached as a collaborative decision that hinges on buy-in from family, reflecting Dutch values of order and social harmony. When family members do not participate in the decision or when individuals are isolated from family, physicians are more reluctant to participate. In the context of hastened death, family members take on new caregiving roles, including (sometimes) struggling with health care providers and "midwifing" the death (Starks et al. 2007). Thus, although the law treats MAID as an individual decision to be made absent pressures from family members or friends, the experience of MAID is relational (Wright 2017). Physicians must likewise negotiate new social roles and identities in accommodating this new medical practice (Buchbinder 2021, Sellars et al. 2022, Wright et al. 2021).

Several social scientific studies have explored the temporality of MAID to show how planning the time of death alters the cultural landscape of dying (Richards & Krawczyk 2021). Although all patients who seek MAID have determined that they are ready to end their suffering, they exhibit different thresholds for suffering and determining when the burdens of illness outweigh the benefits of living (Starks et al. 2005). Stavrianakis (2020) considers how a person determines that they have had enough and that it is time to die. For some, the boundary between "too soon" and "too late" may be extraordinarily thin (Buchbinder 2021). Time may also be a barrier for people who die before the bureaucratic protocol can be completed (Byrnes et al. 2022).

The opportunity to schedule death affords new opportunities for planning. Buchbinder (2021) describes MAID as an active and dynamic process of "making death" as opposed to letting it happen. Derianna, an assisted dying volunteer at the center of Hannig's (2022) ethnography, is clear that she is "doing a death" rather than attending one. This active orientation to "choreographing" death is a distinguishing feature of MAID (Buchbinder 2018b). While some family members may find this strange, it also confers the advantage of being able to say goodbye to one's loved ones (Holmes et al. 2018) and ensure that one's death reflects one's values (Buchbinder 2021, Hannig 2022). Cross-cultural research suggests that such planning may not be so unusual even in the absence of MAID (Allison 2017, Sadruddin 2022).

The performance of MAID varies considerably, whether it includes ordering Chinese food, hosting a party, or standing vigil or ingesting the medication lying in a body bag to ease things for the funeral company (Hannig 2022). Certain ritual elements, such as composing one's final words (Engelhart 2021) or making a final toast (Buchbinder 2021), are common. Moreover, things sometimes go awry. The temporality of assisted deaths is often uncertain, and it may take individuals far longer to die than expected, which can be grueling for families (Buchbinder 2021). Hannig (2022) describes the harrowing case of a man who did not die and actually woke up. Although such outcomes are relatively uncommon (Hedberg & New 2017), they underscore that there are important limits on the human desire to control death technologically through MAID.

Another dimension of assisted deaths addressed in the social science literature entails the ethnographer as witness. Both Hannig (2022) and Engelhart (2021) discuss their attempts to slink against the wall and remain unobtrusive while observing an assisted death, whereas Stavrianakis (2020) describes how the Swiss organization Exit refused to let him accompany one death—in his view, so that they could retain control over the public narrative about their practice. He reflects, "My sense was that an anthropological narrative, even a very minimal beginning of the sketch of some elements for such a narrative, as outlined above, would ruffle and disrupt an easily consumable story about individual choice" (Stavrianakis 2020, p. 93). These comments reveal how social scientific research is poised to bring to light previously hidden narratives regarding assisted death—and highlight the political stakes of doing so.

CONCLUSION

Law and medicine are two of the most important institutions organizing our contemporary society, structuring how we imagine solutions to vexing social problems. Death, for its part, is one of the most universal social phenomena in which they unite (cf. Livne 2014, Timmermans

2006). Yet law and medicine are jointly implicated in a host of other novel medicolegal practices, including issues like transgender health care (van Eijk 2017) and insurance reform (Levitsky 2013), which not only manifest shifting social norms and practices but also demonstrate how law and medicine jointly construct social reality.

Much of end-of-life care is still relegated to the shadows of everyday life; death and dying are rarely discussed in academia or in the public sphere. MAID has been foisted into the spotlight due to highly publicized debates, making it a productive target for social scientific inquiry over the past two decades. Insofar as MAID crystallizes and reflects personal and cultural understandings of key social concepts such as individualism, dependency, dignity, and care, it is a rich site for social scientific theorizing. MAID is a useful case study for capturing social change in action as attitudes, legal standards, and end-of-life practices continue to evolve. It is also sociologically important as a site in which the normative and descriptive converge.

Although considerable social scientific research on MAID has focused on the social movements motivating legalization campaigns, legalization—whether it occurs through the judiciary, legislature, voter referendum, or penal code—is only the starting point for the social construction of law. Law operates alongside other social institutions (such as, in the case of MAID, hospitals and pharmacies) that may limit its potential effects. Law is thus continually made and remade through ongoing social and bureaucratic processes, including the development of policies and protocols, the implementation of new practices, and the negotiation of meanings at every step. These findings may have implications for understanding other legalization movements, including those focused on marijuana (Mosher & Akins 2019) and sex work (Weitzer 2009).

As an exemplar case of a novel medicolegal practice, MAID also highlights how medical professionals are increasingly subjected to a variety of regulatory frames and bureaucratic practices. Such trends are also evident in pain medicine (Knight et al. 2017) and many facets of reproductive healthcare (Morgan & Roberts 2012). The overwhelming evidence on MAID suggests that physicians and other medical professionals work within the boundaries established by law. This may contrast with other contested medical practices, such as abortion, in which physicians may be more willing to work around legislative constraints due to their political commitments to activist goals (Buchbinder 2022).

Social scientific work on MAID also surfaces a more complex portrait than media accounts and advocacy narratives, in which stories are carefully selected to uphold certain rhetorical effects (Buchbinder & Timmermans 2013). In doing so, it reveals narratives that are not often seen or easily translated into political campaigns. Insofar as MAID constitutes a new medicolegal object, social relations and subjectivities may also be transformed in response (Hacking 2006).

While MAID continues to expand rapidly, however, social scientific research on MAID is still in its infancy. There are many unanswered questions regarding how attitudes correlate with actual practice, how utilization patterns shift and change over time, how permissive jurisdictions compare, experiences with MAID among historically marginalized groups, and the extent to which access barriers limit opportunities for MAID. Among the next frontiers for further social scientific analysis are investigations concerning the availability of MAID to people with dementia, psychiatric conditions, or those who are just tired of living (Bolt et al. 2015, Bravo et al. 2022, Dekker 2021). Researchers considering venturing into this space should be forewarned of the high political and ethical stakes of working in this area. In particular, they may wish to consider how they will incorporate and account for their own stances on MAID in the research process, whether and how they will collaborate with activist projects and other forms of political engagement, and whether and how they will translate findings for policy impact. There are abundant opportunities to develop knowledge about MAID, as well as about the larger social processes at play in other new frontiers in medicine, law, and culture. We encourage our social scientist colleagues to consider these productive possibilities.

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