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Fifty years of empirical research on medical assistance in dying: A mapping review

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ABSTRACT

Background: Medical assistance in dying (MAiD) is authorized in an expanding number of jurisdictions, yet as it becomes embedded in routine care, the evidence base remains fragmented and poorly characterized. Across jurisdictions, fundamental questions remain about whether access is equitable, whether safeguards function as intended, and whether the evidence base can support policy evaluation.
Objective: To characterize the empirical MAiD evidence base by describing its scope and examining how study designs, populations, and research questions intersect.
Methods: We conducted a mapping review, searching five databases for empirical studies of MAiD published between 1975 and 2025.
Results: Of 1471 included studies spanning 65 countries, research output accelerated after 2018 but remained geographically and methodologically concentrated. Although quantitative designs dominated the first four decades, qualitative approaches are now modal (39% of recent studies). Study designs did not shift: observational (98.5%) and cross-sectional (78.5%) approaches predominated; longitudinal (1.8%), experimental (1.0%), and quasi-experimental designs (0.5%) were rare. Healthcare professionals constituted 62.1% of study populations while only 8.7% examined patients requesting or receiving MAiD. People denied MAiD, families and caregivers, and structurally marginalized groups were largely unstudied. Studies focused on stakeholder attitudes (46.4%) and public opinion (16.1%) with less attention to access, complex cases, and economic considerations.
Conclusions: The field's research questions have diversified, but its methods and study populations have not. The resulting evidence base is poorly suited to assess patient access, safeguard performance, or cross-jurisdictional comparability, as these priority areas require standardized outcome reporting and linkage to administrative health system data.

1. Background

Medical assistance in dying (MAiD), an umbrella term for the practice of clinician-administered euthanasia or clinician-prescribed self-administration at a patient's voluntary request, is now authorized in an expanding number of jurisdictions. Each of these jurisdictions implements a distinct regulatory framework that shapes who is eligible, how requests are evaluated, and how MAiD intersects with existing health and social care systems [1] As a regulated health system service, MAiD requires ongoing population-level monitoring of access, safeguard performance, and outcomes. Yet as MAiD becomes a more prevalent option within end-of-life care, the evidence base has not kept pace [2] It remains unclear whether access is equitable across populations, whether eligibility criteria and safeguards protect vulnerable groups in practice,

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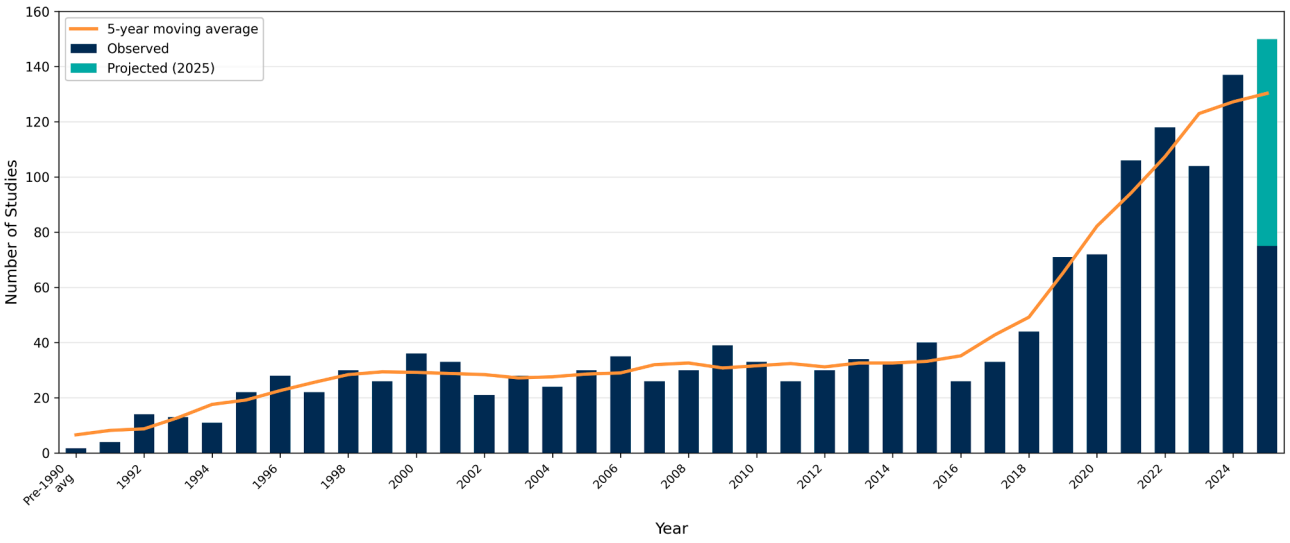

Fig. 1. Frequency of Empirical MAiD Research Publications by Year.

or whether policies produce unintended consequences at the system level [3] Answering these questions requires empirical evidence examining population-level patterns, temporal trends, and policy effects. Whether such evidence is available, however, depends on the institutional conditions under which MAiD research is organized, including oversight mandates, data infrastructure, and funding priorities.

Despite substantial growth in MAiD research over the past two decades, the structure of the empirical evidence base has not been systematically characterized. Prior reviews have synthesized findings on specific topics, including stakeholder attitudes and opinions[4–6], clinical practice and policy implementation[7–9], and bibliometric trends [10] However, these reviews do not assess how research questions, study designs, data sources, and participant populations intersect across the full empirical corpus. Moreover, heterogeneity in terminological and outcome reporting compounds this fragmentation and limits comparability across studies as variation in how MAiD is defined, classified, and reported obscures broader systematic patterns [1,11] Without comprehensive mapping of evidence structure, it remains unclear what types of inferences the literature can support.

This gap has direct consequences for policy evaluation. First, the structure of the evidence shapes what can be learned from it. The ability of researchers to assess causal effects, examine equity across populations, track change over time, or compare policy performance across jurisdictions depends on how studies are designed, who is included, and what data sources are used [2,12,13] Second, characterizing the evidence structure is a prerequisite both for evaluating which population-level questions can currently be answered and for directing future research priorities [3] Mapping the evidence structure thus reveals how institutional arrangements, including governance design, data infrastructure, and research funding, constrain what the existing literature can support regarding population safety, equity, and policy performance. Accordingly, the structure of the evidence directly shapes both the governance capacity surrounding MAiD and the extent to which MAiD can be designed and monitored as a health system service at the population level.

This mapping review systematically characterizes the landscape of empirical MAiD research to assess what the existing evidence base can support and to examine how the field has developed as a domain of empirical inquiry over five decades of legalization, implementation, and policy diffusion. We pursue three objectives: (1) to describe the scope and distribution of MAiD research across geography, publication trends, study designs, data collection methods, and participant populations; (2) to identify where empirical attention has concentrated and where research gaps remain; and (3) to examine how methods, populations, and research questions intersect to reveal which methodological strategies are employed across different research domains.

2. Methods

This mapping review followed the Arksey and O'Malley methodological framework for scoping reviews [14], with mapping review conceptualization per Campbell et al. [15] Unlike standard scoping reviews, which emphasize narrative synthesis of findings, mapping reviews prioritize the visual display of evidence distributions and systematic identification of research gaps across multiple intersecting dimensions [16] The review adhered to PRISMA-ScR guidelines (checklist in appendix), [17] and the protocol was registered with the Open Science Framework (registration DOI: 10.17,605/OSF.IO/KYT6N) [18]

2.1. Search strategy and selection criteria

We searched PubMed, Scopus, PsycINFO, CINAHL, and Web of Science from database inception to 9 May 2024, with an updated search conducted on 15 July 2025. The search strategy is available in the supplementary materials. No publication year or geographic restrictions were applied. The complete search strategy is provided in the appendix.

Studies were eligible if they met all of the following: (1) reported original empirical research (quantitative, qualitative, mixed-methods, or systematic/scoping reviews); (2) addressed MAiD as a primary focus or a substantial secondary analysis; and (3) were published in peer-reviewed academic journals. We excluded non-empirical publications (editorials, commentaries, discussion papers, legal briefs), theses and dissertations, conference abstracts, and grey literature.

Two reviewers independently screened titles and abstracts, then full texts, with disagreements resolved by consensus discussion or third-reviewer adjudication. At the title/abstract stage, no studies were excluded based on language. At full-text review, only articles published in English, French, Dutch, Spanish, Italian, or Portuguese were included to ensure reviewer fluency.

2.2. Data analysis

Data were charted using a standardized form developed through pilot testing and refined iteratively. For each included study, all relevant data was extracted by one reviewer and quality checked for completeness and accuracy by a second reviewer. Research questions, study populations, and methodological characteristics were classified using

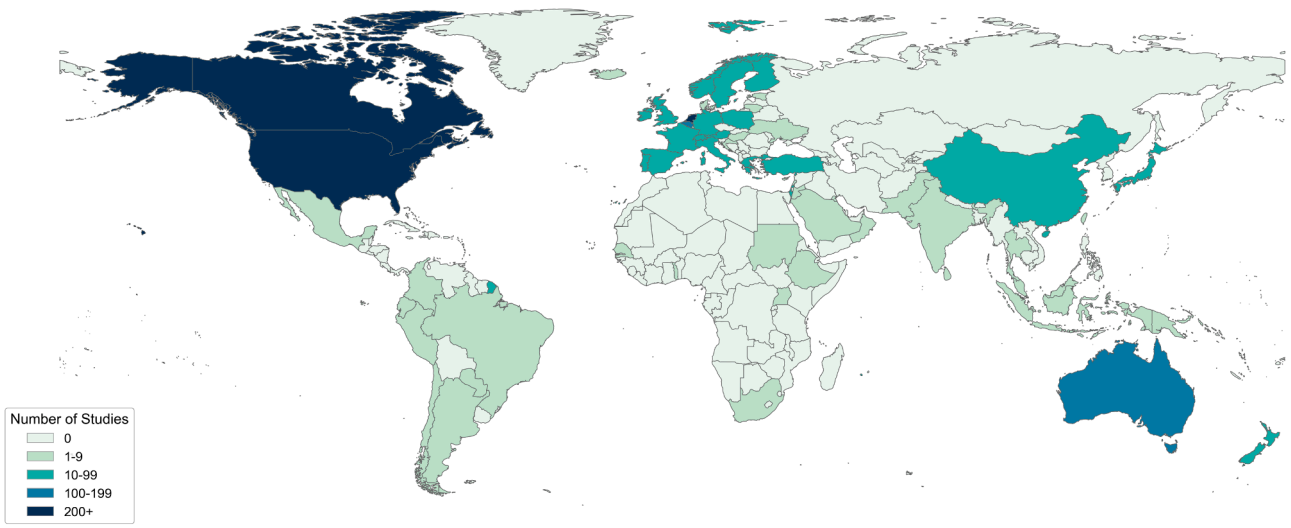

Fig. 2. Geographic Representation of Included Studies
Sixty studies investigated more than one country, therefore counts are non-cumulative and exceed 100%.

inductively developed typologies refined through team consensus. Studies addressing multiple study designs, populations, or research questions were counted in each applicable category and additionally flagged as multi-category studies; category totals therefore exceed the number of included studies. Research questions were recorded verbatim and categorized via conventional content analysis [19] Definitions of analytic categories and research question groupings are provided in the appendix. Consistent with the objectives of a mapping review, we did not conduct a formal critical appraisal of individual studies [15] We summarized study characteristics using descriptive statistics and visualized distributions across time, geography, methods, populations, and research questions using heatmaps.

3. Results

A total of 11,436 records were identified across five databases, with 4559 duplicates removed prior to screening (supplementary figure 1). Of the remaining 6877 records, 3038 reports were assessed for full-text eligibility. In total, 1567 reports were excluded and 1471 studies included in the review. A table showing studies excluded by language is available in the supplementary materials.

3.1. Study characteristics

Annual publication output averaged 8.6 studies from the 1970s through the 2000s before increasing in the mid-2010s, rising from 38 studies published in 2014 to 138 studies in 2024 (Fig. 1). Mean annual output increased from 42.8 studies in 2015–2019 to 107.4 in 2020–2024, a 151% increase. A majority of included studies were published after 2015 (n = 786; 53.4%), with a plurality published in the 2020s (n = 612; 41.6%). This growth period coincides with MAiD legalization in multiple jurisdictions, including Canada (2016), New Zealand (2021), Spain (2021), and the majority of Australian jurisdictions (2019–2025).

Geographical distribution was highly concentrated (Fig. 2). Five countries accounted for 69.3% of included studies: the USA (n = 298), Canada (n = 249), the Netherlands (n = 216), Belgium (n = 137), and Australia (n = 119). Many regions including Latin America, Africa, Eastern Europe, and much of Asia were underrepresented. Overall, 1110 studies (75.4%) examined MAiD where the practice is now legally permitted (although not necessarily at the time of publication). Sixty studies examined more than one country. Among jurisdictions without legal MAiD, the United Kingdom (53 studies), France (36 studies) and Sweden (22 studies) were investigated the most. The literature was predominantly English-language (n = 1406; 95.6%); complete country-level and language distributions are provided in the appendix.

3.2. Research methods

Primary research methods were categorized as quantitative (n = 821; 55.8%), qualitative (n = 402; 27.3%), or mixed-methods (n = 146; 9.9%). Methodological patterns changed over time (Fig. 3A). Quantitative designs dominated early periods, accounting for 82.4% of studies before 1990 and remaining above 60% through 2010 (although denominators were small in early decades). Their proportional share declined to 37.2% in 2020–2025, during which qualitative studies became the most common approach (39.1%). Mixed- and multi-method designs also increased, comprising 12.3% of studies in 2020–2025.

Surveys were the most common study procedures (n = 900; 61.2%), followed by interviews (n = 359; 24.4%) (Fig. 3B). Smaller contributions came from systematic or scoping reviews (n = 102; 6.9%), medical record review (n = 90; 6.1%), document analysis (n = 67; 4.6%; including regulatory case files, legislative texts, and media sources), and focus groups (n = 46; 3.1%). Death certificates served as a sampling frame or primary data source in 28 studies. Procedure distributions shifted over time: surveys accounted for 94.1% of studies before 1990 but declined proportionally to 41.2% in 2020–2025, while interview-based studies increased to 32.0% in the same period. Despite proportional shifts, absolute counts for all major study procedures increased across successive decades.

Research designs varied across two dimensions. Most studies employed observational designs (n = 1449; 98.5%), while experimental (n = 14; 1.0%) and quasi-experimental (n = 7; 0.5%) approaches were rare. Temporally, cross-sectional designs predominated (n = 1154; 78.5%) with an additional 21 repeated cross-sectional studies (1.4%). A limited number of studies employed retrospective (n = 132; 8.9%) or prospective (n = 24; 1.6%) approaches. Longitudinal studies measuring the same population over multiple timepoints were equally rare (n = 27; 1.8%). Regarding data sources, 1160 studies (78.8%) collected primary data, 258 (17.5%) used secondary data, and 53 (3.6%) used some combination of both (mostly mixed methods studies). Sixteen studies (1.1%) were published protocols.

3.3. Study populations

Healthcare professionals were the predominant study population

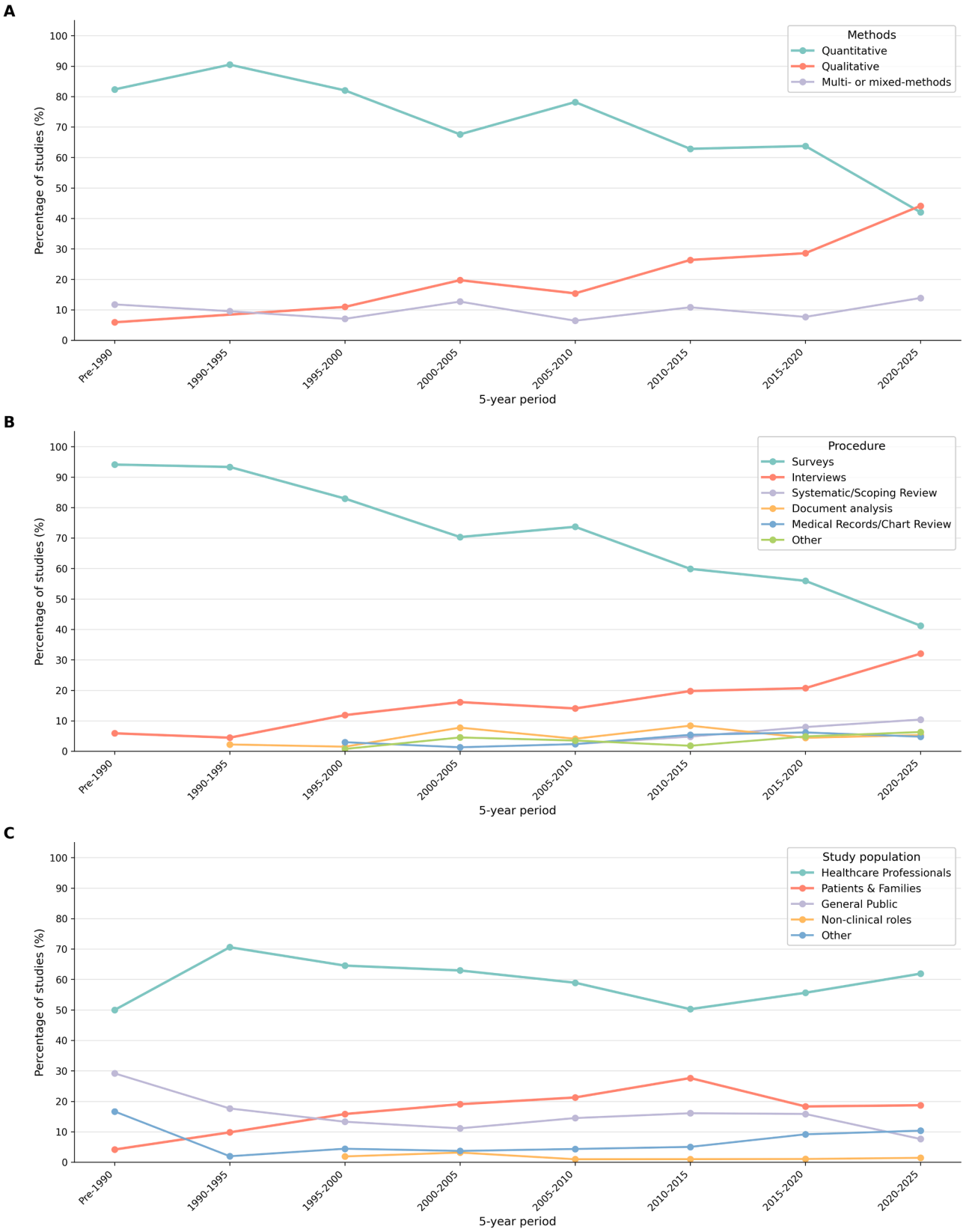

Fig. 3. Changing Composition of Studies by Methods, Procedures, and Populations
Studies with unidentifiable or not applicable methods, procedures, or populations not included. Systematic or scoping reviews excluded from methods counts. Studies often utilized more than one study procedure or included more than one study population.

Table 1
Characteristics of Included Studies (n = 1471).

Methodology	N (%)
Quantitative	821 (55.8%)
Qualitative	402 (27.3%)
Multi or Mixed Methods	146 (9.9%)
Study Design	**N (%)**
Observational	1449 (98.5%)
Quasi-experimental	14 (1.0%)
Experimental	7 (0.5%)
Combination	1 (0.1%)
Temporal Design	**N (%)**
Cross-sectional	1154 (78.5%)
Retrospective	132 (8.9%)
Prospective	24 (1.6%)
Repeated Cross-sectional	21 (1.4%)
Combination	40 (2.7%)
Study Procedure	**N (%)**
Surveys	900 (61.2%)
Interviews	359 (24.4%)
Evidence Synthesis	103 (7.0%)
Systematic Reviews	60 (4.1%)
Scoping Reviews	43 (2.9%)
Meta Analysis	1 (0.1%)
Medical Records/Administrative Data Review	90 (6.1%)
Document Analysis	67 (4.6%)
Focus Groups	46 (3.1%)
Consensus/Deliberative	13 (0.9%)
Observation/Ethnography	9 (0.6%)
Population	**N (%)**
Healthcare Professionals	
Physicians	618 (42.0%)
Nurses	278 (18.9%)
Healthcare students	105 (7.1%)
Social workers	72 (4.9%)
Healthcare administration	52 (3.5%)
Psychologists or psychiatrists	42 (2.9%)
Pharmacists	38 (2.6%)
Other clinical roles (Allied health, PT/OT)	37 (2.5%)
Patients & Families	
Family, caregivers, or surrogates	132 (9.0%)
Patients (general, non-MAiD-requesting)	132 (9.0%)
MAiD patients (requesting or receiving)	128 (8.7%)
General Public	242 (16.4%)
Non-Clinical Roles	
Religious or spiritual roles	32 (2.2%)
Academics, researchers, or bioethicists	22 (1.5%)
Government, legal, or otherwise political roles	18 (1.2%)
Advocates or activists	10 (0.7%)
Other	34 (2.3%)
Not Specified	82 (5.6%)
Research Question Category	**N (%)**
Attitudes and Opinions	
Stakeholder Attitudes and Opinions (Healthcare workers, Patients, Families)	683 (46.4%)
Public Attitudes and Opinions	237 (16.1%)
Clinical Practice and Care Delivery	
Clinical Practice, Workflows, and Protocols	350 (23.8%)
Intersection with other End-of-Life Care	277 (18.8%)
Trends and Utilization	163 (11.1%)
MAiD Education, Training, and Knowledge	88 (6.0%)
Clinical Decision-making	13 (0.9%)
Relational or Social Dimensions	
Family or Caregiver Involvement	58 (3.9%)
Race, Gender, or Inequity	38 (2.6%)
Grief and Bereavement	33 (2.2%)
Art Therapy	2 (0.1%)
Complex Cases and Conditions	
Mental Health or Psychiatric MAiD	91 (6.2%)
Dementia	62 (4.2%)
MAiD Advance Requests	16 (1.1%)
Tired of Living	10 (0.7%)
Minors	10 (0.7%)
Organ Donation	13 (0.9%)
Prisoners	3 (0.2%)
Ethics	
Religion or Spirituality	96 (6.5%)
Moral Reasoning or General Ethics	33 (2.3%)
Suffering	31 (2.0%)
Professional Duty or Conscientious Objection	31 (2.0%)
Autonomy	15 (1.0%)
Decision-making capacity	12 (0.8%)
Healthcare Worker Moral Distress	6 (0.4%)
Trust in Medicine	5 (0.3%)
Dignity	5 (0.3%)
Law, Politics, and Public Health	
Policy and Regulation	103 (7.0%)
Access and Barriers	94 (6.4%)
Legal, Political, Advocacy	49 (3.3%)
Non-Assisted Suicide	23 (1.6%)
Medical Tourism (i.e. "Suicide" tourism)	8 (0.5%)
Costs and Economics	6 (0.4%)
Research Methods and Measurement	
Methods	30 (2.0%)

(*continued on next page*)

Table 1 (*continued*)

308 studies included multiple population groups and research questions; total percent will exceed 100%. Abbreviations: MAiD = Medical Assistance in Dying; PT/OT = Physical Therapy, Occupational Therapy.

across all periods (Fig. 3C; Table 1), accounting for 913 studies (62.1%). Within this group, physicians (n = 618, 42.0%) and nurses (n = 278, 18.9%) constituted the majority, while healthcare students (n = 105, 7.1%) and social workers (n = 72, 4.9%) were less frequently studied. Patients and families were the second most common study population (n = 281; 19.1%), including family members, caregivers, or surrogates (n = 132; 9.0%), general patient populations (n = 132; 9.0%), and patients who requested or received MAiD (n = 128; 8.7%). Studies involving the general public comprised a smaller and declining proportion of the evidence base over time (29.2% before 1990 vs 7.6% in 2020–2025). Policy, legal, research professionals, and other non-clinical roles each constituted a small minority of study populations (<3% in most periods). More than one population group was examined in 380 studies.

3.4. Research questions

Research question frequencies are summarized in Table 1. Studies examining attitudes and clinical practice accounted for the largest share of literature; other domains were substantially less represented. Fig. 4 displays the temporal range of major research question categories, and Fig. 5 presents heatmaps showing how these categories intersect with study procedures and participant populations.

3.4.1. Attitudes and opinions

Studies examining stakeholder attitudes and opinions accounted for 46.4% of all included studies (n = 683), with a further 16.1% examining public attitudes and opinions (n = 237). Attitudinal research was present across all periods, although public opinion studies declined proportionally after the early 2000s. Studies investigating attitudes relied primarily on cross-sectional surveys, most often sampling healthcare professionals, particularly physicians and nurses. Fourteen attitudinal studies employed longitudinal designs.

3.4.2. Clinical practice and care delivery

Clinical practice and care delivery research included studies investigating clinical workflows and protocols (n = 350; 23.8%), how MAiD intersects with other end-of-life care (n = 277; 18.8%), trends and

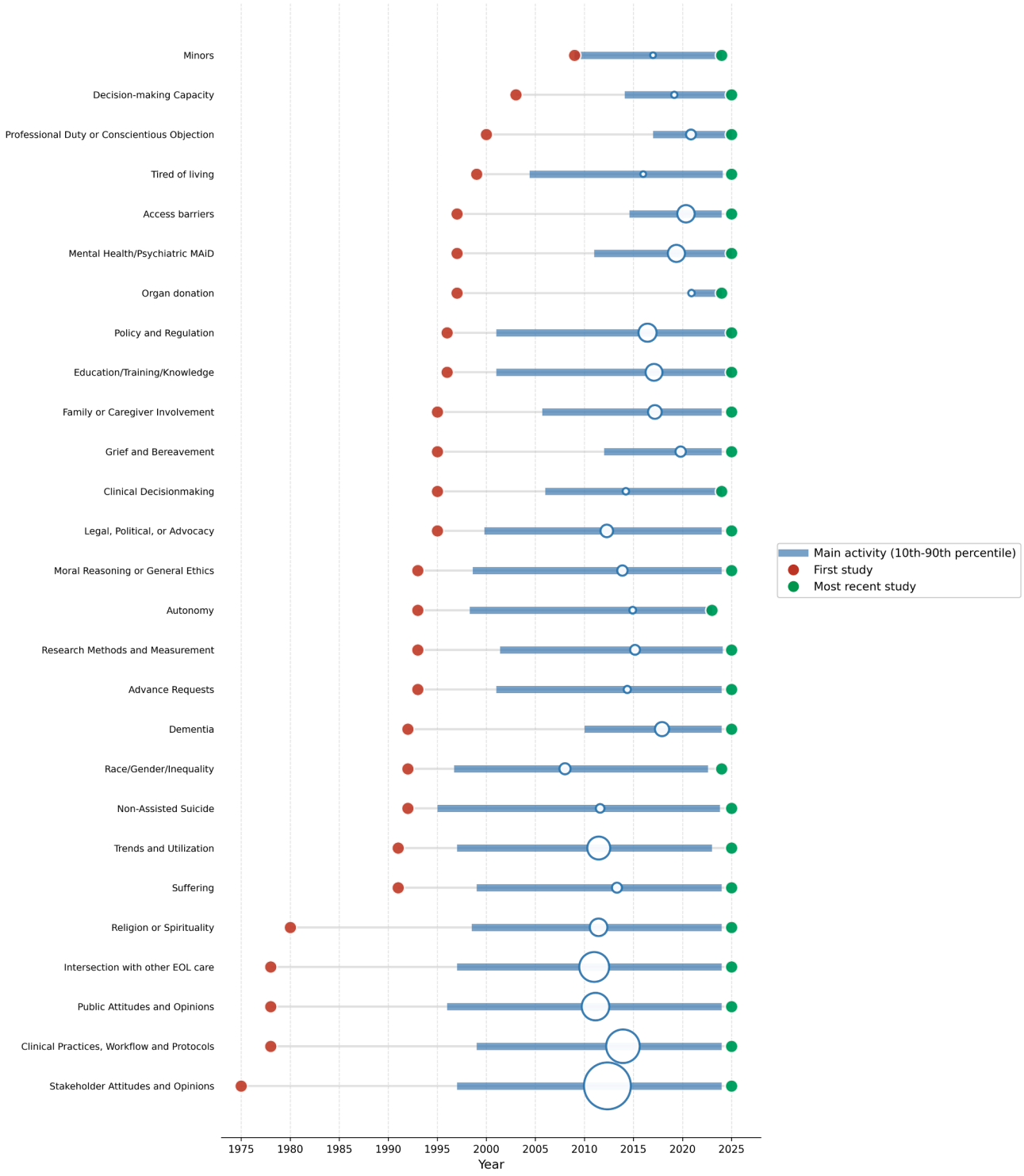

Fig. 4. Temporal trends of research questions
Abbreviations: MAiD = Medical Assistance in Dying.

utilization patterns (n = 163; 11.1%), and education, training, and knowledge of MAiD (n = 88; 6.0%). Research in this domain relied primarily on surveys and interviews using observational, cross-sectional designs, whereas trends and utilization research commonly relied on medical records and chart review procedures.

3.4.3. *Relational or social dimensions*

Relational and social dimensions included studies addressing family or caregiver involvement in the MAiD process (n = 58; 3.9%), racial, gender, or equity-based issues (n = 38; 2.6%), and grief and bereavement (n = 33; 2.2%). Research in this domain relied predominantly on qualitative interviews, with no studies identified using population-based data sources or longitudinal designs.

3.4.4. *Complex cases and conditions*

Research on complex cases and conditions included MAiD involving psychiatric conditions (n = 91; 6.2%), dementia (n = 62; 4.2%), advance requests (n = 16; 1.1%), organ donation (n = 13; 0.9%), minors (n = 10;

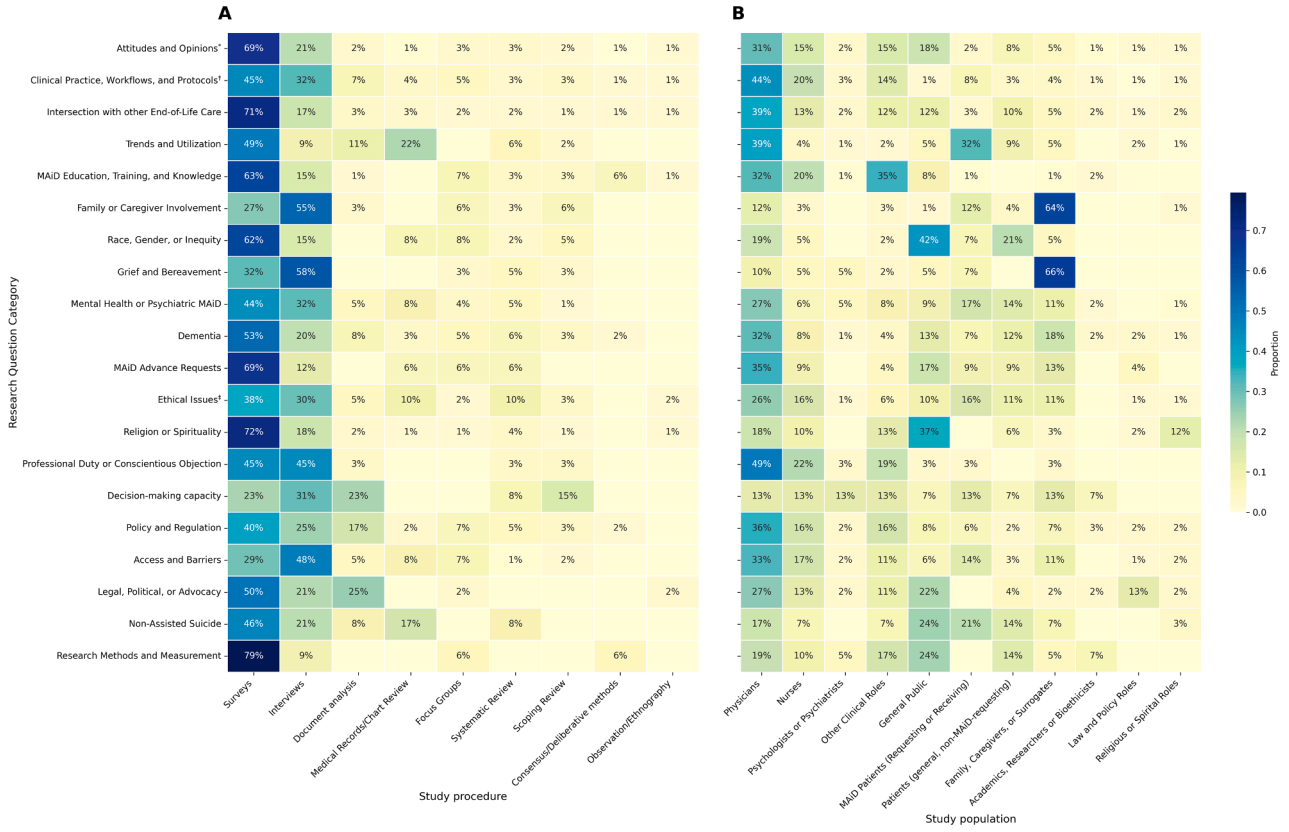

Fig. 5. Heatmap of Research Questions by Study Procedures and by Study Populations
Abbreviations: MAiD = Medical Assistance in Dying
Categories with less than ten studies were not included in the heatmap
*Attitudes and Opinions combines the stakeholders attitudes and opinions and the public attitudes and opinions categories
† Clinical Practice, Workflows, and Protocols includes the clinical decision-making category
‡ Ethical Issues includes the following categories: autonomy, healthcare worker moral distress, dignity, trust in medicine, moral reasoning or general ethics, and suffering.

0.7%), and existential suffering or "tired of living" (n = 10; 0.7%). These studies relied primarily on surveys and interviews with clinicians, although families and caregivers were included in studies involving MAiD advance requests or dementia.

3.4.5. Ethics

Studies investigated a large span of research questions related to ethics, including religion or spirituality (n = 96; 6.5%), moral reasoning or general ethics (n = 33; 2.3%), suffering (n = 31; 2.0%), professional duty or conscientious objection (n = 31; 2.0%), autonomy (n = 15; 1.0%), and decision-making capacity (n = 12; 0.8%). These topics were present throughout the study period, although most categories expanded after 2000. Ethics-focused research relied on surveys and interviews and primarily engaged physicians and nurses, though patients, caregivers, and political or legal roles were also represented. Academics (notably bioethicists) were rarely included across all ethics sub-topics.

3.4.6. Law, politics, and public health

Policy and regulatory research included studies examining regulatory frameworks and oversight (n = 103; 7.0%), access and barriers (n = 94; 6.4%), and legal, political, or advocacy dimensions (n = 49; 3.3%). These topics appeared infrequently before 2010 and increased substantially after 2015. This domain relied primarily on surveys and interviews. Administrative data analysis, cross-jurisdictional comparisons, and quasi-experimental designs exploiting policy variation were rare.

4. Discussion

As the first systematic mapping of empirical MAiD research, this review demonstrates that despite recent growth in publication volume and topical breadth, the evidence base remains structurally concentrated in ways that limit its fitness for policy evaluation. Across jurisdictions and time periods, the literature is characterized by observational, cross-sectional studies relying on surveys or interviews and focusing on healthcare professional attitudes or clinical practice. Although research questions and qualitative methods have diversified, this design-level concentration—observational, cross-sectional, and provider-dominated—persists, and its implications grow as MAiD legalization extends into jurisdictions with different legal traditions, professional structures, and regulatory environments, where the applicability of evidence generated under a narrow set of institutional conditions is uncertain. In particular, the current evidence base cannot reliably address three questions central to MAiD policy evaluation: whether access is equitable across populations, whether procedural safeguards function as intended across diverse settings, and whether policy designs and outcomes are comparable across jurisdictions. These are not questions the literature has neglected to ask; they are questions its methods, populations, and data sources are not structured to answer.

These patterns are driven by three sets of constraints on research feasibility and acceptability. First, in many jurisdictions, MAiD has been legal for less than a decade which renders longitudinal cohorts, prospective designs, and quasi-experimental approaches infeasible until recently [2] Second, infrastructural fragmentation constrains

comparative and population-level research. Many MAiD oversight systems are designed primarily to detect and ensure legal compliance rather than support research-grade data [13,20] This may reflect a compliance-oriented regulatory architecture: systems are foremost designed to confirm that statutory requirements have been met in individual cases, rather than to produce population-level data on access patterns, safety outcomes, or policy performance [21] Most jurisdictions capture data on completed cases but often omit requests, denials, deferrals, and withdrawals, precisely the data needed to assess whether eligibility criteria and safeguards function as intended across populations. Meanwhile, government data collection efforts remain poorly aligned across jurisdictions, with inconsistent metrics[1,22], reporting practices[23], and outcome definitions that limit comparative assessment [11] Third, institutional and political barrier, including heightened ethics scrutiny, variable institutional policies, and limited dedicated funding, further restrict study initiation and data access [20, 24–31]

Within these constraints, the methodological composition of the field has shifted substantially over time. Surveys and interviews have become institutionally accessible methods: they are rapidly deployable, require minimal infrastructure, and are more readily approved [12] Early MAiD research was dominated by quantitative attitudinal surveys measuring public and professional opinions on permissibility. Following legalization in multiple jurisdictions, qualitative studies became the modal approach by 2020–2025, reflecting a turn toward understanding clinical experience, implementation, and the relational dimensions of practice [3] The proportional share of public opinion research declined correspondingly, as the growing field organized itself increasingly around professional and clinical concerns. Legalization and institutionalization appear to have created opportunities for qualitative inquiry at the same time that the field's driving questions shifted from whether MAiD should be permitted to how it is practiced and experienced.

Despite this diversification, study designs capable of supporting causal inference or longitudinal analysis remain rare. Cross-sectional designs predominate, and experimental, quasi-experimental, and longitudinal approaches together account for a small fraction of the evidence base. Even within the expanding qualitative literature, the scarcity of validated measurement instruments means that the rapid growth in descriptive and experiential research has not yet produced a cumulative evidence base. As MAiD legislation continues to evolve across jurisdictions, policy and eligibility changes are generating natural experimental conditions that could support quasi-experimental, repeated cross-sectional, and longitudinal analyses without requiring randomization. Realizing this potential, however, will require developing context-sensitive measurement approaches and clearly defined outcome constructs, particularly where ethical, cultural, and attitudinal factors shape how MAiD is implemented and experienced [32]

This emphasis on institutionally accessible methods also structures whose perspectives dominate the evidence base. Healthcare professionals accounted for 62.1% of the study populations, particularly in research on attitudes, clinical practice, and education, reflecting both their central role in MAiD provision and their relative accessibility as research participants [33] This concentration suggests that the profession responsible for clinical MAiD provision has also disproportionately shaped the field's empirical priorities, a pattern consistent with broader tendencies in health services research where provider accessibility drives sampling decisions. By contrast, patients, families, and other directly involved groups are substantially underrepresented, including minors or patients with limited cognitive capacity for whom ethical review requirements pose heightened challenges to study inclusion, even where their participation is scientifically justified. Provider-reported observations of patient experience, family dynamics, and access barriers do appear across this literature; however, they do not substitute for direct study of these populations. Provider-dominated sampling frames shape not only empirical findings but also the range of questions deemed tractable, prioritizing professional perspectives on eligibility criteria, safeguards, and procedural compliance while potentially obscuring downstream access barriers and experiential consequences that occur outside formal clinical encounters [2]

Current methodological patterns produce systematic blind spots at multiple levels. Only 8.7% of included studies examined patients who had requested or received MAiD, and research with denied applicants, affected families outside the caregiving role, or communities facing structural access barriers is largely absent. These gaps are not random. They reflect the combined effect of limited patient-level research data, ethics review processes that restrict access to populations deemed vulnerable, and professional sampling norms that center provider perspectives. Addressing these constraints will require not only expanding recruitment to patients, families, and denied or withdrawn applicants, but also adopting community-based and participatory approaches capable of reaching populations whose experiences are not captured by clinical or administrative data systems. These are institutional preconditions dependent on ethics governance reform, dedicated funding, and infrastructure for non-clinical recruitment, rather than matters of investigator initiative alone.

Safety cannot be assessed solely through reported compliance with procedural safeguards; it requires independent empirical visibility into grey-zone practices, denied requests, and unintended consequences, including whether patients' own assessments of suffering and decision-making capacity are adequately captured in clinical and administrative records [34] Without diversifying both the populations studied and the questions asked, the field remains unable to evaluate how MAiD policies operate beyond formal clinical encounters, including whether eligibility criteria are applied uniformly across populations, whether access barriers fall disproportionately on specific groups, and how the practice is experienced by those most directly affected.

Beyond study design and sampling, the MAiD literature is limited by the absence of standardized outcome constructs beyond procedural compliance, which restricts comparability even when data and methods are available. This absence is consistent with oversight systems designed to verify legal compliance rather than to support evaluative or comparative research. Patient-centered experience and outcome measures within the MAiD process, family and caregiver impacts, and longer-term system effects are rarely defined or measured, limiting the cumulative value of even methodologically rigorous studies. Comparative inference is further constrained when oversight systems measure different constructs in incompatible ways. The resulting evidence structure cannot answer questions that require causal inference (do interventions work?), longitudinal data (what happens over time?), or diverse samples (who is harmed or helped?).

This review has several limitations. First, consistent with mapping review methodology, we did not undertake study-level quality appraisal, despite its potential value to understanding the state of empirical MAiD literature. Second, the breadth required for comprehensive mapping precluded methodologically differentiated synthesis or examination of how research questions intersect. This mapping review is intended to provide a foundation for future evidence synthesis projects targeting specific jurisdictions, research topics, or methods. Third, classification decisions represent one reasonable interpretation, and alternative frameworks could yield different categorizations, particularly given the diversity in how MAiD is practiced and conceptualized across cultures and over time. Fourth, given our scope was limited to peer reviewed academic research, this mapping review does not encompass the entirety of all available empirical evidence on MAiD; grey literature, including high quality government reports, were excluded. Finally, although language exclusions were minimal, the evidence base was overwhelmingly English-language and restricted to peer-reviewed empirical studies, potentially underrepresenting relevant work published in other languages or in grey literature.

Research in Context

What is already known about the topic?

Prior reviews have synthesized findings on specific MAiD topics, including stakeholder attitudes, clinical practice, and bibliometric trends. However, the structure of the empirical evidence base—how study designs, populations, and research questions intersect across the full corpus—has not been systematically characterized. Without this characterization, it remains unclear what types of policy-relevant inferences the literature can support.

What does this study add to the literature?

This mapping review of 1471 empirical studies across 65 countries demonstrates that despite growth in volume and topical breadth, the MAiD evidence base remains concentrated in observational, cross-sectional designs centered on healthcare professional perspectives, limiting its fitness for policy evaluation.

What are the policy implications?

Current MAiD oversight systems generate compliance data rather than population-level evidence for policy evaluation. Priority areas include standardized reporting of requests and outcomes, linkage to administrative health system data, and harmonized measurement across jurisdictions to support assessment of access equity, safeguard performance, and cross-national comparability.

5. Conclusions

The evidence structure documented here has direct consequences for MAiD policy evaluation. For policymakers, the central issue is not only the volume of evidence but its fitness for evaluating policy performance. If the majority of oversight systems remain oriented toward case-level compliance verification rather than population-level data generation, the evidentiary basis for assessing access equity, safeguard performance, and policy outcomes will continue to depend on ad hoc research rather than systematic monitoring. If jurisdictions were to expand oversight data to support linkage with administrative health, social care, and vital statistics datasets, comparative evaluation of safety and access would become tractable in ways it currently is not. Death certificates and mortality-based records, in particular, represent an underutilized data source for population-level surveillance and linkage, especially in jurisdictions where cause-of-death reporting can be integrated with health and administrative datasets. Similarly, if core measures and reporting standards were aligned across oversight systems, the persistent incomparability that fragments the current evidence base could be substantially reduced. Absent dedicated funding streams and clearer institutional guidance for ethically complex and participatory research, the barriers to study initiation documented across the literature are unlikely to diminish [11]

The methodological gaps identified in this review are not primarily attributable to investigator choices but to the institutional conditions under which MAiD research is conducted; strengthening inferential capacity presupposes changes to the data infrastructure and governance architecture that currently constrain feasible designs. However, where prospective cohorts are impractical, repeated cross-sectional designs using harmonized instruments, administrative data linkage, and quasi-experimental analyses utilizing policy or eligibility changes can support stronger temporal and policy-relevant inference. The appropriateness of study designs should be evaluated relative to the research question and data environment, rather than against a fixed hierarchy of methods [35]

This mapping review is intended both to characterize the current evidence structure and to function as a research-planning resource. By systematically identifying areas of concentrated and underexamined empirical attention, it can guide future inquiry toward populations, outcomes, and study designs. Priority areas include standardized reporting of requests and outcomes, linkage to administrative health system data, and harmonized measurement across jurisdictions to support cross-national comparison. Future updates to this mapping review will incorporate additional jurisdictions, languages, and study types, and will support targeted syntheses addressing specific policy questions or methodological approaches.

Data sharing

Data are available upon request. An online repository is in development.

CRediT authorship contribution statement

Sean Riley: Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Gianna R Strand:** Writing – review & editing, Investigation, Data curation. **Iris Parra Jounou:** Writing – review & editing, Validation, Methodology, Investigation, Data curation, Conceptualization. **Marta Perin:** Writing – review & editing, Validation, Methodology, Investigation, Data curation, Conceptualization. **Chiara Crico:** Writing – review & editing, Validation, Investigation, Data curation. **Fenne Bosma:** Writing – review & editing, Validation, Investigation, Data curation, Conceptualization. **Janet Delgado:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors have no conflicts of interest to declare.

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Supplementary materials

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