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## Experience of Community Physicians Who Provide Medical Assistance in Dying: A Qualitative Analysis

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A thesis submitted in partial fulfillment of the requirements for the Master of Clinical Science degree in Family Medicine

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## Abstract

**Aims:** Since decriminalization in 2016, medical assistance in dying (MAiD) has transformed the landscape of end-of-life care in Canada. This study explored the experiences of community family physicians who provide MAiD.

**Methods:** Using a qualitative study design and phenomenological approach, semi-structured interviews were conducted with twelve physician providers in Southwestern Ontario. The transcripts were coded and inductively analyzed for overarching themes.

**Findings:** At the individual level, providers felt a profound sense of purpose. At the local level, participants reflected on the practical challenges encountered. At the system level, participants described the critical role of organizational support structures, mentorship, and the effects of legislative changes.

**Conclusions:** The results contribute to a deeper understanding of the MAiD experience in Canada, fostering ongoing discourse in this complex and evolving field of healthcare. The findings also hold the potential to impact decisions concerning upcoming training initiatives, policy formulation, legislative efforts, and research.

### Keywords

End-of-life care, Medical Assistance in Dying (MAiD), Community Provider Perspectives, Family Physician, Lived Experiences

## Summary for Lay Audience

Medical assistance in dying (MAiD) is relatively new in Canada. In addition to palliative care, it offers another option for patients to alleviate their suffering at the end of life. MAiD is a controversial, complex, and sensitive topic in healthcare. There have been many changes to its delivery since its decriminalization in 2016. MAiD is often carried out by community family doctors. This study aims to understand the perspectives and experiences of community physicians who are actively involved in the MAiD process.

By listening and appreciating the experiences of community family physicians, the barriers and challenges that exist in MAiD care can be better understood. Twelve community family doctors were interviewed using a semi-structured guide. The analysis of these interviews for key themes revealed the individual, local and system level factors that influenced the providers.

The study offers a unique look at one aspect of the MAiD experience and sheds light on current practices in Canada. This is important work as patients considering or accessing MAiD are in vulnerable positions, therefore it is crucial to reflect on present protocols to ensure ongoing compassionate care. The understanding of the community provider perspective can help improve overall MAiD implementation and ultimately, lead to better care for patients and families.

## Co-Authorship Statement

While the primary researcher (RC) led the conception, planning, and execution of the research for this thesis, recognition is owed to Dr. Shannon Sibbald and Dr. George Kim for their knowledge, expertise, and perspectives. Their contributions substantially enhanced this study from its inception to its conclusion, particularly in creating the methodology and interpreting the qualitative data.

## Acknowledgments

Throughout my graduate studies I navigated many life transitions including the birth of my second child, relocation to a new community, and the establishment of my own comprehensive family practice. These experiences serve as chapters of inspiration in my ongoing journey towards personal and career growth.

I am grateful to have had the chance to delve into a research topic that encapsulates the essence of the human experience. It was incredibly rewarding to interview practitioners who exemplify the dedication and connection inherent in family medicine. I extend my sincere gratitude to each participant for sharing their experiences and life stories with me. I learned that although death is an undeniable part of life's journey, what truly makes life beautiful and meaningful is the compassion, empathy, and shared humanity that individuals bring to each other's lives.

I would also like to thank my co-supervisors, Dr. Shannon Sibbald and Dr. George Kim, whose guidance and support have been invaluable throughout this process. I express gratitude to the Department of Family Medicine and Western University for their academic and financial support towards the research conducted in the thesis as well as to the Martin J. Bass PSI Foundation Bursary and the Dr. John F. Sangster Graduate Studies Family Medicine Award.

To my husband and two wonderful children, you are my pillars of strength. Sharing treasured moments together brings me immense joy and motivation. I am thankful for my family and friends who are sources of companionship and ongoing support. Finally, I dedicate this study to my grandfather, Naunihal Singh Gill (1940-02-02 to 2023-05-11) whose memory continues to inspire me.

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## List of Acronyms

ALS	Amyotrophic lateral sclerosis
ADRAS	Assisted Dying Resource and Assessment Service
CAMAP	Canadian Association of MAiD Assessors and Providers
COVID-19	Coronavirus disease 2019
CPSO	College of Physicians and Surgeons of Ontario
HCP	Healthcare provider
IV	Intravenous
LHIN	Local health integrated network
MAiD	Medical assistance in dying
MD-SUMC	Mental disorder as the sole underlying condition
NP	Nurse practitioner
OCFP	Ontario College of Family Physicians
RFND	Reasonably foreseeable natural death

# Chapter 1

## 1 Introduction

This first chapter presents a brief background of Medical Assistance in Dying (MAiD) emphasizing the issues that influenced the research project. The research question and objectives are outlined and the rationale for the study is explained. The structure of the thesis is provided.

### 1.1 Background

As patients are living longer and assuming more autonomy of their medical decisions, the decriminalization of assistance in dying has gained more attraction in the public and medical community. In Canada, MAiD is the term used to describe the process of the provision of medications to end a patient's life at the request of a patient to alleviate suffering. MAiD is relatively new in Canada and prior to 2016 patients did not have this as an option. As legislation has evolved, so too has the implementation process and the way it is carried out in the community. My goal with this research study is to understand the experiences of community physicians who provide MAiD. As MAiD involves the death of a patient, it can bring up deep feelings for all involved. For this reason, a qualitative study design was chosen to appreciate the depth and nuance of the experience. The purpose of the study is not to prove or disprove an existing hypothesis or replicate research findings from other studies. The ultimate intent is to understand the intricacies of the experience for providers due to the changing landscape of MAiD in Canada. The focus of the study is on community providers as primary care physicians are the principal MAiD providers in Canada (Health Canada, 2022).

The Government of Canada formally defines MAiD as: “1) the administration by a physician or nurse practitioner of a substance to a person, at their request, that causes their death; or 2) the prescribing or providing by a physician or nurse practitioner of a

substance to a person at their request, so that they may self-administer the substance and in doing so cause their own death” (Health Canada, 2022). Physician assisted death (PAD) or physician assisted suicide (PAS) are forms of MAiD where lethal medications are prescribed for patient self-administration versus euthanasia, “a deliberate action undertaken to end a patient’s life at their voluntary request” (Fujioka et al., 2019, p. 207). MAiD assessors help to confirm eligibility whereas MAiD providers administer the medications used to peacefully end the patient’s life.

MAiD is now legalized in some form in several countries (Austria, Belgium, Germany, Italy, Luxembourg, Netherlands, Portugal, Spain, Switzerland), some US states (California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, Washington) and newly in all provinces and territories across Canada (Li et al., 2017, Dyer et al., 2015, Fujioka et al., 2019). The way in which MAiD is implemented varies depending on the authority; however, the universal requirement is the “voluntary and documented consent of the recipient who must be mentally competent at the time of the request” (Fujioka et al., 2019, p. 208). For instance, in the Netherlands physicians who help with assisted death cannot be prosecuted (Van der Heide A. et al. 2007). In Belgium and Luxembourg, voluntary euthanasia by lethal injection is legalized and even extended to children of any age with parental consent (Bilsen, 2009). In Switzerland, assisted suicide is permitted if a person does it for “unselfish reasons” and does not require a medical doctor to be involved (Fischer, 2009). In the United States, laws differ slightly by state, but in general, assisted dying is permitted to mentally competent patients with terminal illness and a limited life expectancy if a consulting physician confirms the diagnosis and psychiatric conditions receive counselling (Dyer et al., 2015). Important differences in the way the process is conducted include whether mental competence is required at the time of the provision, an advanced directive can be used, or mental health can be considered a qualifiable illness. However, all jurisdictions generally require patients to have an incurable condition causing unbearable physical or mental suffering with safeguards in place such as ensuring good pain control and end-of-life care so that the patient does not feel pressure to choose a particular option.

## 1.2 Research Question and Objectives

The intent of this thesis is to answer the following question: What is the experience of community-based physicians who provide MAiD in Canada? The main objective is to explore the lived experiences of community physicians who provide MAiD to better understand the personal and professional impacts as well as influencing characteristics:

- Personal implications for providers.
- Professional ramifications for providers.
- Motivations and driving factors behind their decision to be involved in MAiD practice.
- Obstacles and challenges encountered in the process.

A qualitative phenomenological approach is used to answer the research question and objectives using semi-structured interviews of community family physicians.

## 1.3 Rationale

The law regarding MAiD changed in 2016, however the process was slow to be implemented for many reasons. It took some time for professional licensing bodies to publish their standards and clinician training programs to be available. At the start, there was active opposition by some organizations such as residency programs, hospices, and palliative care advocates (Knox & Wagg, 2023). Over time, training and mentorship have improved. However, there is still a shortage of providers, which is more acute in rural locations (Wiebe, 2021, MacDonald et al., 2018).

While landmark Canadian studies have since examined the Canadian provider perspective on MAiD, as detailed in the literature review in chapter two, significant legal changes have occurred since its initial decriminalization. The coordination of MAiD was further impacted by the COVID-19 pandemic. These evolving dynamics underscore the necessity for ongoing analysis of the processes involved in MAiD to allow for the provision of patient-centred compassionate care to a vulnerable population. Notably, family physicians are the primary providers of MAiD, constituting 67.7% of cases

(Health Canada, 2023). As such, there exists an ongoing need to understand the experiences of community family physicians who provide MAiD.

## 1.4 Structure of Thesis

The thesis follows a structured framework outlined as follows: in chapter one, the topic is introduced with pertinent definitions explained and the purpose of the research outlined. Chapter two presents a comprehensive overview of the current landscape of MAiD in Canada, reviews ethical considerations and synthesizes the existing literature. Chapter three presents the qualitative methodology used in the study. Chapter four outlines participant demographics and findings, categorized into three main levels encompassing ten key themes. Chapter five provides a detailed discussion, addressing each level and the study's strengths, limitations, implications, and recommendations. The final chapter concludes the thesis with a summary of the key insights derived from the research.



## Chapter 2

### 2 Literature Review

This research aimed to understand community provider perspectives when it comes to MAiD. This chapter presents a history of MAiD in Canada detailing its evolution over time. It also presents current statistics concerning MAiD in the country and provides a detailed review of the existing literature on the topic.

#### 2.1 History of MAiD in Canada

The Canadian Supreme Court decriminalized MAiD on February 6, 2016 (Judgments of the Supreme Court of Canada, 2015) and Bill C-14, that laid out the specific conditions for its practice, was passed on June 17, 2016 (Statutes of Canada, 2016). This was a hard-fought battle that started with the *Rodriguez* case in 1993. Sue Rodriguez was a 41-year-old mother when she was diagnosed with amyotrophic lateral sclerosis (ALS), a degenerative neurological condition. With a life expectancy of under five years, Rodriguez did not want her son to see her in the final stages of suffering due to her disease. She asked the courts to recognize the right for her to determine the manner and time of her death as she did not want to slowly lose vital functioning of her body resulting in suffocation or starving to death. She had requested for section 241(b) of the *Criminal Code* that prohibited assisted suicide to be declared invalid. At the time, section 241(b) stated that anyone who counseled or aided a person to commit suicide, whether suicide ensued or not, was guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years (*Criminal Code*, 1985, s.241). Rodriguez felt that the prohibition on assisted suicide violated her section 7 of the *Canadian Charter of Rights and Freedoms*, the right to liberty and security of a person because she was not allowed to make fundamental decisions related to her death. She also felt that the prohibition violated section 12, as it subjected her to cruel punishment due to the prolonged suffering associated with her condition. At the time it was legal in Canada to commit suicide, refuse lifesaving treatments and request palliative sedation. Sue Rodriguez argued this was inconsistent with section 15 which pertains to equality rights as disabled persons

would not be allowed the choice of assisted suicide. Ultimately, Rodriguez lost her case at the Supreme Court of Canada by a narrow margin, a 5-4 split vote as the Court did not believe MAiD could be administered without adequate safeguards in place (Supreme Court of Canada, 1993). Nevertheless, this case shifted the tide and sparked a national discussion about assisted dying in Canada.

In Canada, Quebec first legislated MAiD in 2014 by creating its own assisted dying regime. This started with a Select Committee in 2009 to study the topic of MAiD and in 2012 a report supporting MAiD in certain circumstances. Bill 52 came into effect in December 2015 before legislation changed anywhere else in Canada. Bill 52 included that patients must be “at end of life” to be eligible for MAiD (Bill 52, 2013).

Elsewhere in Canada, MAiD was gaining popularity in the national milieu. In 2011, the *Carter* case began in British Columbia and contested the same prohibition under sections 241 and 14 of the *Criminal Code*. Gloria Taylor was a 64-year-old woman who also suffered from ALS and wanted MAiD from a willing physician, Dr. Shoichet. However, she passed away naturally in 2012 leaving named plaintiffs Lee Carter and Hollis Johnson to continue the case. Kay Carter was an 89-year-old woman who suffered from spinal stenosis, a degenerative neurological condition. Kay Carter traveled to Switzerland with her daughter, Lee, in 2010 to receive an assisted death. Lee and Hollis sued the state for the right to MAiD and this case went all the way to the Supreme Court of Canada. In February of 2015 in a monumental unanimous decision the Supreme Court struck down the blanket prohibition against physician assisted death and gave Parliament one year to enact legislation guidelines consistent with the *Canadian Charter of Rights and Freedoms* (Carter v. Canada, 2015).

Bill C-14 enacted in 2016 was the Canadian government’s response to the required legislative changes (Bill C-14, 2016). Canadian law allows either assisted suicide by physicians or nurse practitioners or euthanasia, the self-administration of lethal drugs, for a person who requests it and meets certain specific criteria (Roehr, 2018). The act allows practitioners to legally help patients to end their life who are at least 18 years old, eligible

for health services funded by the federal government, mentally competent to give informed consent, and have a grievous and irremediable medical condition. There are procedural safeguards in place including the need for two independent assessments by practitioners, the need for a written request for MAiD with an independent witness present and the opportunity to withdraw consent at any time (Li et al., 2017, Health Canada, 2022) (Appendix A). Notably, Bill C14 was more restrictive than the original Carter decision. In an effort to protect vulnerable persons, the stipulations that the patient be in an advanced state of decline and that their death be reasonably foreseeable were included (Bill C-14, 2016). Opponents argued that these elements violated the *Canadian Charter of Rights and Freedoms* as persons with prolonged disabilities would be excluded from accessing MAiD.

Additional changes were made to the Criminal Code with Bill C-7, which came into effect in March 2021. Bill C-7 enabled patients to access MAiD even if their death was not reasonably foreseeable. There are now two procedural tracks to access MAiD. Track one is followed if a person meets eligibility criteria and their natural death is reasonably foreseeable (Appendix A). Track two is followed if a patient's death is not reasonably foreseeable. The track two safeguards include a 90-day assessment period and the individual's express consent at the time of MAiD provision (Summary of these two tracks can be found in Appendix A). This legislation came to be after the successful argument that a natural death be "reasonably foreseeable" violated the Charter rights to access MAiD. Another important addition with Bill C-7 is that persons whose death is reasonably foreseeable who are at risk of losing capacity can agree to waive the final consent requirement of Bill C-14. The waiver of final consent can happen if the individual's natural death is reasonably foreseeable and they have met all eligibility criteria, informed they are at risk of losing capacity, have identified the date they wish to receive MAiD, and have entered into a written agreement to waive final consent with the medical provider should they lose capacity prior to the provision, and do not resist the administration of lethal medications at the time of provision. The ten-day reflective wait period was also removed for persons whose death is reasonably foreseeable (Parliament of Canada, 2021, Variath et al., 2022).

## 2.2 Current Canadian Statistics on MAiD

The most recent data to date shows that 13,241 MAiD provisions were reported in Canada in 2022, accounting for 3.5% of all deaths in Canada. There has been a growth rate of 31.2% over 2021 with a steady yearly growth. Since 2016, the number of assisted deaths in Canada is 44,958. The average age of patients in 2022 was 77.0 years and the most cited underlying medical conditions were cancer (63.0%) followed by cardiovascular conditions (18.8%), other conditions (14.9%), respiratory conditions (13.2%) and neurological conditions (12.6%). Of the total number of MAiD provisions in 2022, 3.5% were not reasonably foreseeable, with the most cited underlying condition in this category being neurological (50.0%). Of note, most MAiD patients received palliative care (77.6%) and disability support services (89.5% of the eligible patients). The nature of suffering that resulted in patients requesting MAiD was consistent from the tested periods of 2019-2022: the loss of ability to engage in meaningful activities (86.3%), the loss of ability to perform activities of daily living (81.9%) and inadequate pain control or concern about controlling pain (59.2%). Family physicians were the principal MAiD providers (67.7%) (Health Canada, 2023).

## 2.3 Intersection with Palliative Care

According to the International Association for Hospice and Palliative Care, the consensus-based definition of palliative care is the “active holistic care of individuals across all ages with serious health-related suffering due to severe illness and especially of those near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers” (Radbruch et al., 2020, p.755). Palliative care involves discussions about goals of care and addresses the physical, psychosocial, and spiritual needs at the end of life. MAiD can complement quality palliative care, and often, they are used concurrently to provide comprehensive support to patients and their families to help alleviate suffering. Studies have shown that palliative care, hospice care and MAiD

should be considered as part of a comprehensive continuum of end-of-life care that is both inclusive and accessible to all Canadians (Wright & Shaw, 2019).

## 2.4 Ethical Considerations

There are still many healthcare professionals who oppose assisted dying and refuse to care for patients who have requested MAiD (Wiebe, 2021). This is because MAiD can be a contentious issue due to the ethics involved. Some doctors oppose assisted dying due to the fundamental ethical principle of non-maleficence as well as strong religious views, however others view that denying patients the choice conflicts with patient autonomy (Roher, 2018). The ethical principle of non-maleficence “is the obligation of a physician not to harm the patient. This simply stated principle supports several moral rules - do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense, and do not deprive others of the goods of life” (Varkey, 2021, p. 18). Physicians are generally taught to prioritize the well-being of their patients and some view assisting patients in dying as inherently harmful. On the contrary, many view it as an act of alleviating suffering and offering dignity and autonomy (James, 2006, Oliphant and Frolic, 2021, Pesut et al., 2021).

Autonomy as an ethical principle means “that all persons have intrinsic and unconditional worth, and therefore, should have the power to make rational decisions and moral choices, and each should be allowed to exercise his or her capacity for self-determination” (Varkey, 2021, p. 19). Although most health care providers agree on the provision of compassionate care that upholds patient autonomy and the legal rights of the terminally ill, there have been considerable concerns regarding the moral, religious, and personal repercussions MAiD providers may experience (Quinn & Detsky, 2017, Upshur, 2016). There are several studies looking at the opinion of providers on the decriminalization of MAiD as well as their willingness to offer the service (Emanuel & Battin, 1998, Curry et al., 2000). However, a robust 2018 scoping review found that “little is known about health care providers’ perspectives in handling requests” (Fujioka et al., 2018).

MAiD is also considered an “active” form of assisted death whereas “passive” forms include withdrawal of life support, refusal of artificial nutrition and hydration and cessation of dialysis. The passive forms of death are considered to have less ethical ramifications as they are generally viewed as more natural due to the underlying condition. As Professor McLachlan described in his 2008 article on the ethics of active and passive euthanasia, “there are significant moral differences between killing and letting die” due to the differing moral duties at play (McLachlan, 2008, p. 636). These definitions have incited much debate as ethicists have argued instances in which humanity and dignity are involved in both options.

## 2.5 Conscientious Objection

The federal legislation did not initially address conscientious objection among health care providers, leaving this up to provinces and their medical colleges. The Ontario College of Family Physicians’ (OCFP) policy states that if physicians object to MAiD, they must still act in a manner that respects patient dignity and to provide patients with available care and resources on the process. There was initially debate about this as opponents felt that they should not be forced to make referrals under religious or moral grounds and likened referrals to assisting with MAiD. However, healthcare providers also have a professional duty of non-abandonment and duty to provide an effective transfer of care. This was argued by the College of Physicians and Surgeons of Ontario (CPSO) opposing the views of the Christian Medical and Dental Society of Canada who claimed the College policy violated the Charter rights of freedom of religion and equality (Court of Appeal for Ontario, 2019). The Court of Appeal’s decision from May 14, 2019, states that: “1) Practicing medicine is not a right. Protecting patients is paramount. 2) Physicians can choose an area of medicine that is less likely to receive these requests, but if they do receive requests for MAiD they are obligated to make an effective referral”. The Divisional Court argued that physicians are members of a regulated and publicly funded profession and are therefore subject to the requirements that focus on public interest. Further, the fiduciary nature of the patient-physician relationship requires

physicians to act in the patient's best interest (CPSO, 2018). In Ontario, the ministry has established a care coordination service where patients and caregivers can request directly to be connected to a MAiD provider (Kelsall, 2018).

## 2.6 Factors Influencing Provider Participation

A literature search helped to understand the depth of current knowledge about provider experiences with MAiD (Appendix B). Google Scholar was used to get an understanding into the available literature followed by utilizing PubMed for conducting queries. The key terms were used in different combinations in the search strategy: MAiD, assistance in dying, assisted death, family physician, provider, community, physician, experiences, perspectives, and qualitative. The PubMed search was limited to publications from 2016, when MAiD was first decriminalized in Canada. This approach ensured that the literature captured relevant demographic and contextual data for accurate comparison. Literature that reviewed patient or caregiver experience was excluded as the focus of the study was the provider experience. Studies that solely focused on the nurse, nurse practitioner, medical student, hospice, or palliative care experience were also excluded as the primary goal was to understand community physician provider perspectives.

There are numerous factors that influence the decision to provide MAiD given it is a complex and dynamic process that involves ethical, moral, legal, and social ramifications. As Curry et al. have summarized: "It has been established that attitudes toward PAS (Physician Assisted Suicide) are shaped by multiple factors, such as the physician's demographic and personality characteristics, personal values, religiosity, respect for patient autonomy, fear of litigation, and experience with terminally ill patients. However, the complex interrelationships among these factors are not well understood" (Curry et al., 2000, p. 338). As such, a qualitative study may help elucidate the linking of these factors to allow a more holistic understanding of the process within the current Canadian context.

A qualitative study that looked at the most significant contributing factors to conscientious participation found that key factors included: professional identity and values, personal identity and values, experience with death and dying and organisation context (Oliphant & Frolic, 2021). Although these factors influence a providers' involvement in MAiD, it would be useful to understand the impacts of providing MAiD given that participation is an act of conscience. Understanding the positive or negative implications for practitioners would help determine how best to modify training and how to improve policy.

Brown et al. (2021) investigated the endogenous and exogenous factors influencing non-participation in MAiD. The endogenous factors that influenced non-participation included the impact of 1) previous personal and professional experiences, 2) comfort with death, 3) conceptualization of duty, 4) preferred end-of-life care approaches, 5) faith or spirituality beliefs, 6) self-accountability, 7) consideration of emotional labor, and 8) the future emotional impact (Brown et al., 2021). This study highlighted the influence of personal feelings and experiences of physicians and nurse practitioners on their willingness to engage in MAiD practice. The exogenous factors influencing non-participation were related to: 1) the healthcare system they work within, 2) the community where they live, 3) the current practice context, 4) how their participation choices were visible to others, 5) the risks of participation to themselves and others, 6) time factors, 7) the impact of participation on the patient's family, and 8) the patient-healthcare provider relationship and contextual factors (Brown et al., 2021). This study shed light on the impact of external factors that influenced healthcare providers regarding their willingness to participate in MAiD practice. Both endogenous and exogenous factors are crucial in understanding the complexities of individuals' willingness to take on the role of a MAiD provider.

## 2.7 Impact of MAiD on Providers

Other studies examined the impact of MAiD provision on healthcare providers (McKee & Sellick, 2018), explored challenges in integrating MAiD into existing health systems



(Fujioka et al., 2018) and investigated the experiences of formal healthcare providers with MAiD provision (Ward et al., 2021). Key themes such as the emotional impact, regulatory challenges and the importance of team support consistently occurred across the various studies. Brassolotto et al. (2023) examined MAiD provision in rural Alberta, highlighting themes related to the unique challenges of providing MAiD in a rural setting. It is crucial to understand the impact rurality can have on MAiD practice due to challenges related to access, resources, and availability of providers.

Another qualitative study conducted prior to the introduction of Bill C-7 looked at the experiences of physicians who participated in assisted dying. This Canadian study revealed three encompassing themes: “1) rediscovering the art of medicine, 2) unexpected rewards, and 3) negotiating risks and challenges” (Beuthin et al., 2020, p. 1). In a more recent study by Beuthin et al. (2023), the existential lived experience of eight physicians providing MAiD was examined. The study highlighted the significance of embodied emotional language and utilized narrative accounts to convey the depth of emotion, sincerity and compassion involved in the process. This work is significant because it delves into the emotional aspect of MAiD practice, emphasizing the importance of comprehending the nuanced language used to describe the experience. While these studies contribute to our understanding of the MAiD experience for providers, ongoing analysis is essential due to the significant shifts resulting from recent legislative changes and updates in its practice over time.

## 2.8 Synthesis of Literature: Current Understanding of Providers' Experiences

Scoping reviews are used to map the key concepts in a research field with the aim to explore the breadth of literature and summarize available evidence. They can serve as a precursor to systematic reviews, identify available evidence types, analyze knowledge gaps, clarify concepts, examine research methodologies, and identify key factors related to a concept (Peters et al., 2017). A scoping review of over 170 articles by Variath et al. found that “addressing the needs of family members and healthcare providers is vital to

improving the assisted dying process” (p. 1501). The researchers found that five themes occurred that influenced the providers’ experiences including 1) relationships being central to starting the process, 2) social and political influences on making decisions, 3) complex roles and responsibilities, 4) the unique experience of death and 5) varying experiences following death (Variath et al., 2020). Since this study, there have been legislative changes with the addition of Bill C-7 as well as a worldwide pandemic.

There have been a few notable scoping reviews on the topic. Brooks (2019) conducted a scoping review to synthesize literature from various countries, highlighting healthcare providers’ experiences in the MAiD process. The key themes elucidated include recognizing MAiD as a complex process, emphasizing the importance of relationship and communication, and outlining coping strategies for the emotional impacts inherent in MAiD work. Fujioka et al. (2018) explored barriers to integrating MAiD into existing healthcare systems. Their review identified six categories of implementation challenges including regulatory, legal, social, logistical, financial and harmony with palliative care. Similarly, Ward et al. (2021) conducted a scoping review of healthcare providers' experiences with MAiD provision and highlighted the providers’ emotional experiences, reinforcing the need for team support and self-care strategies to mitigate the psychological impact. In summary, these scoping reviews emphasize the importance of creating supportive environments for healthcare providers involved in MAiD work.

Additionally, two systematic reviews were identified on the topic. Systematic reviews help to summarize a large body of evidence and help to explain the differences between studies on the same question resulting in increased precision of the results (Gopalakrishnan & Ganeshkumar, 2013). Dholakia, Bagheri, and Simpson (2022) conducted a systematic review of qualitative studies from April to August 2021, revealing three descriptive emotional themes among healthcare providers involved in MAiD: 1) polarized emotions, 2) reflective emotions framing MAiD as a "sense-making process," and 3) professional value-driven emotions. Similarly, Patel et al. (2021) synthesized primary qualitative research articles on the topic and identified seven distinct domains providers considered when responding to MAiD inquiries including: 1) policies,

2) professional identity, 3) commitment to patient autonomy, 4) personal values, 5) the patient-clinician relationship, 6) the hastened death request, and 7) the provider's emotional response. These systematic reviews shed light on the emotional and ethical complexities inherent in MAiD work, contributing to the understanding of its unique challenges.

## 2.9 Impact of COVID-19

It is important to acknowledge the impact COVID-19 may have had on the research findings as the pandemic resulted in changes to how healthcare was delivered. As per Wiebe et al., 2021, providers and coordinators faced hurdles in offering MAiD due to the pandemic related restrictions and personal protective equipment requirements, noting heightened patient suffering. Telemedicine and virtual healthcare proved instrumental in mitigating some of the challenges and changed the way care could be accessed (Wiebe et al., 2021). Tremblay-Huet et al. describe the impact of the pandemic on MAiD in a qualitative study of fifteen Canadian providers, describing that providers did not always follow public health rules due to the implicit exceptionality of the MAiD context (Tremblay-Huet et al., 2020). The impact of COVID-19 on the lived experiences of the interviewed physicians is discussed to some extent. However, as the research did not specifically focus on this as a topic, future research could delve deeper into this aspect for a more comprehensive understanding of the impact of the pandemic on MAiD provision.

## 2.10 Summary

Involvement in MAiD is intrinsically emotional work that requires empathic resonance while dealing with suffering, grief, and death. Providers share an intimate experience with families as they navigate end of life questions and the complex psycho-social-medico-legal practice that is MAiD. Studies on MAiD in Canada are still relatively new primarily because of the recent decriminalization and ongoing legislative changes. Based on the literature, there exists a clear gap in understanding the impact of the recent legal and procedural changes regarding MAiD within the contemporary Canadian context. This

research will fill that gap by aiming to understand the impact of MAiD for providers to allow for deeper insight into the overall procedure, which ultimately may help improve the process for all involved.

## Chapter 3

### 3 Methodology

This chapter describes the qualitative study design used to examine the experiences of community physicians who provide MAiD. It starts with an explanation of the study design and methodology and then delves into the data collection process including participant recruitment and data analysis. The importance of trustworthiness, credibility and reflexivity in study design and implementation are reviewed. Ultimately, this research aimed to answer the overall thesis question: What is the experience of community-based physicians who provide MAiD in Canada?

#### 3.1 Research Design

Research on MAiD in Canada is relatively new due to the recent decriminalization and ongoing legislative changes. Therefore, qualitative methodology was chosen to allow for the exploration of varied participant responses to better understand the MAiD experience and contribute to the evolution of research in this field. In contrast, a quantitative methodology would have restricted the exploration of participant experiences to predefined variables and would not have allowed for the elucidation of underlying patterns or nuanced insight (Busetto et al., 2020).

Phenomenology, founded by Edmund Husserl (1859-1938), encompasses both a philosophical framework and a research methodology. As a method, hermeneutical phenomenology emphasizes understanding an individual's experience within a specific context. Four existential themes guide phenomenological inquiry: temporality (lived time), spatiality (lived space), corporeality (lived body), and relationality or communality (lived human relations). Individuals are intricately connected to their environments and are best understood within their contexts. Existence, or being in the world, is imbued with meaning, with a central focus on the lived experience (Morse, 2012). In this definition, lived experience refers to the first-hand accounts and impressions or knowledge gained by the experience. The experience is reflected on after it has been lived through rather

than while it is ongoing. The overall goal is to understand the essence of the experience where the experience is presented as a descriptive narrative in a way that both the subjective and objective components can be appreciated (Bevan, 2014, Given, 2008, Groenewald, 2004). Ultimately, phenomenology seeks to uncover the significance of the lived experience. In this research, a qualitative study design using a phenomenological approach was used to understand the essence of the lived experience for community physicians who provide MAiD.

Phenomenology focuses on the essence of lived experiences as described by participants to make sense of and interpret their experiences. This allows for the elucidation of rich descriptions of subjective experiences to create a theoretical construct (Morse, 1994). In contrast, qualitative descriptive studies provide a more surface level description of the experience (Sandelowski, 2000, Morse, 2012). In this topic, a qualitative descriptive study would summarize the superficial understanding of MAiD providers to capture the basic features and characteristics of the phenomenon without diving deeper into the underlying meanings or interpretations. Ethnography seeks to understand the characteristics of a particular social context (Morse, 2012). For the research topic, this would have required an observational method necessitating the researcher's presence during MAiD provision to observe and document the beliefs, values, and practices of MAiD providers. Of course, this presents significant ethical challenges. Grounded Theory aims to develop a theory of how individuals and groups collectively derive meaning and engage in interactions. Applied to the topic, the purpose would be to develop a theory about MAiD providers to explain their experience (Morse, 2012). Case studies involve the selection of a small number of cases to understand the relationship between a phenomenon and context. This usually involves participant observation, field notes, interviews or focus groups and data coding guided by prior questions of theory to inform detailed understanding and comparison (Morse, 2012). In the current topic, there was no preconceived theory established about MAiD provider experiences, rather the goal was to understand the nuanced experiences of participants without any predetermined biases.

## 3.2 Participant Recruitment

Purposive sampling was used to recruit a sample size of 12 community physicians from Southern Ontario (Etikan et al., 2016). Purposive sampling was needed as the goal of the study was to understand community provider experiences with MAiD. The recommended sample size for phenomenological studies has been anywhere from 5-25 participants to achieve saturation (Creswell, 1998, Morse, 1994). The existing literature on qualitative studies examining the provider experience with MAiD includes participant numbers ranging from 8 to 30 (Appendix B). The sample size of 12 participants was felt to allow a robust enough sample size to draw accurate and holistic conclusions while not losing the nuance in the data. It was found that after the twelfth interview, any additional data would be redundant. Therefore, the research team (RC, SLS, GK) deemed the sample size to be sufficient (Thorne, 2020, Vasileiou et al., 2018). Data saturation is the point in qualitative research where new data does not provide additional insights, whereas data sufficiency refers to having enough data to address the research question thoroughly. Sufficient data means having enough rich and detailed information to understand the phenomenon under study thoroughly (LaDonna & Artino, 2021).

Physician providers were recruited from multiple cities across Southwestern Ontario. Recruitment occurred by email and telephone (Appendix C and D) by contacting known MAiD community-based physician providers through established networks via telephone and email and inviting them to participate in the study. These networks consisted of the local MAiD teams established in each health jurisdiction. Verbal and written consent was taken prior to conducting the interviews.

The inclusion criteria included participants that were English speaking licensed community-based Ontario physicians who had directly assisted with MAiD for at least one year. Participants were excluded if they did not practice in the community or as family physicians at some point of their career. The participants' gender, practice size, demographic (rural versus urban) and personal religious beliefs and affiliation were recorded to allow for objective analysis of participant characteristics (Table 2).

The investigator explained the nature of the research and provided each participant with a letter of information and consent form (Appendix F) to sign prior to conducting the study.

### 3.3 Data Collection

Semi-structured interviews were conducted through video teleconferencing using Western University's licensed version of *Zoom* by the primary researcher (RC). An open ended semi-structured interview guide was used to organize the interviews while allowing for flexibility and further exploration of findings. The interview guide was created by the research team and pre-tested with an external community physician for feedback on clarity and thoroughness. The interview style was conversational and non-interventionist with the only structure coming from the interview guide (Appendix B). The interviews took place between March to September 2023 and lasted an average of 30 minutes but varied in length from 20 to 60 minutes. Interviews were audio recorded and stored on a secure server. Transcripts were anonymized and created verbatim by a professional transcriptionist. The primary researcher (RC) also recorded field notes during the interviews to ensure the full depth of the interviews including the emotional and tacit findings; these were included in the analysis.

### 3.4 Data Analysis

As is typical with qualitative studies, the data was collected concurrently with the data analysis. The research team consisted of the primary researcher (RC) and two additional investigators (SLS and GK). Using an iterative and interpretive approach, interviews were recorded and analyzed first by the primary researcher (RC) and after three interviews, by the investigators (SLS and GK). Initially, the research team independently reviewed transcripts to determine key codes within the transcripts. The team then met to share findings, amalgamate codes, and delineate themes. RC coded all 12 interviews and SLS and GK coded four interviews each. Field notes created by the primary researcher



(RC) during each interview helped to illuminate the emotive response by participants to ensure this tacit knowledge was not lost in the transcripts. The field notes influenced the selection of the exemplar quotes, facilitated preliminary coding and complemented data collection and analysis by providing greater context to the data (Phillippi & Lauderdale, 2018). This is because the field notes recorded the emotions expressed by the participants during the interviews as well as those felt by the primary researcher (RC). Certain participant responses were expressed with heightened emotion and elicited stronger emotional reactions. These instances were documented in the field notes to capture the nuanced aspects of the experience.

An inductive or “ground up” approach was used as the data drove the analysis as opposed to utilizing a deductive approach that tends to be framework driven. The inductive approach offers flexibility in allowing themes to develop organically versus being confined to a specific predetermined structure (Braun & Clarke, 2006). In the context of phenomenology, this approach enables a detailed exploration of the lived experiences of MAiD providers without the need to evaluate pre-existing theories (Morse, 2012). The transcripts were analyzed using inductive coding to develop the overall understanding of the lived experiences of MAiD providers. This allowed the condensation of the raw interview data into a summarized format to better establish links and themes without restraint versus structured methodologies that may have been limiting (Thomas, 2006). By the twelfth interview, no new codes were being generated and as there was informational redundancy, it was felt that sufficient data had been obtained to provide a detailed and thorough understanding of the lived experiences of the participants. These insights were synthesized into main themes and then further organized into three levels encompassing the individual, local and system domains (Saunders et al., 2018).

### 3.5 Trustworthiness, Credibility, Reflexivity

The Standards for Reporting Qualitative Research Report helped inform the study design to ensure the trustworthiness and credibility of the research (O’Brien et al., 2014). Each interview was recorded and professionally transcribed verbatim. This helped increase the

accuracy of the data collection. After each interview, the researcher recorded field notes to allow for inclusion of emotions and tacit findings to enhance the richness of the transcription. An iterative approach was used with each researcher initially independently analyzing the transcripts followed by team examination to amalgamate the results. Exemplar quotes were used to substantiate and highlight the key findings.

Reflexivity involves understanding the relationship the researcher may have with the participants and the effect this may have on the data collection and analysis as a whole. In qualitative research, it is especially important to take into account the researcher's own biases and contextual factors throughout the research process. Reflexivity increases transparency by honestly considering how past experiences, values or bias shape research through interpretations and assumptions (Creswell and Creswell, 2018).

The primary researcher, RC, is a family physician who is a proponent of MAiD, however, was not involved with MAiD assessment or provision at the time of the research study; this minimized potential bias. Reflection was used as a means to minimize the influence of any personal biases or judgements and ask questions neutrally to allow for in depth and nuanced data to be collected. The research team also included GK and SLS. GK is a family physician, Associate Dean of Admissions at a major medical school and has prior experience with MAiD provision through his palliative work. SLS is an experienced academic researcher in qualitative research and an Associate Professor in the same institution. SLS does not have any experience of assessing or providing MAiD or being involved in any MAiD related research. The diversity and variation in the research team's background characteristics helped to mitigate potential biases in the data interpretation process. The research team was cognizant to acknowledge their personal biases at each stage of the process and brought up potential issues at the research meetings. The extensive experience of GK and SLS in this type of research helped to ensure individual biases did not overtly influence the coding and analysis of the data.

### 3.6 Ethics Approval

The study was approved by the Health Sciences Research Ethics Board at Western University in London, Ontario, project identification number 122118 (Appendix F).

### 3.7 Summary

In summary, a qualitative approach was used to explore community provider experiences with MAiD. Phenomenology was chosen as the methodological framework to understand the essence of the lived experiences. Data collection involved semi-structured interviews that were analyzed iteratively and supplemented by field notes to capture emotional nuances. The data was analyzed using inductive coding allowing themes to be collected organically. The themes were then grouped into three overarching levels to capture the depth of the experience and provide holistic understanding.

## Chapter 4

### 4 Results

The purpose of the study was to understand the experiences of community-based physicians who provide MAiD in Canada. This chapter presents the demographics of the participants and discusses the key findings of the study. The main findings can be summarized as: 1) at the individual level, the deep sense of meaning that providers felt in practicing the art of medicine, 2) at the local level, the practical and team-based resources that need to be considered and 3) at the system level, the organisational and legislative components that impacted the experience for providers.

#### 4.1 Participant Demographics

The final sample consisted of 12 participants of which half identified as female ( $n=6$ ; 50%) and half as male ( $n=6$ ; 50%) (Table 1). The ages ranged from 25 to 77 years with diversity amongst the age groups (mean age 46-55 years). Most participants ( $n=10$ ; 83%) were Caucasian. Half practiced in a rural location ( $n=6$ ; 50%) while the other half practiced in a suburban ( $n=2$ ; 17%) or urban setting ( $n=4$ ; 33%). The years of experience as a family physician varied from a minimum of one year to greater than 50 with diversity in this category (median 11-20 years). Years of experience with MAiD provision varied from one to eight with most participants having more than four years of experience (median of 6-7 years).

**Table 1:** Participant Characteristics

All participants were community healthcare providers practicing as family physicians for some part of their career ( $n = 12$ )

Characteristics	
Gender, $n$ (%)	
Male	6 (50)
Female	6 (50)
Age range, $n$ (%)	
25-35	4 (33)

36-45	0
46-55	3 (25)
56-65	2 (17)
66-75	2 (17)
76-85	1 (8)
Racial background, <i>n</i> (%)	
Caucasian	10 (83)
South Asian	2 (17)
Geographic Location in Southwest Ontario, <i>n</i> (%)	
Rural	6 (50)
Suburban	2 (17)
Urban	4 (33)
Years of experience as a family physician, <i>n</i> (%)	
0-10	4 (33)
11-20	3 (25)
21-30	0 (0)
31-40	2 (17)
41-50	2 (17)
>51	1 (8)
Years of experience in MAiD provision, <i>n</i> (%)	
0-1	1 (8)
2-3	1 (8)
4-5	3 (25)
6-7	6 (50)
8	1 (8)

## 4.2 Key Findings

Through inductive analysis of the interviews, ten themes were found, which were grouped into three overarching levels to understand the participants' lived experiences with MAiD provision (Table 2: Summary of levels and themes). At the individual level, providers felt a deep sense of meaning in the work and in practicing the art of medicine. This was exemplified by three themes: 1. the gratitude they felt in supporting patients at the end of life, 2) the privilege in helping patients die with dignity, and 3) the ability to extend how they practised patient-centered care. At the local level, providers addressed important practical considerations of their work characterized by three themes: 1) the availability of multidisciplinary support, 2) the added complexity of geographical barriers and, 3) the impact of MAiD work on time and practice management. At the system level, providers navigated organizational support and legislative barriers, which was captured in

four themes: 1) the benefit of national organizations, 2) the training support needed, 3) the concerns with existing legislation and, 4) the difficulty with track two cases. Overall, the levels and themes capture a holistic understanding of the lived experiences of community family physicians who provide MAiD.

**Table 2:** Summary of levels and themes.

<b>Level</b>	<b>Themes</b>	<b>Description</b>
At the <b>individual level</b> , providers find a deep sense of meaning in the work and in practicing the art of medicine.	<ol style="list-style-type: none"> <li>1. Gratitude and privilege in supporting patients at the end-of-life</li> <li>2. Providing patients with dignity and relief from suffering at the end of life</li> <li>3. Extension of patient-centred care</li> </ol>	<p>This level highlights the internal factors that influence providers' engagement.</p> <p>All providers shared incredibly meaningful patient experiences that reinforced their participation in MAiD. They felt this work provided fulfillment and some felt this work contrasted the burnout that can be prevalent with the day-to-day challenges of modern family medicine.</p>
At the <b>local level</b> , providers navigate important practical considerations of their work.	<ol style="list-style-type: none"> <li>1. Availability of multidisciplinary team support and preparation challenges</li> <li>2. Geographical barriers</li> <li>3. Impact on time and practice management</li> </ol>	<p>This level highlights the practical day to day considerations that impact practice management.</p> <p>All providers commented on the practical considerations of providing MAiD. Their experience is influenced by the preparation process, proximity to local supports and ability to navigate competing schedules.</p>
At the <b>system level</b> , providers navigate organizational supports and system level barriers.	<ol style="list-style-type: none"> <li>1. Access to organizational supports</li> <li>2. Training support</li> <li>3. Interpreting law/legislative concerns</li> <li>4. Difficulty with track two cases</li> </ol>	<p>This level focuses on the impact of structural elements including provincial, and national resources.</p> <p>All providers touched on the benefit of organizational and mentorship programs. These supports helped navigate the changing legislation and guidelines. There was an emphasis on difficulty with track two cases, especially in the absence of these external supports.</p>

## 4.2.1 The Individual Level

### **Theme 1: Gratitude and Privilege in Supporting Patients at the End of Life**

All providers touched on the rewarding aspects of participating in MAiD. They felt immense gratitude for the privilege in helping patients at the end of life with great meaning in the service. As summarized by two participants, *“you got a lot of gratitude for this work”* (Participant 2), *“I think it’s been a very positive experience. I find it very fulfilling”* (Participant 10). Participants felt that being involved with MAiD was, at times, *“a lot more rewarding than some aspects of family medicine”* (Participant 3). This was due to the ability to help patients in a tangible way, whereas in family medicine many times there is no one diagnosis or single answer. In addition, patients may not always want to see their family doctor but are brought by parents or loved ones to seek support. As one participant described, *“...every single patient that you see wants to see you, which you can’t really always say with family medicine, in general, I believe”* (Participant 1). Participants described the gratitude and acknowledgement they felt from patients in having the option of MAiD: *“And everyone is so thankful... before the provisions, people saying just, “Thank you” and to be able to offer that kind of mercy to someone is really I think an unbelievable part of our profession”* (Participant 8).

Participants described a feeling of privilege in being entrusted with the care of patients in their last moments of life. This was in part due to the act of relieving suffering: *“And then the other part, of course, is the amazing privilege to be involved with people’s lives at the end of life and to provide care and the ability of choice to alleviate suffering”* (Participant 7). But also, in the gravity of being present with someone during their final moments: *“The other thing that is just always so humbling is when the last words that somebody says, not necessarily to their family, but they turn to me and say, “Thank you.” It’s like, whoa, yeah, you’re welcome”* (Participant 7). Providing MAiD can thus be a profound experience in human connection and personal fulfillment. Universally, participants felt MAiD offered a better way to die and felt honoured to be a part of that process.

So, I just find it an incredibly rewarding experience. I got into this because I believe people choose to live the way they want and can choose to die the way they want. And nobody can argue with me after six years of doing this that MAiD isn't a better way to die. It is a better way to die, without a question. And every patient and family... will express that. (Participant 4)

## **Theme 2: Providing Patients with Dignity and Relief from Suffering**

Participants described how MAiD can help patients alleviate suffering by offering a choice and opportunity for a dignified death. *“But also, fundamentally I believe that this is something that people should be offered. We do it for animals all the time... I am okay with sitting with the decision that this person's suffering, this person wants this, and that ultimately, I'm providing them a relief of their suffering”* (Participant 12). Participants detailed examples of how MAiD can offer patients an alternate way to approach their end of life in a more autonomous way and one that also offers a sense of freedom and liberation. One participant described a memorable moment highlighting the experience for their patient:

So, we drove out to this gentleman's house, and he was having a party... And they were having a celebration of life with him still physically alive... it was still very emotional for the family at the time of the procedure and everything like that, but I think when you think of MAiD... is that you think that you're walking in and someone is... unable to fully speak, just writhing in pain, writhing in suffering. But really there's also that existential component and it gives people a chance to have their way of saying goodbye. So, I think that was kind of a good experience because it gives the flip side of the coin to what kind of stereotypical thing that people think about it. (Participant 3)

Suffering at the end of life is complex in that it involves physical pain but also includes the emotional, spiritual, and existential crises that patients face. Providers felt MAiD



offered choice and another option of reducing suffering. There was a strong belief in patient autonomy and the right to self-determination. *“Simply having the ability to deal sort of honestly and forthrightly with dreadful circumstances in many instances, where previously our hands have been tied” (Participant 6)*. MAiD provided another option, so patients felt less helpless in what their end of life would look like: *“Most people... feel like they have absolutely no control... but having that sort of process completed, knowing that it was available, restored a sense of dignity and control to them. And they go on with other things. Where their time before had been totally taken up by this hopeless, helpless feeling that there was nothing they could do” (Participant 6)*.

Many participants felt that MAiD was not an alternative to good palliative care but an extension of palliative care in that it offered additional options at the end of life. Participants felt that some patients had such a degree of suffering that palliative care options were not enough to ease the distress. As one physician described: *“I see this as just another tool in the palliative care toolkit, certainly for those track one patients. So, I feel positive about it. I think it’s quite important (Participant 2)”*. As such, MAiD offered another route for clinicians to consider in their arsenal of options for care at the end of life.

I would say that I see MAiD as an extension of palliative care, as an option that should be provided to patients and I find that in my experience it’s primarily used by individuals who, despite you know all the pain medication, anxiety medication, supports socially, medically, there are some individuals whose level of suffering simply can’t be alleviated to their satisfaction; and thus I certainly can understand why some people would want to pursue it, so I really do look at it as an extension of palliative care actually. (Participant 11)

### **Theme 3: Extension of Patient-Centred Care**

The patient-centred clinical method involves an approach that takes into consideration the individual patient context including patient values and beliefs to come

to a collaborative understanding (McWhinney & Freeman, 2009). Participants felt that MAiD is an extension of patient-centred care because it involves knowing the person as a whole and their individual situation to provide care. The physician providers described how understanding the individual context was valuable in aiding their assessments and provisions. It allowed for a deeper appreciation of the reasons behind the patient's decisions. This process involved meeting the patient in their homes and meeting with their loved ones beforehand. This aided in a deeper and holistic understanding of the patient and how they wanted their end of life to look like. In fact, understanding the patient's context opened the doors for a meaningful discussion around death as the provider already acknowledged the patient's medical and social history.

I try to learn as much about the person, both from their disease process and a personal perspective, so that I get a picture of them early on. And then I can have some really great conversations without having to waste a lot of time understanding them. And I think they all appreciate doing that for them – that the conversation then can become very focused on what they want to talk about, and not wasting their valuable time repeating things they don't want to repeat anymore. They don't want to talk about their cancer anymore – every time they go to the Cancer Centre, they're asked a thousand questions by residents and the students and stuff – they don't want to do it anymore. They want to talk about providing for them and how they want to die. (Participant 4)

Participants also felt that providing care to patients in their own homes aided their contextual awareness and overall understanding of disease processes in medicine and particularly in their individual communities.

Professionally, I think it's actually expanded my understanding of some diseases or what it's like for some people out in the community because we actually see these people in their own homes with their own families, whereas we don't do a lot of house calls unless people are really sick. So, I think it's given me a broader perspective on the population. (Participant 8)

There was also an added benefit of participants being community providers as this allowed them to know patients in their family practices and thus understand them on a deeper level. Providers felt that being family doctors also helped make the process easier for them as there was already some contextual understanding.

If anything, assessing and providing for my own patients is actually ...easier because you have thorough documentation and just so many conversations with them over time that this is what they want. So, if anything, providing and assessing [my] own practice is even easier in my opinion. (Participant 3)

Due to this prior understanding of patients and their contexts and histories, some participants felt that care would be expedited if more family doctors were involved in MAiD related care. Family physicians would be best positioned to provide patient-centred care due to already established therapeutic relationships and contextual understanding.

But I feel like family physicians, we know our patients very well and we would know if something's coming out of thin air or if something has been like, "Yes, this is absolutely your personality." And I feel like assessments would be faster and more timely and everything... [would be] expedited. It would expedite care if more family physicians would be willing to do it for their patients. (Participant 3)

### **Summary of the Individual Level**

Overall, participants felt a deep sense of meaning in their work and in practicing the art of medicine. They described the gratitude and privilege in supporting patients at the end of life by offering choice and dignity. The experience of being present during a patient's final moments was especially meaningful. Participants felt that MAiD was intrinsically an extension of patient-centred care as it involves understanding the patient as a whole in their individual context. For this reason, they also expressed that family

doctors are well suited for MAiD related work due to their already established patient and family connections and understanding of contextual factors. All providers shared significant patient experiences that reinforced their participation in MAiD due to these reasons.

#### 4.2.2 The Local Level

##### **Theme 1: Availability of Multidisciplinary Support and Preparation Challenges**

All providers reflected on the importance of local team support. The benefit of having local support helped providers feel confident with their assessments and helped patients receive timely care. For example, one participant commented: *“I have a number of colleagues that I can just call any time, whether it's to bounce case details off someone, I can do that. If I need a secondary assessment real fast, there's a number of people I can call and we can usually arrange for a quick virtual secondary assessment if that's what the patient needs” (Participant 1)*. One participant reflected that local supports are so vital for their ability to provide good care that without this support, they would not feel comfortable being involved in MAiD work: *“I don't think I would want to do this if I was just on that list, where people can call in and you're not supported and you don't have the people to help you coordinate. I actually don't think that is ideal care and a coordinated team is really important” (Participant 8)*.

The additional benefit of team support is the added expertise that other healthcare professionals bring. For example, nurses bring their own skill set, perspectives and potential guidance for physicians.

They are nurses with the MAiD team, the nurses will think to ask questions... like, “Did I miss anything, anything you think you'd want to ask” and they're really skilled at asking those things. Or they know some more than the nursing aspect issues and are more in tune with what's available with the LHIN (local health integrated network) services. So, what we could get in place until MAiD.

So yes, there was a nurse with me yesterday, I would never want to do it alone.  
(Participant 8)

When these supports are not available, it makes the ability to provide timely care more difficult. Further, there is added administrative burden on arranging this support when it is not readily available in the community:

And then from the negative perspective I do think it's an administrative difficulty, for sure, that we're going to have to secure the nursing for this. Primarily, that's the most difficult thing. Yes, it can be difficult to arrange the assessments and the provision dates with our busy schedules, but I would argue securing the nursing by far is the most difficult. (Participant 11)

Participants expressed the importance of adequate procedural preparation in their work. For instance, IV set up was a large component of this preparation as it could potentially ease the process or make it more difficult. As MAiD provision is inherently a meaningful and profound moment for patients that ultimately results in their death, providers reflected on the importance of optimizing the preparatory steps. *"I anticipate all the things that can happen and then make sure I try to mitigate those things"* (Participant 4). Some participants found additional steps in preparation helped the process go more smoothly for them. An example of this is using heating pads to help with IV access. *"But mainly it's less difficult because I've discovered that it pays huge dividends to warm your patients up for half an hour before they come"* (Participant 2).

The rapid timeline associated with MAiD provision necessitates this procedural consideration. One provider exemplifies the importance of preparation with their experience. This example shows how the preparation is integral to the experience for the patient, family, and provider:

We thought that we weren't going to be able to get it, but just at the last moment, with a saline flush suddenly the IV was well established into the neck vein... And

during the procedure itself, the patient, realising the difficulty of the situation, had her hand placed on my face as though I was administering the drugs as a gesture of gratitude. So that just sort of randomly comes to mind. There's been many, many other memorable cases that have been very positive. (Participant 1)

Providers shared their individual preparation procedures and due diligence that they have improved upon over time to help with their confidence and overall ability to provide the patient a smooth experience. Again, due to the nature of the work and ultimate outcome, participants reflected on even the mundane preparation as a needed and important step in the overall process.

Well, really... due diligence is the preparation. Once I learn that a patient... has requested a procedure, I make sure that I have all the documents in place... I then check over my notes and I remind myself what we're anticipating for venous access for this patient if we're doing the procedure in a non-hospital site. And [I] make sure that I've ordered the medications, make sure that I've sent the order for the nurse attending, that's required. So, really, I just go through a full due diligence, that's how I prepare for any MAiD case. And if you go through proper due diligence, then you're going to have the confidence to go ahead with it. (Participant 1)

Participants also reflected on the changes they have made to this preparation over time. One participant reported how focusing on the smaller details prior to the procedure can help mitigate challenges and improve the process overall. The preparation helped them counsel patients and their families better as there were more clear expectations from the outset.

I mean there's subtle little things you do differently. I certainly ask for more information from families than I ever did at the beginning. And I always got their medical records but now I get more family stuff... I think now I'm really good at

anticipating what they want to know, and I can put that as part of the process. So, for example, subtle – little things like they want to know does it cost anything, so I can tell them that early on. And I can say to them, look, your death certificate will have this on it – it has nothing about assisted dying – there’s no impact on the legal process and life insurance, and you can just see huge relief. I anticipate those questions that they have, that they may not want to answer – or ask. (Participant 4)

Medication choices were another important consideration for providers. Participants shared their experiences with using MAiD medications and how they made improvements in how they used these medications over time. One participant shared that medication choices have a drastic influence on the experience *“Like the propofol if you push it, it’s just whoa. So, the midazolam, you just kind of drift off and that’s been a change with our team using the midazolam because of that”* (Participant 8).

## **Theme 2: Geographical Barriers**

Access to MAiD can be dependent on the geographical location of patients and providers. Participants reflected on the challenges of working in a rural location where there were only limited providers, which added more stress on the system and burden on the individual providers. *“But that’s the big problem right now is that there’s just a few of us doing it and we do the vast majority of it”* (Participant 2). Increased rurality also increased complexity, as one participant summarized, *“I think the only take-home I have is to make sure that if anybody is doing any assessments around provision and medical assistance that they understand that there’s a difference in a rural lens. And that what works in the urban areas doesn’t necessarily work in the rural areas or the remote area (Participant 7)”*.

As supports are harder to access in a rural location, providers felt more isolated in their work. One participant who worked in a rural setting described, *“We don’t have a great community of experts other than if I occasionally talk to the nurse practitioner navigator*

*or something through the LHIN (local health integrated network).” (Participant 5).* Another participant also living in a rural area reiterated, *“So I think partly because we’re sort of isolated in the peninsula, we’ve been working on a much more individual basis than say in [the city] where they’ve had formal organization. Really, I’ve been working on my own” (Participant 2).* Another participant also discussed how the decision to be involved in MAiD work was influenced by the lack of providers in the area. *“The [rural] area is incredibly lacking in people and physicians who are willing to provide such a procedure. And then it kind of came down to the situation of, okay, well, I’m able, I’m willing, so if it’s a need you kind of fill that need. And I think the statistic is something like every year it grows by about 40%, which is quite significant” (Participant 3).* Rurality significantly influenced the disparities in support and overall experience reported by participants.

### **Theme 3: Impact on Time and Practice Management**

Family physicians have felt the added stress of administrative burden in their practices. In a recent survey by the OCFP (Ontario College of Family Physicians), ninety-four percent of family doctors reported they were overwhelmed with administrative work (OCFP 2023). All participants acknowledged this stress and shared that MAiD practice in contrast felt less tedious and more impactful:

So, I find the [MAiD] work itself to be very meaningful and you feel very efficacious in a way that a lot of family practice doesn’t lend itself to. Particularly, over time I’ve seen family practices change where it’s become much more administrative. You know, we used to deal with a lot of things ourselves, and now it seems you do a lot of referrals. So, I actually found that increasingly I wasn’t enjoying family practice so much. (Participant 2)

Participants shared their feelings about family medicine becoming more complex with increasing responsibilities and as a result, more burnout:



So, I think one of the big hurdles currently is the fact that family medicine is overburdened and overburdened with administrative responsibilities. I think the expectations that family practice has for all the things that they have to do and are responsible for, they just can't. The reason that family doctors are burning out and, like me, leaving is because we're done. We're done. It's like, I love taking care of patients, but when I spend most of my time doing administrative work and a lot of it unpaid, but yet expected, it's just intolerable. And so, they can't add anymore to their plate. Which is why they're not taking care of their palliative patients anymore, why they're not doing home visits anymore, and why they're not taking up MAiD. It's a clearly broken system. (Participant 7)

In fact, some participants felt that MAiD work also added to the administrative burden due to the additional demands on their time. As one participant described, *"I didn't realize how much administrative burden there actually is involved with [MAiD], in terms of it being actually very challenging at times to book provisions when patients want them and when I'm available because again I do palliative care and family medicine"* (Participant 11).

Participants reflected on the impact of MAiD work on their existing community family practices. They shared the added stress of trying to manage additional responsibility with their already busy schedules:

My colleagues and I still have day jobs. This isn't the only thing we're doing; I'm trying to run a family practice and do all these other things... I think, if this was your only job, then yeah, you could deliver the kind of flexibility that might be aspirational. But I must also manage my own practice. And I look at this as sometimes competing time pressures. I think once I've met someone or been able to assess the urgency, then it is not difficult for me to sacrifice a day of clinic or something to make sure we get it done. (Participant 5)

To mitigate this added stress, some participants had transitioned from full time to part time family medicine. One semi-retired physician described, *“I mean, I didn’t have that much time to do this work when I was in full-time family practice and I think that’s a big barrier for folks as well, the learning curve plus the time commitment you have to organize around it”* (Participant 2).

Recently, healthcare workers had to endure the added stress of the coronavirus 2019 pandemic. Participants reflected on the changes this brought to their work. The pandemic caused its own challenges with making access to interdisciplinary team and overall supports more difficult.

Well, we are having challenges in getting nurses at the moment, and that’s been since COVID. And I don’t know if there’s any magic solution to that. We actually had our first one a couple of weeks ago where there were no nurses to put the IVs in, and so they sent the paramedics in to start the IVs. (Participant 9)

The pandemic necessitated changes in how providers adapted to their practices leading to increased use of telemedicine and caring for patients with more complexity. They had to be creative in the way care was delivered and accessed as summarized by an exemplar quote, *“Through the pandemic, things changed a lot. We saw the number of late requests and urgent requests for [MAiD] increase and the number of home provisions increase as well. So, we had to get kind of creative looking for alternative locations”* (Participant 5).

### **Summary of the Local Level**

In conclusion, participants reflected on the impact of local resources on their experience with MAiD. Increased access to interdisciplinary team and nursing support helped participants to feel more confident and supported in their work. In contrast, lack of access and geographical barriers led to isolation and posed unique challenges. Providers also shared the importance of these supports in their overall diligent preparation for cases. The

preparation itself was integral to the overall provider and patient experience. Participants also reflected on the administrative burden in family medicine and how MAiD practice fit into this reality. Recently, there were even more changes to this work due to the challenges of the pandemic, which required creativity and ingenuity to manage.

### 4.2.3 The System Level

#### **Theme 1: Access to Organizational Supports**

All participants touched on the importance of national organizational supports. The main national group in Canada is the Canadian Association of MAiD Assessors and Providers (CAMAP). Participants reflected on the benefit of group membership for added support, *“So if I need help beyond a local level, I just can reach out to the membership forum on CAMAP and post a question there and get at least ten totally different answers. So, it's all very helpful”* (Participant 1). CAMAP offered a forum for collegiality, guidance, and knowledge.

...with groups like CAMAP coming onboard early and really focusing on helping providers interpret the law, interpret things, has been great. And besides, it's probably the single most wonderful group of people I've ever been associated with. Because they're focused on one thing, right, MAiD. And so that's an incredible organisation and the amount of credibility they've developed over the four or five years is amazing, and so they've been incredibly helpful. (Participant 4)

Participants shared that they found membership very useful and felt that earlier knowledge of the group would have provided additional benefit: *“I probably would have gotten involved with CAMAP earlier, only I just didn't know about CAMAP because they're certainly a huge source of support and information”* (Participant 2). Membership in the national group provided support with challenging cases by offering a place where clinicians could ask questions about challenging cases and share collective wisdom:

I think what's been incredibly helpful is CAMAP and the webinars and the chat line that we have, where anybody can post a question. And then very quickly you can get an answer. For example, I've got a patient who wants MAiD in [City], [Province], "Anybody know a provider in [City]?" and you're connected within hours. Or people post on challenging cases and, "What would you do in this?" (Participant 9)

Although providers felt that they benefited from improved access to organizational support as clinicians, they felt there was a lack of universal support for the caregivers and families of patients. They shared that improved resources for grief counseling and family support are still needed. This is an area that still needs further advancement as exemplified by the following quote:

It's interesting because if you go to hospice there's bereavement counselling and there's grief counselling, and there's all this great stuff; and we don't have that same access for MAiD that I've noticed. So, years later you're seeing this patient – especially with family doctors, seeing the daughter or the husband... and they didn't get any supportive counselling on what to expect. And if we think about trauma and we think about post-PTSD and symptoms like that, often it's a death where there was no preparation, right? And so, when we know this is a risk factor and it happens quickly, especially with the guideline changes, why don't we have those resources for [them]? That's why I feel like we ... could develop that more with MAiD. Like automatically if you get the process, you should be connected probably with somebody who's a social worker to help the families going through the process. (Participant 2)

Participants emphasized the necessity for additional support systems for caregivers and families following MAiD provision.

## **Theme 2: Training Support**

Participants discussed the importance of mentorship and training: *“The most helpful step was a colleague of mine who was doing it already, and that she helped me with one of my patients that was asking for it. And that really was what got me into it”* (Participant 10). Access to this type of support helped increase provider comfort and confidence. This was especially important for early providers as there was no formal training or significant resources available at the time. *“Getting help to get started back in June of 2016, there was no course, there was no manual... Nobody in the [City] Hospital had any experience in it”* (Participant 9). One participant new to practice at the time of the legislation changes shared his experience as a new graduate.

My most difficult step was probably comfort. I would say [I] just did not have any exposure, obviously, as a resident in 2013 through 2015. MAiD was not something we could learn. And in our area, I didn't have a lot in the way of mentorship, we didn't have anyone else. I was not the first provider here, but I was the second among our local group. (Participant 5)

Mentorship helped provide the necessary knowledge and training needed. As one participant expressed, *“I think you simply wouldn't be able to provide without mentorship”* (Participant 11). Participants described how mentors helped them gain procedural and legislation knowledge and helped to decrease some of the fear and uncertainty with the process:

I was fortunate enough to have a mentor who I did assessments with, and I got to attend provisions, so that provided me with the education... I did my first provision with them present, which went smoothly but you know if I didn't have access to individuals who helped me it was quite a bit – it was daunting, frankly. (Participant 11)

All participants felt that MAiD education and training needed to be included in the medical school curriculum. *“The most difficult step for me was a lack of [an] actual*

*training program that's formalized to get that sort of training" (Participant 11). They felt that this education was paramount to ensure providers had the necessary knowledge to counsel patients when needed.*

And to ensure that it's part of the curriculum for both medical students and residents... I understand there are people who have conscientious objection, but understanding what the requirements are, that they must refer, that they must provide palliative care, they must not abandon their patients. And what that means as a clinician. (Participant 7)

In addition to medical student and resident training, participants also felt that education needs to be targeted to existing family doctors in the community. *"The training needs to be there for people. Until then, you've got outside of the academic centers, it's just – well, it's a few practitioners..." (Participant 2).* This type of education would increase awareness and resources available for patients at the end of life.

### **Theme 3: Interpreting Law/ Legislative Concerns**

All participants agreed on the importance of understanding the law. They felt that ambiguity with the law could result in real consequences for patients. This was especially an issue early in the process when guidelines had not been formalized. One participant described the difficulty determining the meaning of "reasonably foreseeable":

Well, I think the difficult thing at the beginning was just feeling my way into what was allowed. I mean, the first case I was involved with I was asked by a family doctor to do a second assessment on a lady with really severe Parkinson's disease. Really awful tremor to the point where she could barely sleep. It was clearly intolerable to her. And I struggled around it, and this was pre case AB where we had some definition of what reasonably foreseeable meant. So, I struggled trying to figure out what was reasonably foreseeable, was this reasonably foreseeable?... And by then the family said no, she's had enough. She ended up going to

Switzerland for MAiD and had MAiD in Switzerland. So that was difficult both from our sort of trying to figure out what the law meant at that time, and in terms of seeing this person suffering and feeling poorly about, you know, what she had to do to get the relief that she sought. (Participant 2)

Universally, participants felt that there could be improvements in how MAiD work was funded. They touched on financial remuneration concerns with one participant summarizing the consensus: *“I wish we had more support. I wish the government would recognize all the volunteer time we do as clinicians in general, not just MAiD”* (Participant 7). A big component of this was the lack of MAiD specific billing codes: *“And I also do not think that’s been recognized by the government or the Ministry as far as we do not have billing codes. And we built palliative care billing codes, there is no reason not to have codes. By now we should have a code and we do not have codes”* (Participant 8).

Participants also reflected on some inconsistencies in the law. One participant described how a patient had to be moved from a religiously affiliated hospital to her home to access MAiD, despite being eligible and having willing support from a provider:

And also, she was exhausted. She came from [religiously affiliated hospital] and had to get moved to her condo and then had MAiD that day. Again, that’s not kind, that’s not patient-centred, that’s not loving. And that’s my one biggest thing about [the] system and I really do think there needs to be law or government intervention on that. (Participant 8)

Participants were concerned with these gaps in the legislation that failed to address adequate remuneration and access to MAiD in religiously affiliated institutions:

And the Ontario legislation in particular when it became legalized, in the sense of lack of policies and procedures and supports. Even lack of billing codes. Lack of the fact that nurse practitioners don't get paid for doing this work unless they are

affiliated with an organization. Frustration with the fact that publicly funded hospitals and institutions can deny people the right to choose. Those are all very disturbing and upsetting pieces that I continue to be frustrated about. (Participant 7)

Recently, there have been more positive changes in legislation. For instance, electronic reporting to the coroner's office has made the process more efficient. *"And now we report online, we do not have to call the coroner, that has made a huge difference"* (Participant 8). It was felt that this systems level change helped providers save time and improved the process overall.

More recently, I'm sure you know, we now do report electronically for the coroner's office. It's not really MAiD law, but it is a systems approach. I've found it quite good; it's saved me time. Instead of waiting for the case investigator to phone me back while we're waiting in the patient's house, I can leave it for a more appropriate time and do the report later. So, we're actually quite pleased with the electronic reporting that we now do in Ontario. (Participant 1)

However, there was also some trepidation that continued legislative changes and oversight would increase the number of restrictions placed on providers. There was fear that too much government control would hinder practitioner autonomy.

I think the law was written well. It gave direction without restricting too much. It gave us the opportunity to interpret what reasonably foreseeable means. What's a serious and incurable disease or disability? What is intolerable suffering? What's an advanced irreversible decline look like? So, it gave us a chance to interpret it. So I think the words are still pretty good... I think I worry [that] more system-level regulations will make it worse. So, I think I know what the road is, I know what the safeguards are, I know what the guardrails are, and I know how to stay on the road. And I think more restrictions are going to potentially make it more



difficult. And may make new providers worry more because there's so much – there's too much guidance and regulation. (Participant 4)

Participants expressed concerns about the potential consequences of excessive regulations that could restrict their autonomy in selecting patient-centred options.

#### **Theme 4: Difficulty with Track Two Cases**

All participants reflected on the significant time commitment in being involved in track two cases where patients do not need to meet the criteria of a reasonably foreseeable natural death (RFND). *“They tend to be very time-consuming”* (Participant 2). Participants felt that track two cases were inherently more complex and therefore they did not have the extra time to commit to them, especially for those who had full time family medicine work already.

And I think there needs to be the recognition of that because as someone in a full time family practice who does the other work that I do, I don't have the time to actually dedicate to track two cases. It's a lot more [complex]– they say the rate for most of these people is six months by the time you are getting the extra referral. And we are responsible for that, making sure they have got all their options, they have sought all the possible care for their condition, they have had all the maximum support, you have talked to their specialists. So, it's just not something I have the time to be able to do. (Participant 8)

The added referrals and coordination for track two cases made them more difficult for clinicians:

It is the workload. It is the responsibility of what they are asking for track two that I just do not have the capacity to do... I just do not have the capacity to be responsible for making sure this one person has had all the possible referrals to all the possible clinicians to make sure that they've received a full breadth of what is

available to them. I just – I do not have the time. (Participant 7)

There was also a clear lack of comfort in assessing track two cases not only in terms of complexity but also due to the work and volume of cases because “...they are complicated assessments and often times you have to tell people that you don’t really think that they are eligible for whatever reason, or you just simply cannot get to them because the volume of people that are applying for track two is too high” (Participant 10). In comparison, participants felt that track one cases were more straightforward and easier to manage. “I am comfortable doing the track one cases, which means death in the foreseeable future. The track two cases I am not comfortable with at all yet in terms of assessing them” (Participant 3). Assessing track two patients was distinctly challenging, with providers expressing a heightened sense of complexity and burden.

### **Summary of the System Level**

In summary, provider experiences were shaped by systems level factors. These included access to organizational supports such as CAMAP, the opportunity for mentorship and training and judicial factors. Participants felt supported by CAMAP, close mentors and some positive changes in the law. However, there were concerns about lack of medical training, challenges in interpreting the law at the beginning, frustration with the lack of adequate billing codes, dissatisfaction with denial of care by religiously affiliated institutions and difficulty with track two cases. This section highlighted the system level issues impacting provider experiences.

### **Chapter Summary**

The overall aim of the study was to explore the experiences of community-based physicians engaged in providing MAiD in Canada. The chapter outlined the participant demographics and presented the key findings of the qualitative research. The main themes were synthesized into three overarching levels to facilitate a structured and comprehensive understanding of the providers’ holistic experience. These included at the

individual level the sense of purpose and fulfillment providers experienced in practicing the art of medicine, at the local level the practical considerations and importance of team collaboration and at system level, the organizational structures influencing the overall experience of MAiD providers.

## Chapter 5

### 5 Discussion

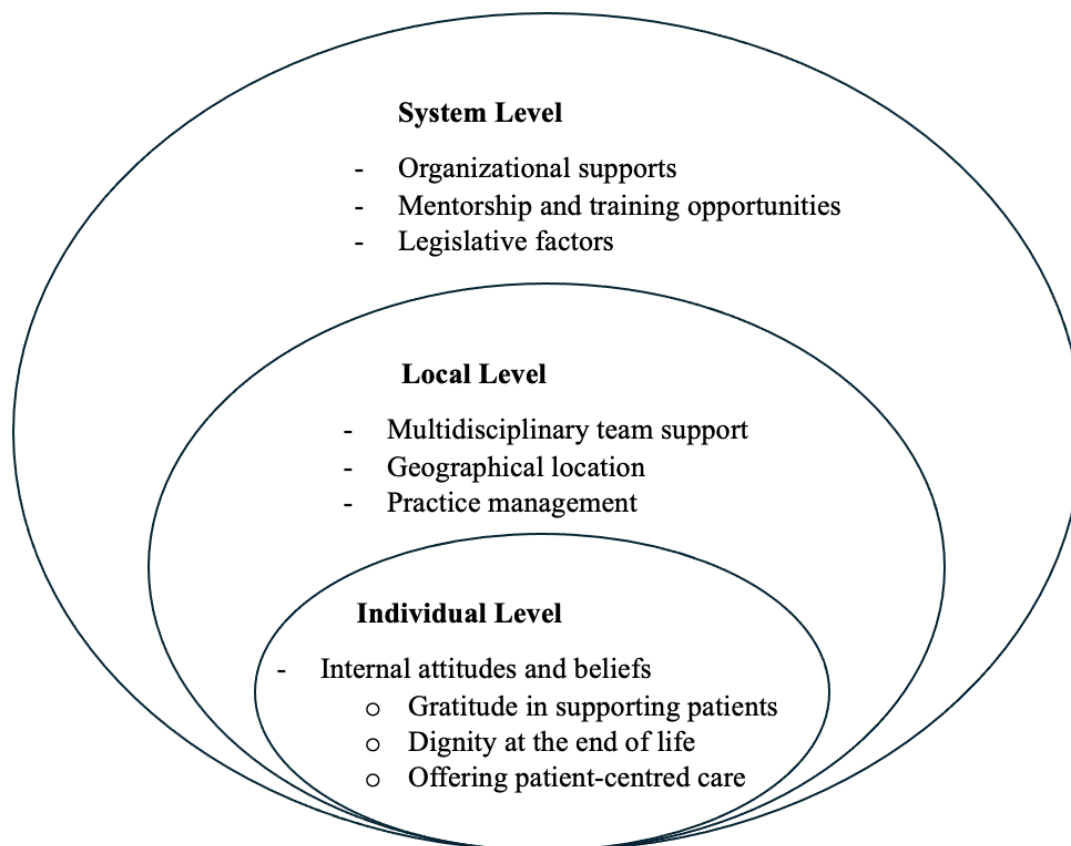
This chapter focuses on integrating and discussing the findings in relation to the objective, which was to understand the lived experiences of community physicians who assist with MAiD in the current Canadian context. The strengths, limitations and implications of the research are addressed and recommendations for future research are provided.

#### 5.1 Summary of Findings

This qualitative phenomenological study sought to understand the community physicians' lived experiences in providing MAiD. Through inductive thematic analysis it became apparent that the overall experiences by providers could be broken into three levels (Figure 1). At the individual level, the themes relate to the internal beliefs and attitudes held by the providers including the feeling of privilege and gratitude in helping patients at the end of life, offering patients dignity in dying and expanding on patient-centred care. At the local level, the themes involve the access to multidisciplinary team support, geographical location in terms of rurality, and family medicine practice burden influencing the experience. At the system level these included themes involving system level factors such as access to wider organizational supports, opportunity for mentorship and training and legislative considerations. The analysis of the different levels allows for a holistic understanding of the provider experience. The landscape of MAiD has changed drastically since its decriminalization in Canada in 2016 with updates in legislation and practice changes due to a pandemic. This study aimed to understand the community family physician experience with MAiD given these changes.

The three levels provide a comprehensive understanding of the participants' lived experiences by structuring the themes in an organized manner to understand the different factors involved. The themes interconnect across levels, influencing one another. For instance, enhanced access to team support and geographical proximity to resources can

augment providers' capacity to deliver patient-centred care, thereby improving overall fulfillment. As such, the themes are not intended to be understood in isolation or confined to one level. Rather, the integration of each level allows for a comprehensive understanding of the participants' lived experiences.



**Figure 1:** Framework of the levels that influence the community physician experience.

### 5.1.1 Discussion of the Individual Level

All the participants endorsed a deep sense of gratitude and privilege in supporting patients at the end of life. The personal narratives exemplified the profound experience of human connection. In their study of the stories and metaphors of physician providers' existential lived experience, Beuthin et. al (2023) described the unique experience of physicians assisting with MAiD as an “embodied existential experience” and described “the experience hold[ing] a dimension of the existential and provid[ing] a way to get closer to the unsayable profoundness that occurs in that space of providing death for a

suffering other” (p. 1). This is in fact a recurring phenomenon in personal narratives across Canada where providers universally describe a rewarding experience (Beuthin et al. 2020, Khoshnood et al., 2018). There was a real sense of privilege in being able to offer patients relief from suffering. Beuthin et al. (2020) conceptualized the unexpected rewards as “compassion satisfaction”. Additionally, participants described the innate patient-centredness of the process due to the nature of provisions in the patient’s home which helped with contextual awareness and more holistic insight into the individual. This is especially relevant in the current Canadian context due to the high level of burnout and moral injury among family doctors (Glazier, 2023, Beuthin et al., 2020). MAiD work could be an additional or alternative pathway that offers physicians more personal and professional fulfillment and the opportunity to provide genuine patient-centred care (Bybee, 2018).

### 5.1.2 Discussion of the Local Level

Local factors influenced the provider experience, including the availability and importance of team support, which has been well documented in MAiD literature (Durant & Kortess-Miller, 2020, Beauthin et al., 2020, Shaw et al., 2018). Providers felt better supported and more confident when there was readily available access to interdisciplinary team support and local mentorship. Given this, it is important to include the team-based approach in the creation of models of care. The Assisted Dying Resource and Assessment Service (ADRAS) team is one such example of a “high quality, values-based, sustainable and integrated model of assisted dying that meets the needs of diverse stakeholders across [the] tertiary, multi-site health system” (p. 410). The ADRAS team is based on a model of care ecology that prioritizes sustainable team-based service. Since its implementation, “the results of [the] program evaluation project received feedback from multiple stakeholders impacted by MAiD services indicat[ing] high satisfaction with the program from clinical teams, senior leaders and ADRAS members themselves” (Frolic et al., 2022 p. 423). Although the importance of the team-based approach is evident in literature, the practical application requires significant investment in resources and time that

communities outside of tertiary academic health systems do not have the funding to access (Frolic et al., 2022).

As such, a real barrier to this type of team support is geographical context. Participants in rural communities described their unique challenges of feeling isolated from collegial and healthcare team support. This is important to recognize because “almost 18% of the Canadian population lives in a rural area, but they are served by only 8% of the physicians in Canada and only 11% of registered nurses, including NPs” (Schiller, 2017). Proposed unique solutions to the problem of MAiD care coordination in rural communities could include the use of telemedicine or virtual support (Wiebe et al., 2021).

In addition to physician support, participants had highlighted the importance of resources for families grieving the loss of loved ones through MAiD. A quality improvement study that surveyed 18 physicians in a Canadian province found that bereavement following MAiD is unique and thus support is required (Trouton et al., 2020). A further scoping review of 28 articles of grief and bereavement of family and friends around MAiD found that “support is needed to address the complicated and changing emotions of family/friends before, during and after a MAiD death” (Yan et al., 2022, p. 414). This highlights the necessity of readily available bereavement resources that providers and patients can access. The CAMAP organization has a section on Public Resources on their website, which offers a great starting place for helpful links surrounding MAiD grief, bereavement, and available support.

Participants described the fulfilling aspect of MAiD in relation to their family practices, which were burdened by increasing administrative demands. At times, providers felt that MAiD work also added to the administrative burden. This risk has been outlined by Frolic et al. in 2022 where the administrative load includes coordinating communication, record gathering, form completion, finding an independent MAiD assessor, care coordination, eligibility assessment, regular follow up, reporting requirements, communicating with the coroner and travel to patients’ homes. There must be policies in

place to help support providers in their role and one such solution has been addressed with the ADRAS team as previously described. The team-based approach allows shared responsibilities and accessible support. Unfortunately, Canadian primary care is in a crisis due to lack of family doctors, increasing burnout, further demands on the system and unattractive practice environments for new physicians (Glazier, 2023). It is important to address these wider issues so that family doctors can feel empowered in their role to provide comprehensive patient-centred care to their communities, especially as they are well positioned to understand the unique contextual needs of their patients.

Adding to the stresses of family medicine in the 21st century was the recent Coronavirus-19 pandemic, which resulted in providers needing to use innovative methods to help patients at the end of life. Wiebe et al. (2021) summarized the experience through a qualitative study of 15 providers before and during the pandemic and found the increasing isolation felt by patients and loved ones considering MAiD, difficulty of providers establishing closeness at the end of life due to physical distancing and personal protective equipment requirements, access difficulties due to restrictions and the many adaptations needed to solve these issues. These adjustments included the use of virtual care and making exceptions for end-of-life patients.

### 5.1.3 Discussion of the System Level

Every participant indicated the benefit of access to organizational support such as CAMAP (Canadian Association of MAiD Assessors and Providers) for education, resources, and a community of practice. This was a recurring finding in the MAiD literature. Oczkowski et al., conducted a multicentre qualitative study at four Canadian centres in 2021 and highlighted the importance of developing a community of support and resources for improving overall high-quality MAiD care. A study by Close et al. in 2023 highlighted the importance of organizations like CAMAP that “provided the most comprehensive information, and thought that guidance developed by clinicians, rather than material from federal or provincial/ territorial government or other regulatory bodies, was most relevant” (p. 13). Participants who practiced in rural settings felt the



benefit from a community of practice as they generally worked in resource limited settings with minimal team support.

Another key finding was the importance of mentorship and training. A scoping review “found 24% (eight of 33) of included sources explicitly discussed the lack of knowledge and/ or training about end-of-life matters and MAiD among nurses, physicians, and medical examiners” (Fujioka et al., 2018, p. 1572). Participants highlighted their willingness and enthusiasm for such training, a finding also seen in a large study of family medicine preceptors and residents in Southeastern Ontario. Overwhelmingly, the outcome was that preceptors and residents were willing and wanting to learn about MAiD (MacDonald, 2018). Thus, training is needed at the medical curriculum, residency training and community physician level to ensure greater opportunity for knowledge translation and confidence around MAiD as an end-of-life option. Since the start and completion of the study, there have been significant improvements in the training and support available. Notably, in Fall 2023, a nationally accredited Canadian MAiD Curriculum was developed with the support of CAMAP. This training is available both in-person and online, with funding from Health Canada to ensure the curriculum’s accessibility for a period of time (CAMAP, 2024).

Notably, there was some concern regarding upcoming legislative changes and the possibility of increased restrictions. Providers expressed wanting to have safeguards and guidelines in place but were concerned that added regulations would become too constraining. A further significant concern was the difficulty providers felt with track two cases. A key reason for this was the time commitment and complexity involved in assessing patients that did not have a reasonably foreseeable death. In their 2023 survey of 23 Canadian providers, Wiebe et al. found that the most common issue was in relation to patients having concurrent mental illness and difficulty in ensuring adequate referral and treatment for patients. “Many providers experienced moral distress in attempting to balance patients’ rights with what might be in patients’ best interests” (p. 853). This was distinctly different from the experience with track one patients who generally had end stage disease and rarely had unmet health care needs. In another qualitative study of 32

Canadian MAiD assessors a prominent theme was also the onerous nature of track two cases (Close et al., 2023). This highlights the importance of ensuring improved access to appropriate and timely resources for patients in the track two category, which unfortunately is a larger systems issue requiring decrease in referral wait times and improved access to necessary social supports.

#### 5.1.4 Summary

The themes were broken down into three levels to facilitate a holistic understanding of the providers' experiences with MAiD. At the individual level the themes encompassed the deep sense of gratitude among participants and the ability to provide patients with dignity at the end of life. Personal narratives emphasized the profound human connection experienced with providers describing the rewarding nature of the work as compassion satisfaction. The patient-centred nature of MAiD particularly in the patient's home, allowed for a holistic understanding of the patient's context. However, providers also felt significant administrative burden exacerbated by challenges in Canadian primary care including physician shortages and increasing burnout. At the local level, the importance of team support and access to resources were emphasized, especially in rural communities. At the system level, providers discussed the necessity of organizational support, mentorship, and training to ensure high quality and compassionate MAiD care. Concerns were raised about upcoming legislative changes and challenges associated with track two cases, highlighting the need for improved resources in this category.

## 5.2 Strengths, Limitations, and Implications

### 5.2.1 Strengths

As with any research, there are unique strengths and limitations that need to be considered. MAiD is new to Canada with decriminalization in 2016 and ongoing legislative changes since then. The phenomenological approach was useful in allowing a rich and nuanced exploration of the subjective experience of participants. Individual and

collective narratives were integral in understanding the experience of MAiD as it is a complex and deeply personal issue with many ethical, moral, and legal repercussions. Of course, this experience is contextually dependent and thus the context was acknowledged when placing this research amidst wider MAiD discourse.

Additionally, an integrated research team allowed for varying levels of expertise to be utilized. One researcher (GK) was an expert in the field, whereas another (RC) was a family doctor with understanding of MAiD without direct exposure, and the third researcher had no experience in MAiD research. This resulted in diversity in perspectives and opinions, thus decreasing individual biases. Further, the participant selection included an equal mix of providers from rural and urban settings allowing for a greater understanding of the unique benefits and challenges of demographic location and experience, particularly as resource allocation and access differ greatly depending on the jurisdiction of practice. Lastly, the researchers aimed to consider the themes broadly, without losing some of the nuance and richness of the data. This was well captured by dividing the themes into the individual, local and system level categories to better understand the experiences holistically.

### 5.2.2 Limitations

It is important to consider the inherent limitations of the study. To begin with, the research focused only on the community physician experience neglecting the nurse practitioner, caregiver, and patient perspectives. Although this was intentional to narrow down the research focus, the results are not widely transferable to all key players in the MAiD process and to the population. Further, the interviews were conducted in 2023. MAiD has a rapidly evolving legal and practice landscape, and this temporal limitation could affect the relevance and applicability of the results in the future. It is also important to recognize the impact of the recent COVID-19 pandemic and the influence it had on the overall experience for providers. Although there was some discussion on the impact of the pandemic on the process, this study did not specifically delve into the impacts of COVID-19 for the providers, a topic that may be relevant for future studies.

It is also important to recognize the normative stance of the primary researcher (RC) who is a community family physician and a proponent of MAiD. There is a possibility that the interpretations of the findings may be unintentionally influenced by researcher bias. Although efforts were made to include participants of different genders, age groups, practice types and location, there was the possibility of selection bias as participants who already participate in MAiD work self-selected for the study. This impacts the diversity of perspectives represented. There may also have been a social desirability bias as participants may have provided answers to present themselves favorably in the social context. This could affect the accuracy and reliability of the qualitative data (Bergen & Labonte, 2020).

Further, as the study was qualitative in nature, the narrative condensation of participant stories into manageable quotes may have diminished the richness of the narratives, potentially obscuring the depth of understanding. Effort was made to include longer quotes to ensure the depth and intensity of the narratives were preserved.

### 5.2.3 Implications

The study offers valuable insights into the broader discourse on MAiD by specifically illuminating the unique experiences of community physician providers within Southwestern Ontario. The focus on firsthand provider experiences offers critical insights into the experience as a whole and sheds light on existing gaps within the system at the individual, local and national levels. Consequently, there exists the potential for this study to influence research, policy decisions and educational gaps to improve the overall MAiD process.

There is the potential to influence research by providing insight into the 2023 Canadian MAiD context. Comparative research across different settings would allow for understanding of effective and ineffective practices. Likewise, there is the potential to impact policy by fostering a deeper understanding of the provider experience, thereby

enabling the creation of more supportive and conducive work environments. This could include improvements such as increased team support, enhanced resources, easier billing practices and reduced administrative burden. Further, there is potential for impact on education and training by highlighting the current gaps felt by providers. Increasing awareness about existing educational opportunities and enhancing medical training on this topic would be beneficial.

Future research could also focus on amalgamating and comparing the community physician experience to providers in other settings such as hospital or hospices as well as adding the nurse practitioner, interdisciplinary team, caregiver, and patient perspectives. As the Canadian population continues to age and the acceptance of MAiD widens, the number of MAiD requests is expected to increase over time (Statistics Canada, 2019, Brown et al., 2021). The study focused specifically on the community provider experience in the 2023 Canadian context. There are anticipated upcoming legislative changes that may allow patients to seek MAiD for those with a mental disorder as the sole underlying condition, known as MAiD MD-SUMC. The date for the determination of this has been extended to March 2027 (Dying with Dignity Canada, 2024). Exploring the repercussions of this change for providers as well as tracking the evolution of MAiD in response to shifting legislation would be necessary to allow for continued improvements in the process.

### 5.3 Recommendations

The study offered valuable insight into community physician provider experiences with MAiD. Notably, the need for training and education was apparent throughout the interviews and analysis. As such, mentoring programs should be established and promoted to support new MAiD providers with guidance in navigating the complexities of MAiD delivery. Existing MAiD practitioners would also benefit from enhanced practice support mechanisms including resources and community connections to manage the high-stakes and emotionally charged nature of the work. Interdisciplinary education

should be prioritized to foster a collaborative approach to MAiD provision. The education also needs to be aimed at the medical school and residency level so that all healthcare providers are equipped with the skills and knowledge necessary to provide compassionate care related to MAiD, whether this is referral to appropriate services, answering of patient questions or direct involvement. This need for standardized education on MAiD has also been highlighted in several Canadian publications (Bator et al., 2017, Khoshnood et al., 2018, Shaw et al., 2018).

Additionally, there needs to be an appreciation of the current gaps in legislation. Addressing remuneration concerns and lack of billing codes is necessary. Family physicians want to provide comprehensive patient-centred care (Glazier, 2023). However, they expressed the need for support, time, and adequate compensation to do so effectively. Specifically, the taxing administrative duties and responsibilities should be acknowledged and addressed, perhaps with separate billing allowable for administrative work or dedicated paid time for this considerable component of their practice. Moreover, government involvement is needed to address the stance of religiously affiliated institutions on MAiD to ensure equitable, compassionate, and patient-centred care for all individuals.

Participants expressed significant concerns regarding the increased complexity and time demands associated with track two cases. Enhancing support systems, expanding access to referral services, and revising compensation structures could improve the track two process. Nevertheless, further research is needed to ascertain the most effective strategies for addressing these concerns.

In summary, understanding how MAiD is delivered and experienced in Canada is vital for responsive, sustainable, and effective implementation. Ongoing research is needed to monitor and evaluate the evolving landscape of MAiD provision, ensuring that policies and practices remain responsive to the needs of patients and healthcare providers alike.

## Chapter 6

This final chapter concludes the thesis by summarizing the research question: what are the experiences of community physician providers when it comes to MAiD?

### 6.1 Conclusion

The legalization of MAiD marked one of the most significant legislative shifts in healthcare practices since decriminalization in 2016. Due to the rapidly evolving legal and practice context, providers had to adapt quickly to support patients and families. Understanding the perspectives and experiences of community family physicians regarding MAiD provision allows for a deeper analysis of the barriers and challenges that still exist so that the overall implementation can be improved. The distinct but interconnected themes that arose from the thematic analysis in this qualitative phenomenological study included the interplay between individual, local and system level factors that impacted the provider experience.

Provider experiences were shaped by individual factoring including the emotional aspect of the work. There was a profound sense of gratitude and feeling of human connection among participants. While providers found the work rewarding, they also grappled with significant administrative burdens, particularly within the current family medicine context in Canada. Local factors such as team support and resource accessibility played a crucial role in shaping provider experiences, with an increased need observed especially in rural settings. At the systemic level, the impact included the importance of organizational support, mentorship, and training. Concern was raised regarding upcoming legislative changes and the complexity associated with track two cases, highlighting the need for increased support in these areas.

Patients who inquire about or access MAiD are at a very vulnerable time in their lives. Research into the experience allows for the thoughtful reflection on current practices to

strive for the provision of compassionate and thoughtful care to this population. This research project highlights the existing information gaps within the changing landscape of MAiD care. The study allows for introspection but also the opportunity for objective analysis of current practices. By understanding and questioning the way things are done it can help avoid complacency and strive for optimum patient and family-centred care. This understanding can potentially allow for improvements in overall MAiD access, provision, and training.



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## Appendix A: Summary of Bill C-14 and Bill C-7 with Procedural Safeguards (Voriath et al., 2022)

**Table 1** Bill C-14 eligibility criteria and safeguards (previous legislation)

<b>BILL C-14 eligibility criteria</b>
18 + years of age
Eligible for publicly funded health services
Has decision-making capacity at the time of request and to provide final consent
Informed consent to receive MAID given after patient informed of means available to relieve suffering
Voluntary request for MAID
Person has "grievous and irremediable medical condition", meaning: <ul style="list-style-type: none"> <li>serious and incurable illness, disease or disability and has an advanced state of irreversible decline in capability;</li> <li>has enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they consider acceptable</li> </ul>
Their natural death has become reasonably foreseeable
<b>Bill C-14 safeguards</b>
Patient must make a written request that must be witnessed and signed by two independent witnesses
Witness may not be a family member or a health care worker
Two independent practitioners must confirm all eligibility criteria
Person must be informed that they can withdraw request at any time, by any means
Mandatory 10-day reflection period after written request is signed, unless death or loss of capacity imminent
Immediately before MAID is provided, person must be given opportunity to withdraw consent
Must confirm consent at the time of provision to receive MAID
Government of Canada [6]

**Table 2** Bill C-7 eligibility criteria and safeguards (current legislation)

<b>BILL C-7 eligibility criteria</b>	
18 + years of age	
Eligible for publicly funded health services	
Has decision-making capacity	
Informed consent to receive MAID given after patient informed of means available to relieve suffering	
Voluntary request for MAID	
Person has "grievous and irremediable medical condition", meaning: <ul style="list-style-type: none"> <li>serious and incurable illness, disease or disability and has an advanced state of irreversible decline in capability;</li> <li>has enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they consider acceptable</li> </ul>	
Person whose natural death is reasonably foreseeable (track-1 safeguards)	
Person whose natural death is not reasonably foreseeable (track-2 safeguards)	
<b>BILL C-7 TRACK-1 SAFEGUARDS (For persons whose death is reasonably foreseeable)</b>	<b>BILL C-7 TRACK-2 SAFEGUARDS (For persons whose death is not reasonably foreseeable)</b>
Patient must make a written request that must be witnessed and signed by one independent witness	Patient must make a written request that must be witnessed and signed by one independent witness
Two independent practitioners must confirm all eligibility criteria	Two independent practitioners must confirm all eligibility criteria
Person must be informed that they can withdraw request at any time, by any means	Ensure that the assessors consult with a medical practitioner or nurse practitioner who has that expertise in the condition the person is suffering from, and share the results of that consultation with the two assessors
No reflection period	Ensure that the healthcare provider have discussed with the person the reasonable and available means to relieve the person's suffering
Immediately before MAID is provided, person must be given opportunity to withdraw consent	Ensure that there are at least 90 clear days between the day eligibility criteria is established and the MAiD provision date
Ensure that the person gives express consent to receive medical assistance in dying	Person must be informed that they can
<b>Final express consent confirmation can be waived if consent agreement is given in advance<sup>a</sup></b>	Withdraw request at any time, by any means
	Immediately before MAID is provided, person must be given opportunity to withdraw consent
	Ensure that the person gives express consent to receive medical assistance in dying

<sup>a</sup> Focus of this study

Government of Canada [6] and Parliament of Canada [7]

## Appendix B: Literature Review Summary

Citation	Key Findings
<p>Beuthin, R., Bruce A., Hopwood M., Robertson W.D., &amp; Bertoni K. (2020). Rediscovering the art of medicine, rewards, and risks: physicians' experiences of providing medical assistance in dying in Canada. <i>SAGE Open Med</i>, <b>8</b>.  <a href="https://doi.org/10.1177/2050312120913452">https://doi.org/10.1177/2050312120913452</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 8 physicians engaged in assessing and providing MAiD</li> <li>• Main themes: 1) rediscovering the art of medicine, 2) unexpected rewards, 3) negotiating risks and challenges</li> </ul>
<p>Beuthin, R., &amp; Bruce, A. (2023). MAiD as human connection: Stories and metaphors of physician providers' existential lived experience. <i>Death Studies</i>, 1-11.  <a href="https://doi.org/10.1080/07481187.2023.2293717">https://doi.org/10.1080/07481187.2023.2293717</a></p>	<ul style="list-style-type: none"> <li>• Aimed to understand the existential experiences of Canadian physicians providing MAiD, qualitative study of 8 providers including community physicians</li> <li>• Presented findings focused on embodied emotional language, narrative accounts to reflect the depth of emotion, sincerity and caring in physicians existential experiences of providing MAiD</li> </ul>
<p>Brassolotto, J., Manduca-Barone, A., &amp; Sedgwick, M. (2023). Placing MAiD: A qualitative study of medical assistance in dying in rural Alberta. <i>Health &amp; place</i>, <b>83</b>, 103073.  <a href="https://doi.org/10.1016/j.healthplace.2023.103073">https://doi.org/10.1016/j.healthplace.2023.103073</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of MAiD providers and caregivers, including physicians in southern Alberta</li> <li>• Three main themes: 1) placing MAiD in southern Alberta, 2) the realities of the relational rural, 3) notion of 'working with what you've got'</li> </ul>
<p>Brooks L. (2019). Health Care Provider Experiences of and Perspectives on Medical Assistance in Dying: A Scoping Review of Qualitative Studies. <i>Canadian journal on aging</i>, <b>38</b>(3), 384–396.  <a href="https://doi.org/10.1017/S0714980818000600">https://doi.org/10.1017/S0714980818000600</a></p>	<ul style="list-style-type: none"> <li>• Scoping review summarizing existing qualitative literature focused on provider experiences in the MAiD process</li> <li>• Included many countries</li> <li>• Main themes: complex process, importance of</li> </ul>

	<p>relationships and communication, interprofessional roles and dynamics, and coping</p>
<p>Brown, J., Goodridge, D., Harrison, A., Kemp, J., Thorpe, L., &amp; Weiler, R. (2020). Medical Assistance in Dying: Patients', Families', and Health Care Providers' Perspectives on Access and Care Delivery. <i>Journal of palliative medicine</i>, 23(11), 1468–1477.  <a href="https://doi.org/10.1089/jpm.2019.0509">https://doi.org/10.1089/jpm.2019.0509</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study using semi-structured interviews of patients, families and healthcare providers</li> <li>• Highlighted access and delivery concerns, care pathway ambiguity, lack of support for care choices, institutional conscientious objection, post death documentation</li> <li>• Healthcare providers unsure of their care provision responsibilities, confusion regarding communication with patients and families and scopes of practice</li> <li>• MAiD practitioners find working with patients and families rewarding</li> <li>• Challenges related to level of stress, administrative demands, impact of denying patients who did not qualify, working with family and friends through grief, inadequate compensation for time, complex reporting and logistics and travel required to provide care</li> </ul>
<p>Brown, J., Goodridge, D., Harrison, A., Kemp, J., Thorpe, L., &amp; Weiler, R. (2022). Care Considerations in a Patient- and Family-Centered Medical Assistance in Dying Program. <i>Journal of palliative care</i>, 37(3), 341–351.  <a href="https://doi.org/10.1177/0825859720951661">https://doi.org/10.1177/0825859720951661</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 30 participants including healthcare providers to assess opportunities to enhance patient- and family-centered care</li> <li>• Emotional, physical, spiritual and relational</li> </ul>

	considerations
<p>Brown, J., Goodridge, D., Thorpe, L., &amp; Crizzle, A. (2021). "I Am Okay With It, But I Am Not Going to Do It": The Exogenous Factors Influencing Non-Participation in Medical Assistance in Dying. <i>Qualitative health research</i>, 31(12), 2274–2289.  <a href="https://doi.org/10.1177/10497323211027130">https://doi.org/10.1177/10497323211027130</a></p>	<ul style="list-style-type: none"> <li>• Interviewed 17 physicians and 18 nurse practitioners in Saskatchewan, Canada who identified as non-participants, non-participation factors related to: 1) health care system they work within, 2) community where they live, 3) current practice context, 4) how their participation choices were visible to others, 5) risks of participation to themselves and others, 6) time factors, 7) impact of participation on the patient's family, 8) patient-HCP relationship, and contextual factors</li> </ul>
<p>Brown, J., Goodridge, D., Thorpe, L., &amp; Crizzle, A. (2021). "What Is Right for Me, Is Not Necessarily Right for You": The Endogenous Factors Influencing Nonparticipation in Medical Assistance in Dying. <i>Qualitative health research</i>, 31(10), 1786–1800.  <a href="https://doi.org/10.1177/10497323211008843">https://doi.org/10.1177/10497323211008843</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study, interviewed 17 physicians and 18 nurse practitioners who identified as non-participants in formal MAiD process, non-participation influenced by 1) previous personal and professional experiences, 2) comfort with death, 3) conceptualization of duty, 4) preferred end of life care approaches, 5) faith or spirituality beliefs, 6) self-accountability, 7) consideration of emotional labor, 8) future emotional impact</li> </ul>

<p>Brown, J., Goodridge, D., Harrison, A., Kemp, J., Thorpe, L., &amp; Weiler, R. (2020). Medical Assistance in Dying: Patients', Families', and Health Care Providers' Perspectives on Access and Care Delivery. <i>Journal of palliative medicine</i>, 23(11), 1468–1477.  <a href="https://doi.org/10.1089/jpm.2019.0509">https://doi.org/10.1089/jpm.2019.0509</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study interviewing 5 patients, 11 family members and 14 healthcare providers in 2017</li> <li>• Summary: participants highlighted access and deliver concerns, care pathway ambiguity, lack of support for care choices, institutional conscientious objection (CO), navigating care in institutions with a CO, post death documentation</li> <li>• Recommendations made to improve regional MAiD care</li> </ul>
<p>Campbell, E. G., Kini, V., Ressalam, J., Mosley, B. S., Bolcic-Jankovic, D., Lum, H. D., Kessler, E. R., &amp; DeCamp, M. (2022). Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey. <i>Journal of general internal medicine</i>, 37(13), 3310–3317.  <a href="https://doi.org/10.1007/s11606-021-07300-8">https://doi.org/10.1007/s11606-021-07300-8</a></p>	<ul style="list-style-type: none"> <li>• Mailed survey to Colorado physicians, sample of 583</li> <li>• 81.1% respondents willing to discuss MAiD with a patient, 88.3% to refer for MAiD, 46.3% to be a consultant and 28.1 to be an attending</li> <li>• 75% reported that their most recent MAiD case was emotionally fulfilling and professionally rewarding</li> <li>• 75% reported time consuming, 46.9% ethically challenging</li> <li>• Barriers to participation: lack of knowledge of MAiD (46.8%), emotional, time investment and ethical concerns</li> </ul>

<p>Close, E., Downie, J. &amp; White, B.P. (2023). Practitioners' experiences with 2021 amendments to Canada's medical assistance in dying law: a qualitative analysis. <i>Palliative Care and Social Practice</i>, 17.  <a href="https://doi.org/10.1177/26323524231218282">https://doi.org/10.1177/26323524231218282</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study investigating experiences of MAiD assessors and providers regarding Bill C-7 amendments (removed reasonably foreseeable natural death requirement, final consent waiver), 25 physicians and 7 nurse practitioners, main themes; 1) removing barriers to MAiD access, 2) navigating regulatory and systems recalibration, 3) recognizing workload burdens, 4) determining individual ethical boundaries of practice and 5) grappling with ethical tensions arising from broader health system challenges</li> </ul>
<p>Dholakia, S. Y., Bagheri, A., &amp; Simpson, A. (2022). Emotional impact on healthcare providers involved in medical assistance in dying (MAiD): a systematic review and qualitative meta-synthesis. <i>BMJ open</i>, 12(7), e058523.  <a href="https://doi.org/10.1136/bmjopen-2021-058523">https://doi.org/10.1136/bmjopen-2021-058523</a></p>	<ul style="list-style-type: none"> <li>• Systematic review of qualitative research studies from April to August 2021</li> <li>• 3 descriptive emotional themes: 1) polarised emotions including moral distress, 2) reflective emotions with MAiD as a "sense-making process", 3) professional value-driven emotions</li> </ul>
<p>Durant, K., &amp; Kortes-Miller, K. (2020). Physician snapshot: the forming landscape of MAiD in northwestern Ontario. <i>Palliative Care &amp; Social Practice</i>, 14, 1-14.  <a href="https://doi.org/10.1177/2632352420932927">https://doi.org/10.1177/2632352420932927</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study that explored physicians' experiences in Northwestern Ontario with MAiD</li> <li>• 4 themes 1) physician perception of patient awareness 2) appreciation and understanding of MAiD: challenges providing true choice at end of life, 3) burgeoning relationships between palliative care and MAiD, 4) physician recommendations</li> </ul>



<p>Fujioka, J. K., Mirza, R. M., McDonald, P. L., &amp; Klinger, C. A. (2018). Implementation of Medical Assistance in Dying: A Scoping Review of Health Care Providers' Perspectives. <i>Journal of pain and symptom management</i>, 55(6), 1564–1576.e9. <a href="https://doi.org/10.1016/j.jpainsymman.2018.02.011">https://doi.org/10.1016/j.jpainsymman.2018.02.011</a></p>	<ul style="list-style-type: none"> <li>• Scoping review to explore key barriers for the integration of MAiD into existing health systems</li> <li>• 6 categories of implementation challenges: regulatory, legal, social, logistical, financial, and compatibility with palliative care</li> </ul>
<p>Khoshnood, N., Hopwood, M. C., Lokuge, B., Kurahashi, A., Tobin, A., Isenberg, S., &amp; Husain, A. (2018). Exploring Canadian Physicians' Experiences Providing Medical Assistance in Dying: A Qualitative Study. <i>Journal of pain and symptom management</i>, 56(2), 222–229.e1. <a href="https://doi.org/10.1016/j.jpainsymman.2018.05.006">https://doi.org/10.1016/j.jpainsymman.2018.05.006</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 16 physicians across Canada</li> <li>• 3 challenges with MAiD provision: 1) relationship issues, 2) inadequate financial compensation for time, 3) increased workload resulting in sacrifices to personal time</li> <li>• Discussed importance of training and current lack of training in residency programs</li> </ul>
<p>Kortes-Miller, K., &amp; Durant, K. L. (2022). Physician experiences with medical assistance in dying: Qualitative study in northwestern Ontario. <i>Canadian family physician</i>, 68(5), e161–e168. <a href="https://doi.org/10.46747/cfp.6805e161">https://doi.org/10.46747/cfp.6805e161</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 23 physicians involved with the MAiD process in Northwestern Ontario</li> <li>• 4 main themes identified: relationships, motivation, time and resources, and getting others on board</li> </ul>

<p>MacDonald, S., LeBlanc, S., Dalgarno, N., Schultz, K., Johnston, E., Martin, M., &amp; Zimmerman, D. (2018). Exploring family medicine preceptor and resident perceptions of medical assistance in dying and desires for education. <i>Canadian family physician</i>, 64(9), e400–e406.</p>	<ul style="list-style-type: none"> <li>• Survey of 71 Family Medicine preceptors and 62 residents in Canada (Queen’s University)</li> <li>• Lack of competency and comfort in exploring MAiD with patients</li> <li>• Preceptors and residents are willing and want to learn about MAiD, suggestion to integrate MAiD into the residency curriculum</li> </ul>
<p>Manzhura, A. (2021). Accessing Medical Assistance in Death (MAiD): An interpretative phenomenological analysis of experiences with MAiD by family members and providers in Manitoba. <i>Diss. University of Winnipeg</i>. <a href="https://doi.org/10.36939/ir.202104301208">https://doi.org/10.36939/ir.202104301208</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study exploring experiences of MAiD for providers and family members</li> <li>• Main themes: lack of awareness of MAiD requirements, how moral objections impact the process</li> </ul>
<p>McKee, M., &amp; Sellick, M. (2018). The impact of providing medical assistance in dying (MAiD) on providers. <i>J Pain Symptom Manage</i>, 56(6), E89. <a href="https://doi.org/10.1016/j.jpainsymman.2018.10.312">https://doi.org/10.1016/j.jpainsymman.2018.10.312</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 22 Canadian physicians who provide MAiD</li> <li>• Conclusions: process was rewarding, emotional nature of the work, the largest source of stress in the MAiD process stemmed from administrative or institutional barriers – “largely related to the administrative aspects of being a provider (the time commitment and work-load, the learning curve, the geographic isolation and lack of team support in some areas), and for some providers, to a sense of emotional and professional isolation from disapproving colleagues”</li> </ul>

<p>Oczkowski, S. J. W., Crawshaw, D., Austin, P., Versluis, D., Kalles-Chan, G., Kekewich, M., Curran, D., Miller, P. Q., Kelly, M., Wiebe, E., Dees, M., &amp; Frolic, A. (2021). How We Can Improve the Quality of Care for Patients Requesting Medical Assistance in Dying: A Qualitative Study of Health Care Providers. <i>Journal of pain and symptom management</i>, 61(3), 513–521.e8.  <a href="https://doi.org/10.1016/j.jpainsymman.2020.08.018">https://doi.org/10.1016/j.jpainsymman.2020.08.018</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study at four Canadian centers of 20 healthcare providers, three main themes, 1) improving access and patient experience: clinicians described struggles in ensuring equitable access to MAiD and supporting MAiD patients and families, 2) supporting providers and sustainability: clinicians described managing MAiD workload, remuneration, educational needs, and the emotional impact of participating in assisted dying, 3) institutional support: descriptions of MAiD communication tools and training, use of standardized care pathways, interprofessional collaboration, and human resource planning</li> </ul>
<p>Oliphant, A., &amp; Frolic, A. N. (2021). Becoming a medical assistance in dying (MAiD) provider: an exploration of the conditions that produce conscientious participation. <i>Journal of medical ethics</i>, 47(1), 51–58.  <a href="https://doi.org/10.1136/medethics-2019-105758">https://doi.org/10.1136/medethics-2019-105758</a></p>	<ul style="list-style-type: none"> <li>• Qualitative mixed methods study that occurred at outset of MAiD practice in 2016 and one year later once MAiD was established</li> <li>• Most significant contributors to conscientious participation for MAiD providers and supports: 1) professional identity and values, 2) personal identity and values, 3) experience with death and dying, 4) organisation context</li> </ul>

<p>Patel, T., Christy, K., Grierson, L., Shadd, J., Farag, A., O'Toole, D., Lawson, J., &amp; Vanstone, M. (2021). Clinician responses to legal requests for hastened death: a systematic review and meta-synthesis of qualitative research. <i>BMJ supportive &amp; palliative care</i>, 11(1), 59–67.  <a href="https://doi.org/10.1136/bmjspcare-2019-002018">https://doi.org/10.1136/bmjspcare-2019-002018</a></p>	<ul style="list-style-type: none"> <li>• Systematic review and meta-synthesis of primary qualitative research articles that described the experiences of healthcare providers</li> <li>• Providers considered 7 distinct domains when responding to MAiD inquiries: policies, professional identity, commitment to patient autonomy, personal values and beliefs, the patient-clinician relationship, the request for hastened death, and the provider's emotional and psychological response</li> </ul>
<p>Reid T. (2018). Reflections from a provider of medical assistance in dying. <i>Can Fam Physician</i>, 64(9), 639–640.</p>	<ul style="list-style-type: none"> <li>• Reflections from a family physician on her experience with MAiD provision</li> <li>• “The most powerful factor in this care is the stories that patients tell us. They really solidify my conviction that this care is appropriate and compassionate.”</li> <li>• “I have found providing MAiD to be astonishingly rewarding, as it combines so many of the skills and art that make family medicine so fulfilling.”</li> </ul>
<p>Ritchie, K., Gérin-Lajoie, C., &amp; Naik, V. (2017). Medical Assistance in Dying. <i>The New England journal of medicine</i>, 377(9), 896–897.  <a href="https://doi.org/10.1056/NEJMc1708958">https://doi.org/10.1056/NEJMc1708958</a></p>	<ul style="list-style-type: none"> <li>• Experience of a physician in his first case of assisting with MAiD</li> <li>• “What frightens me is how simple it is to die now.”</li> <li>• “Medical assistance in dying definitely changes things: What is the value of life? And what is it worth when it becomes unbearable?”</li> </ul>

<p>Shaw, J., Wiebe, E., Nuhn, A., Holmes, S., Kelly, M., &amp; Just, A. (2018). Providing medical assistance in dying: Practice perspectives. <i>Canadian family physician</i>, 64(9), e394–e399.</p>	<ul style="list-style-type: none"> <li>• Explored experiences of first cohort of physicians to offer MAiD in British Columbia</li> <li>• Participants believed MAiD was rewarding, structural/emotional challenges included refusal of faith-based institutions to provide info/ support for MAiD, denying MAiD when patients didn't qualify, disagreement with colleagues who did not support MAiD provision, dealing with grief, feeling like on call</li> <li>• Recommended legislative changes</li> </ul>
<p>Tremblay-Huet, S., McMorrow, T., Wiebe, E., Kelly, M., Hennawy, M., &amp; Sum, B. (2020). The impact of the COVID-19 pandemic on medical assistance in dying in Canada and the relationship of public health laws to private understandings of the legal order. <i>Journal of law and the biosciences</i>, 7(1), lsa087. <a href="https://doi.org/10.1093/jlb/lsa087">https://doi.org/10.1093/jlb/lsa087</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 15 MAiD providers from across Canada examining impact of coronavirus 2019 pandemic on their practice</li> <li>• Providers did not allow follow public health rules, used various techniques to do this, “implicitly invoked the exceptionality and emotionality of the MAiD context”</li> </ul>
<p>Variath, C. (2023). Loss of Capacity to Consent and Access to Medical Assistance in Dying: Healthcare Providers' Experiences and Perspectives. <i>Diss. University of Toronto</i>. <a href="https://hdl.handle.net/1807/128089">https://hdl.handle.net/1807/128089</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study exploring healthcare providers' perspectives on providing MAiD in absence of a final consent</li> <li>• Findings that experiences were influenced by socio-political, personal, and professional factors</li> </ul>

<p>Ward, V., Freeman, S., Callander, T., &amp; Xiong, B. (2021). Professional experiences of formal healthcare providers in the provision of medical assistance in dying (MAiD): A scoping review. <i>Palliative &amp; supportive care, 19</i>(6), 744–758. <a href="https://doi.org/10.1017/S1478951521000146">https://doi.org/10.1017/S1478951521000146</a></p>	<ul style="list-style-type: none"> <li>• Scoping review describing existing literature examining healthcare providers’ experiences with MAiD provision</li> <li>• Describes emotional experiences, importance of team support, self-care for team members</li> </ul>
<p>Wiebe, E., Kelly, M., McMorrow, T., Tremblay-Huet, S., &amp; Hennawy, M. (2021). Assessment of capacity to give informed consent for medical assistance in dying: a qualitative study of clinicians' experience. <i>CMAJ open, 9</i>(2), E358–E363. <a href="https://doi.org/10.9778/cmajo.20200136">https://doi.org/10.9778/cmajo.20200136</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 20 Canadian MAiD providers with intent to understand how clinicians assess capacity in patients who request MAiD</li> <li>• Main themes: “participants used the conversation about how the patient had come to choose MAiD to get the information they needed”, formal capacity assessment tools more for documentation, rare to ask for psychiatric consults</li> </ul>
<p>Wiebe, E., Kelly, M., McMorrow, T., Tremblay-Huet, S., Sum, B., &amp; Hennawy, M. (2021). How the experience of medical assistance in dying changed during the COVID-19 pandemic in Canada: a qualitative study of providers. <i>CMAJ open, 9</i>(2): 400-405. <a href="https://doi.org/0.9778/cmajo.20200163">https://doi.org/0.9778/cmajo.20200163</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study interviewing one MAiD coordinator and 15 providers before and during the pandemic , theme 1) perception that pandemic increased suffering of patients receiving MAiD by isolating them from loved ones and reducing available services, 2) providers distressed by difficulty establishing rapport and closeness at end of life, given the requirements for physical distancing and PPE, 3) logistics and access to MAiD more difficult because of new restrictions, 4) many adaptations to solve these problems</li> </ul>

<p>Wiebe, E., &amp; Kelly, M. (2023). Medical assistance in dying when natural death is not reasonably foreseeable: Survey of providers' experiences with patients making track 2 requests. <i>Canadian family physician Medecin de famille canadien</i>, 69(12), 853–858. <a href="https://doi.org/10.46747/cfp.6912853">https://doi.org/10.46747/cfp.6912853</a></p>	<ul style="list-style-type: none"> <li>• Online survey of 23 providers to explore experiences with patients making track 2 MAiD requests in Canada</li> <li>• Reviewed most common diagnoses, most common challenges were related to patients having concurrent mental illness, difficulty in finding experts to help with assessment, difficulty in finding treatments for patients, feeling that not all patients had been offered the available treatments</li> </ul>
<p>Wiebe, E. R., Kelly, M., Spiegel, L., Menard, J. F., Hawse, E., &amp; Dickinson, R. (2023). Are unmet needs driving requests for Medical Assistance in Dying (MAiD)? A qualitative study of Canadian MAiD providers. <i>Death studies</i>, 47(2), 204–210. <a href="https://doi.org/10.1080/07481187.2022.2042754">https://doi.org/10.1080/07481187.2022.2042754</a></p>	<ul style="list-style-type: none"> <li>• Qualitative study of 20 MAiD providers regarding assessing patient with unmet needs</li> <li>• Found that unmet needs were rare, when present usually related to loneliness and poverty</li> </ul>

Winters, J. P., Pickering, N., & Jaye, C. (2021). Because it was new: Unexpected experiences of physician providers during Canada's early years of legal medical assistance in dying. *Health policy (Amsterdam, Netherlands)*, 125(11), 1489–1497. <https://doi.org/10.1016/j.healthpol.2021.09.012>

- Qualitative study reporting experiences of 21 physicians who provided MAiD in first years after legalization in Canada
- Positive experiences: sense of role fulfillment, public awareness of end of life planning and palliative care, developed peer group for education, role interpretation, education and support, planned nature of MAiD increased interdisciplinary work, unexpected role fulfillment of provider
- Negative experiences: legislation changes, oversight and review, unclear rules, lack of consensus or guidance on rules, lack of training for health care team members, institutional or individual objections to performing MAiD requiring delay of procedure or unwanted transfer, lack of communication within healthcare team, emotional distress of a colleague, pressure because not enough providers, demands from patient-perceived urgency, provider vulnerability, safety or anxiety, insufficient information for families, insufficient knowledge or experience in choreography, technical issues



Winters, J. P., Pickering, N., & Jaye, C. (2022). Winging it: a qualitative study of knowledge-acquisition experiences for early adopting providers of medical assistance in dying. *Palliative care and social practice*, 16.  
<https://doi.org/10.1177/26323524221103889>.

- Qualitative study of 21 early adopting physician-providers in 5 Canadian provinces
- Found that few formal training opportunities existed, used variety of strategies to meet their needs: self-training, organizing provider education groups, reflected on uncertainty, desire for early training and mentorship

## Appendix C: Interview Guide

The interviews will be guided by six broad questions. The researcher will probe participants to discuss their feelings, experiences and provide stories.

The initial conversational prompt will include the following:

“We are interested in learning about MAiD from the perspective of community physician providers. I would now like to ask you a series of questions to better understand your experiences. Please note that the interview can be stopped at any time if it becomes emotionally too difficult.”

Table: 1: Interview Questions

Primary Questions	Additional probing questions will be asked to clarify points or seek additional information		
1. Tell me about your experience with MAiD.	a. How do you feel about the decriminalization of MAiD?	b. What was the most difficult step in deciding to be involved?	c. What was the most helpful step in the process?
2. How has the experience affected you?	a. How has the experience affected you personally?	b. How has the experience affected you professionally?	
3. Please share any specific experiences in providing MAiD that stand out for you.	a. What made this memorable/ impactful?		
4. How do you prepare for assisting with MAiD?	a. How has this preparation changed/ evolved since you started providing MAiD?		
5. What factors influence your decision to provide MAiD?	a. What are the personal factors?	b. What are the professional factors?	
6. Knowing what you know now, is there anything you would do differently?	a. What supports or resources would be helpful for you?	b. How have system level policies helped or hindered the process?	c. Is there any advice you would give to new providers?
Each interview will conclude with asking the participant if there is anything to add about their experience.			
Each participant will be asked their 1) age, 2) gender, 3) religious affiliation, 4) years of experience, 5) experience with MAiD provision, 6) location of practice (rural vs urban)			

## Appendix D: Email Script for Recruitment



### **Invitation to participate in research on Medical Assistance in Dying (MAiD) for healthcare providers.**

Hello,

We have received your email address from online/ Dr. \_\_\_\_\_ (*depending on how participant's information received*). You are being invited to participate in a study that we, Doctors George Kim, Shannon Sibbald and Rimpay Cheema are conducting. Briefly, the study involves trying to better appreciate the perceptions, emotions and consequences involved in administering MAiD for community physicians. As such, we will be carrying out a qualitative study using semi-structured interviews to synthesize the overall essence of the experience for healthcare providers. It is expected that this will allow a more complete understanding of the MAiD process in order to potentially help improve its implementation. The interview will take under 30 minutes to complete and will be done using teleconferencing at a time that suits your schedule.

If you would like to participate or receive more information on this study, please contact one of the researchers at the contact information given below.

Thank you,

Dr. Rimpay Cheema  
Research Trainee  
MCIsc(FM) Candidate, CCFP, MB BCh BAO

Dr. George Kim  
Principal Investigator  
George Kim MD, MCIsc(FM), CCFP, FCFP  
Associate Professor  
Department of Family Medicine  
Assistant Dean  
Rural/Regional Community Engagement  
Schulich School of Medicine/Dentistry

## Appendix E: Telephone Script for Recruitment

### **Invitation to participate in research on Medical Assistance in Dying (MAiD) for healthcare providers.**

Hello,

We have received your phone number from online/ Dr. \_\_\_\_\_ (*depending on how participant's information received*). You are being invited to participate in a study that we, Doctors George Kim, Shannon Sibbald and Rimpay Cheema are conducting. Briefly, the study involves trying to better appreciate the perceptions, emotions and consequences involved in administering MAiD for community physicians. As such, we will be carrying out a qualitative study using semi-structured interviews to synthesize the overall essence of the experience for healthcare providers. It is expected that this will allow a more complete understanding of the MAiD process in order to potentially help improve its implementation. The interview will take under 30 minutes to complete and can be done via teleconferencing at a date and time that suits your schedule.

If you are interested and would like to receive more information on this study, please provide your email for further correspondence. I will send a more detailed description of the study as well as work with you to find the best time to conduct the interview.

I appreciate your support and look forward to hearing from you soon.

Thank you,

Dr. Rimpay Cheema  
Research Trainee  
MCISc(FM) Candidate, CCFP, MB BCh BAO

Dr. George Kim  
Principal Investigator  
George Kim MD, MCISc(FM), CCFP, FCFP  
Associate Professor  
Department of Family Medicine  
Assistant Dean  
Rural/Regional Community Engagement  
Schulich School of Medicine/Dentistry

# Appendix F: Letter of Information and Consent

## Letter of Information & Consent Form



**Project Title:** A Qualitative Analysis of the Experience of Community Physicians Who Provide Medical Assistance in Dying in Canada

### Principal Investigator:

1. Dr. George Kim, Department of Family Medicine, University of Western Ontario

Contact Information: \_\_\_\_\_

### Research Team:

2. Dr. Rimpay Cheema, Graduate Student, University of Western Ontario

Contact Information: \_\_\_\_\_

3. Dr. Shannon Sibbald, Family Medicine, University of Western Ontario

### Letter of Information – HEALTHCARE PROVIDER

#### 1. Invitation to Participate

You are being invited to participate in this research study because you are a community healthcare provider that assists with MAiD for qualified patients. This qualitative study aims to provide a better understanding of the perceptions, emotions and consequences of MAiD involved for providers. This study will involve semi-structured interviews that will be qualitatively analyzed for underlying themes and essence of the experience for healthcare providers.

#### 2. Purpose of the Letter

The purpose of this letter is to provide you with the information required to make an informed decision regarding participation in this research study. It is important for you to know why the study is being done and what it will involve. Please take the time to read this letter carefully and feel free to ask questions if anything is unclear or if there are words or phrases you do not understand. All individuals participating in the study will be informed of any changes or new information as it may affect your decision to participate.

#### 3. Purpose of this Study

The Canadian Supreme Court decriminalized MAiD on February 6, 2016 and a bill that laid out the specific conditions for its practice was passed on June 17, 2016. The Canadian MAiD law allows either assisted suicide or euthanasia for a person who requests it and meets certain specific criteria. The act allows physicians to legally aid patients in an advanced state of irreversible decline whose natural death is “reasonably foreseeable”. The Ontario College’s policy states that if physicians object to MAiD, they must still act in a manner that respects patient dignity and to provide patients with available care and resources on the process. The Ontario ministry has also established a care coordination service where patients and caregivers can request directly to be connected to a MAiD provider.

Although most healthcare providers agree on the provision of compassionate care that upholds patient autonomy and the legal rights of the terminally ill, there have been considerable concerns regarding the

Participant Initials: \_\_\_\_\_

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Version Date: 02/03/2023

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## Letter of Information & Consent Form

moral, religious and personal repercussions MAiD providers may experience. Due to this, there is a need to understand provider experiences with MAiD in Canada. The purpose of this study is to understand the experiences, whether positive or negative, in delivering MAiD for healthcare providers. This is a student's Master's of Clinical Science thesis project.

### 4. Inclusion Criteria

Community healthcare providers that participate MAiD provision in Southern Ontario will be invited to participate. This study seeks to obtain **fifteen to twenty** licensed Ontario physician providers that have been authorised to provide MAiD for at least one year.

### 5. Exclusion Criteria

No healthcare providers meeting the above criteria will be excluded.

### 6. Study Procedures

If you agree to participate in the study, you will be asked to partake in a semi-structured interview through teleconference using the Zoom platform. This will be an audio-only interview.

The interview will take about 30 minutes and can take place at a time that is convenient for you. The interview will be audio-recorded. These recordings are mandatory for study purposes.

After the completion of the interview you will be provided with the researcher's contact information should you have any questions or follow up comments. After the completion of data analysis, a report will be provided upon request with the findings of the study. If you have any concerns or questions about the findings, you are welcome to contact the PI.

### 7. Possible Risks and Harms

There are no known harms associated with participation in this study. However, for some people, these questions can be distressing and this distress can occur during or after they complete the study. There may be some social or emotional risks or discomforts to healthcare providers as participants will be asked about their experience with MAiD, including the emotions, perceptions and consequences involved. However, we believe that this study is low risk. If you experience any emotional distress because of the interview, we suggest that you use the Ministry of Health support resources already available to you. Either participating or not in this study will not affect any employment opportunities, promotions or other career related consequences. Further, data breach is a risk with any study, however a secure method of transferring and storing data will be used (Microsoft OneDrive).

### 8. Possible Benefits

Participant Initials: \_\_\_ \_\_\_

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## Letter of Information & Consent Form

Healthcare providers will have the opportunity to reflect on their experiences providing MAiD; they will also have the chance to improve the process by learning about any potential areas for improvement. As well, information gathered from this study may provide benefits to society that will, in general, enhance our understanding of the MAiD process and more specifically, improve the quality of health services in Ontario.

### 9. Compensation

You will not be compensated for your participation in this research.

### 10. Voluntary Participation

Participation in the study is completely voluntary. You may at any time withdraw from the study without giving a reason. Please see Confidentiality Section of this Letter of Information, which deals with the data collected after withdrawal from the study. You do not have to take part in the study if you do not want to. Refusal to participate, consent or withdraw will generate no consequence for your employment. By signing the consent from you do not waive any personal legal rights. You have the right to not answer any questions. You should only agree to take part if you are satisfied that you know enough about these things.

### 11. Confidentiality

Your research results will be stored in the following manner:

- All electronic data will be stored on a secure network behind institutional firewalls at Western University. All electronic files will be password protected. Only the research team directly involved in this study will have access to these data.

The study data will be kept for a minimum of 15 years according to Lawson Health Research Institute policies. As this is a qualitative study, participants who withdraw prior to the conclusion of the study can have their information completely withdrawn. Their interview will not be included in the thematic analysis and the methods will indicate that a study was withdrawn. However, once the study is completed, retroactive withdrawal will not be possible as the information would have already been used to conduct the analysis and draw conclusions. The audio recordings and transcription of the interview sessions will be stored with stored on a secure network behind institutional firewalls at Western University. Representatives from University of Western Ontario Health Sciences Research Ethics Board and Lawson Quality Assurance and Education Program may require access to their study records for quality assurance purposes.

For study purposes, certain identifiers will be collected. These include your name, age, sex, gender, race, ethnicity, and religious affiliation. A unique identifier will be used throughout the study so that your specific information remains confidential.

### 12. Contacts for Further Information

If you require any further information regarding this research project or your participation in the study you may contact the Principle Investigator, Dr. George Kim by phone at (519) 889-1000 or by email at gkim@uwo.ca. You may also contact the Research Trainee, Dr. Rimpay Cheema by phone at (519) 889-1000 or by email at rcheema@uwo.ca.

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Participant Initials: \_\_\_\_\_

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**Letter of Information & Consent Form**

If you would like to receive a copy of any potential study results, please contact Dr. George Kim or Dr. Rimpay Cheema at the above information.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics (519) 661-3036, email: ethics@uwo.ca.

**13. Publication.**

The results of this study are to be published in peer-reviewed journals as well as graduate student thesis. Any identifying information will not be used in any publications.

**14. Participation in Concurrent or Future Studies.**

If you are participating in another study at this time you do not need to inform the research team as this is a low-risk study.

*This letter is yours to keep for future reference.*

**Participant Initials:** \_\_\_ \_\_\_

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Letter of Information & Consent Form

**Participant Consent Form**

**Project Title:** Provider Experiences with Medical Assistance in Dying (MAiD) in Canada

**Study Investigator's Name:** Dr. George Kim

Contact Information: gkim@utoronto.ca

Research Trainee: Dr. Rimpay Cheema

Contact Information: rcheema@utoronto.ca

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

You do not waive any legal rights by agreeing to participate.

Participant's Name (please print): \_\_\_\_\_

Participants Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Participant Initials:** \_\_\_\_\_

## Appendix G: Western Research Ethics Board Study Approval



**Date:** 8 March 2023

**To:** Dr. George Kim

**Project ID:** 122118

**Review Reference:** 2023-122118-76897

**Study Title:** A Qualitative Analysis of the Experience of Community Physicians Who Provide Medical Assistance in Dying in Canada

**Application Type:** HSREB Initial Application

**Review Type:** Delegated

**Full Board Reporting Date:** 21/Mar/2023

**Date Approval Issued:** 08/Mar/2023 10:36

**REB Approval Expiry Date:** 08/Mar/2024

Dear Dr. George Kim

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

**Documents Approved:**

Document Name	Document Type	Document Date	Document Version
Telephone Script for Recruitment	Telephone Script	20/Nov/2022	1
Research Plan (2)	Protocol	16/Feb/2023	2
Email Script for Recruitment (2)	Email Script	16/Feb/2023	2
INTERVIEW GUIDE (3)	Interview Guide	23/Feb/2023	3
Letter of Information and Consent (4)	Written Consent/Assent	02/Mar/2023	4

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Electronically signed by:

Nicola Geoghegan-Morphet, Ethics Officer on behalf of Dr. Philip Jones, HSREB Chair, 08/Mar/2023 10:36

**Reason:** I am approving this document

**Note:** This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations, See [Electronic System Compliance Review](#))

## Curriculum Vitae

**Name:** Rimpay Cheema

**Post-secondary Education and Degrees:** McMaster University  
Hamilton, Ontario, Canada  
2007-2011 Hons. B.Sc.

Royal College of Surgeons Ireland  
Dublin, Ireland  
2011-2015 MB BAO BCH

McMaster University  
Hamilton, Ontario, Canada  
2015-2018 Postgraduate Family Medicine Residency Training

Western University  
London, Ontario, Canada  
2018-Present M.Cl.Sc. Candidate

**Honours and Awards:** Martin J. Bass/ PSI Memorial Award in Family Medicine  
Western University, London, Ontario, Canada, 2020 and 2023

Schulich Trust Fund Grant  
Western University, London, Ontario, Canada, 2023

Professionalism Award Nomination  
Family Medicine Residency, McMaster University, Hamilton,  
Ontario, Canada, 2018, 2016

Kanwal Shankardass Care of the Elderly Award  
McMaster University, Hamilton, Ontario, Canada, 2017

Dr. HH. Stewart Scholarship and Prize Examination in Psychiatry  
Royal College of Surgeons, Dublin, Ireland, 2014

Hilary Standish-Barry Prize in Psychiatry  
Royal College of Surgeons, Dublin, Ireland, 2014

Bronze Medal  
Royal College of Surgeons, Dublin, Ireland, 2012

McMaster Senate Scholarship  
 McMaster University, Hamilton, Ontario, Canada, 2009-2011

Lieutenant Governor's Volunteer Award, Principal's Leadership  
 Award, Millennium Scholarship  
 Mayfield Secondary School, Caledon, Ontario, Canada, 2007

### **Related Work Experience:**

2021-Present: Physician, Halton McMaster Family Health Centre, Burlington, Ontario, Canada

2021-2020: Locum Physician, Virtual MD Family Physician, Cambridge, Ontario, Canada

2019-2021: Physician, McMaster University Student Health Centre, Hamilton, Ontario, Canada

2019- Present: Professional Staff, Newborn Care Rota, St. Joseph's Hospital, Hamilton, Ontario, Canada

2018-2021: Physician, Dundurn Walk-In Clinic, Hamilton, Ontario, Canada

2018-2019: Locum Physician, Stonechurch Family Health Centre Locum, Hamilton, Ontario, Canada

2018-2019: Locum Physician, Southmount Medical Clinic Locum Family Physician, Hamilton, Ontario, Canada

2018: Locum Physician, Burnhamthorpe Family Health Centre Locum Physician, Hamilton, Ontario, Canada

2017: Physician Volunteer at REFUGE: Hamilton Centre for Newcomer Health, Hamilton, Ontario, Canada

2015-2018: Resident Physician, Stonechurch Family Health Centre, St. Joseph's Hospital, McMaster Children's Hospital, McMaster University, Hamilton, Ontario, Canada

### **Publications:**

#### **Article**

Bal A., Cheema R., Arora N. "Let's Listen to Patients' Hearts, Even If We Don't Have To." *Healthy Debate*, 26 June 2019, [healthydebate.ca/opinions/annual-physical-exams](https://healthydebate.ca/opinions/annual-physical-exams).

#### **Book Contribution**

Yu E., Murphy K., Jaffer N., Chung T., Naraghi A., Rajan D., O'Malley M., Rogalla P. (2014). RadCases: Emergency Radiology. Toronto: Thieme Medical Publishers.

### **Presentations**

2017: Consultant Rounds Presentation - Canadian Task Force Guidelines on Preventative Health, McMaster University

2016: Family Medicine Forum (FMF) Vancouver - Medication Discrepancies and Medication Wallet Cards, Chart Audit and Quality Assurance Residency Project

### **Scholarly and Professional Activities:**

2024, 2017: SOCH Mental Health Speaker and Workshop Facilitator

2024: CARMS Family Medicine Residency Interviewer, McMaster University

2024: Dermatology Conference for Primary Care

2023: CAMAP MAiD Curriculum Facilitated Sessions

2023: Conference: UOSSM 5th Primary Care Update

2023: Hamilton Academy of Medicine Clinical Day

2022: Moderator for HerStory Virtual Seminar on Women's Hormonal Health

2022: Rainbow Health Program for Transition-Related Surgeries

2021: Rainbow Health Program for Transition-Related Hormone Therapy in Primary Care

2020: CARMS Family Medicine Residency Interviewer, McMaster University

2017: CFPC Licensing Exam Evaluator

2017: CARMS FM Residency IMG Interviewer, McMaster University

2016 – 2017: McMaster Academic Half-Day Committee President

2017: Conference: Inspiring Better Healthcare in Our Community

2017: Conference: Patient Safety

2017: Seminars: Medical Education Workshop, Learning How to Teach

2015 – 2016: McMaster Academic Half-Day Committee Member

2016: McMaster Medical School MMI Evaluator

2015 – 2016: Research in Residency Committee, McMaster University

2015 – 2016: CARMS Committee, McMaster University

2015: Evaluator McMaster Medical School OSCEs

2014 – 2015: RCSI Student Medical Journal Weekly Journal Club

**Teaching Activities:**

2023-Present: Preceptor for the McMaster University Family Medicine Residency Program, Burlington, Ontario, Canada

2018 – Present: Preceptor for the Newborn Care Rota, St. Joseph's Hospital, Hamilton, Ontario, Canada

2018: McMaster Family Health Team Resident Supervisor, Hamilton, Ontario, Canada

2017: Supervisor of McMaster University Medical Students, Hamilton, Ontario, Canada

2016: Supervisor to Junior Pre-Residency Program Residents, McMaster University, Hamilton, Ontario, Canada