

Physician snapshot: the forming landscape of MAiD in northwestern Ontario

Keri-Lyn Durant and Katherine Kortés-Miller^{ID}

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Abstract

Background: Options available to Canadians at the end of life increased with the legalization of medical assistance in dying (MAiD). Bill C-14 modified the Canadian Criminal Code allowing individuals who meet very specific criteria to receive a medical intervention to hasten their death. June 2019 marked 3 years since the legislation has changed and while met with favour from most Canadians who believe it will provide enhanced options for quality of life at the end of life, there remains much debate over both its moral implications and practical components. Little is known regarding the Canadian healthcare provider experience with MAiD, in particular in rural and remote parts of the country such as northwestern Ontario.

Objectives: The purpose of this study was to explore physicians' experiences in Northwestern Ontario with MAiD. The geographic location of this study is of particular significance as physicians in rural and remote parts of Canada face unique challenges in the provision of high-quality palliative and end-of-life services. This qualitative research focused on developing a better understanding of physicians' perceptions and practices with MAiD, in particular regarding access, decision-making, provision of service and role clarity.

Methods: The researchers employed an exploratory qualitative research approach, using 1 semi-structured focus group and 18 semi-structured interviews comprising 9 set of questions. Data were collected through audio-taped semi-structured interviews, in person and by telephone.

Findings: Four distinct but interconnected themes emerged from thematic analysis of the transcripts of the focus group and interviews: physician perception of patient awareness, appreciation and understanding of MAiD; challenges providing true choice at end of life; burgeoning relationships between palliative care and MAiD; and physician recommendations.

Conclusion: The results of this study provide a snapshot of the Northwestern physician experiences with MAiD and contribute to the growing body of work exploring these issues on a national scale. MAiD is highlighted as both a rewarding and challenging experience for physicians in Northwestern Ontario in this study.

Keywords: medical assistance in dying, palliative care, rural

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Introduction

The history of MAiD in Canada

The path to legalization of medical assistance in dying (MAiD) in Canada was not without obstacles. To fully appreciate the impetus for Bill C-14, an Act to amend the Canadian Criminal Code and to make related amendments to other Acts regarding MAiD,¹ it is a worthwhile endeavour to

explore where medically assisted death, in all of its forms, was sanctioned globally, as well as examine the legal precedents for its use in Canada itself.

Public conversations about end-of-life choices in Canada date back to the middle of the last century.² Post World War II (WWII), changes in technology and demography and advancements

Correspondence to:
Katherine Kortés-Miller
Assistant Professor,
School of Social Work
and Associate Director of
the Centre for Education
and Research on Aging
and Health, Lakehead
University, 955 Oliver Rd.,
Thunder Bay, ON P7B 5E1,
Canada.
kkortesm@lakeheadu.ca

Keri-Lyn Durant
Faculty of Education,
Lakehead University,
Thunder Bay, ON, Canada

in the prolongation of human life saw myriad debates rise and attitudes shift regarding end-of-life decisions and death.^{2,3} In particular, discussions surrounding the control of how, when and where we die contributed to the foundation of current assistance in dying practices, especially in the four countries in which euthanasia is now legal – the Netherlands, Belgium, Luxembourg and Colombia.^{3,4} For a more comprehensive and user-friendly guide to euthanasia and physician-assisted dying in other countries, this study looked to Dalhousie University Health Law Institute's End of Life Law & Policy in Canada (eol.law.dal.ca). But in recent decades, countries such as Switzerland, where eight 'right-to-die societies' are available to Swiss citizens as well as 'foreigners',⁵ and the United States, where high-profile cases of comatose patients on life-support systems, such as Karen Ann Quinlan and Terri Schiavo, both in receipt of passive euthanasia, have served to further spark debates regarding cessation of treatment and what constitutes quality of life.^{2,6} By 2005, *Dignitas*, a 'right-to-die society' was operating in Germany as well,⁵ and as of March 2020 death with dignity laws, affording the end-of-life option of physician-assisted dying, exist in eight U.S. states as well as in the District of Columbia.⁷ In Canada, as early as 1982, legal reports began to surface regarding recommendations to not decriminalize but to clarify the legal right of a patient to refuse treatment, leading to the landmark case of Nancy B. v. Hôtel Dieu de Québec in 1992 in which the aforementioned patient living with Guillain-Barré syndrome had the court-mandated option to refuse treatment.⁸

Three cases set legal precedence that led to the enactment of Bill C-14 and the current practice of MAiD. From the early 1990s, Sue Rodriguez, a BC resident living with amyotrophic lateral sclerosis (ALS), challenged both provincial and federal laws that prohibition on assisted suicide was unconstitutional.² Rodriguez was unsuccessful; but, the decision by Supreme Court justices, with a majority of five to four, suggested that prohibition might feasibly one day cease.² Another BC resident, Gloria Taylor, also living with ALS, took the challenge of the right to die again to the BC provincial courts. Although Taylor died of natural causes,⁹ prohibition of assisted death was posthumously deemed unconstitutional.¹⁰ As such, Taylor was also a key component of the *Carter v. Canada* case, in which she, two members of Kay Carter's family, a woman who had

travelled to *Dignitas* for an assisted suicide, and William Shoichet, a medical doctor willing to participate in physician-assisted death, along with the British Columbia Civil Liberties Association, challenged federal prohibition of physician-assisted dying.² Unlike the close ruling in *Rodriguez v. Canada*, the *Carter* decision was unanimous – 9-0, stating that 'a blanket prohibition on assisted suicide deprives adults of the right to life, liberty, and security of the person'² (p. 17). It was at this point that the Supreme Court allocated a suspension of the invalidity of the prohibition for 1 year in order to allow time for a response to the judgement.² A year later, on 17 June 2016, Bill C-14 was enacted to amend the Criminal Code of Canada and to make related amendments to other Acts, specifically MAiD;¹ however, it should be noted that the province of Québec provided the precursor to this legislation with the enactment of right-to-die legislation in June 2014.¹

Current state of MAiD in Canada

In June 2016, federal legislation was passed in Canada allowing eligible adults to request MAiD. Eligibility requirements include that individuals must be at least 18 years of age and capable of making healthcare decisions. Applicants must also have a 'grievous and irremediable medical condition' which is incurable and in an advanced, irreversible state. Once approved, Canadians are required to have a 10-day reflection period unless death is imminent or in a critical condition. Finally, the individual must have the capacity to provide consent for the MAiD intervention immediately before they receive the medication.¹¹

In the first 10 months of 2018, MAiD accounted for approximately 1.12% of the estimated total of deaths in Canada.¹¹ The provincial coroner's office states that during the same period in Ontario, roughly 1.5% of all deaths were medically assisted.¹² Unlike *Dignitas*, where patients are required to participate *by self-administering* the lethal cocktail of medications,⁵ MAiD in Canada may be *administered* to patients who may be experiencing intolerable suffering due to a grievous and irremediable (incurable) medical condition,¹³ although the option to self-administer is also available.¹ 2018 also brought challenges to the surface surrounding the term 'reasonably foreseeable death', as exemplified in the case of *AB vs. Attorney General* (eol.law.dal.ca), creating further contestation and confusion.

As such, physicians and nurse practitioners specifically and Canadians in general are now faced with the challenge of incorporating and implementing this unprecedented (in Canada) medical procedure¹⁴ and response to it is mixed and likely to remain so.¹⁵ Affording choice at the end of life not only created logistical changes to physicians' professional practice, it also meant they were confronted with their own value judgements regarding physician-assisted death and to what extent they felt they could be involved in this new legislation.

It must be noted that this provincially based study was conducted prior to the ruling by the College of Physicians and Surgeons in the province of Ontario (May 2019) that stipulates that physicians have a duty to refer patients for medical services, regardless of whether they believe said services are contrary to their moral or religious beliefs.¹⁶ While this has provided support regarding one facet of the legislation and acknowledging that implementation varies from province to province to territory,¹⁷ physicians report frustration 'with the lack of clarity for medically assisted dying practices in Canada'.¹⁵ For palliative care physicians, this has often meant confusion about the role MAiD potentially plays in their end-of-life practice and protocols, to the point of questioning whether there is even a relationship between assisted death and palliative care.¹⁸⁻²⁰ There is also concern within the palliative care community, especially in rural and remote regions of the country, that a lack of access to palliative care might instigate use of MAiD because there is no viable other option.¹⁹ As such, moving forward, it is an imperative to ascertain the needs of both patients and practitioners, particularly in rural communities.¹⁴

Rationale and purpose

The purpose of this study was to explore physician experience in Northwestern Ontario with MAiD. The geographic location of this study is of particular significance as physicians in rural and remote parts of Canada face unique challenges in the provision of high-quality palliative and end-of-life services.²⁰ This research focused on developing a better understanding of physicians' perceptions and practices with MAiD, in particular regarding access, decision-making, provision of service, role clarity, and conscientious objection.

About Northwestern Ontario

Spanning 526,417.35 km², the region of Northwestern Ontario constitutes the geographical area that lies north and west of Lake Superior, and west of Hudson Bay and James Bay. It includes most of subarctic Ontario. Its western boundary is the province of Manitoba and to the east the town of White River. Northwestern Ontario is the province's most sparsely populated region, with 54% of the population living in the Thunder Bay district. There are 65 First Nations in the region (Indigenous and Northern Affairs Canada). The North West Local Health Integration Network (LHIN), responsible for the entire region, is further divided into five sub-regions in an effort to better identify and respond to population health needs at the local level while improving access to care as close to home as possible.²¹

Methods

Study design

The researchers employed an exploratory qualitative research approach, using 1 semi-structured focus group and 18 semi-structured interviews comprising 9 set of questions; this study was granted approval by Lakehead University's Research Ethics Board (REB#146468). Physician participants were recruited from across Northwestern Ontario using social media, specifically Facebook and Twitter, as well as snowball sampling. All participants received an information letter and demographic questionnaire, and each one provided informed consent. None of the participants withdrew from the study.

To better understand the experiences of physicians in Northwestern Ontario with MAiD, the study worked from a social constructivist perspective. Constructivism is a theoretical framework that focuses on both social and psychological ways of knowing.²² Thus, constructivism examines how the development of knowledge is created or determined within power, economic, social and political forces.²³ The social constructivist framework affords both a focus on the individual experience and its self-attributed meaning together with recognition of the social and historical influences of systems, relationships, social interactions, legislation and policy.²⁴

Participants

The 23 physician participants ranged in age from 26 to 63, with a mean age of 43 years. In terms of

sex, 11 participants self-identified as female, and 12 did so as male. We did not ask questions pertaining to ethnicity. Years in medical practice ranged from 1 to 36 years. Physicians worked in a variety of settings, with 14 in an urban setting – in family practice, as a hospitalist or other specialist, in the emergency department, in palliative care, and in long-term care. Nine participants declared a rural practice, and self-identified as rural generalists, working on a First Nations' reserve, in a community, at a satellite clinic, or 'All of the above'.

The participants had varying experiences with MAiD, with 11 identifying themselves as acting both as assessor and provider, 1 as assessor only, 4 as providing referrals upon request, and 7 without any direct/indirect experience. These seven were included in the study because they expressed a desire to participate and reported that their practice and the community had been impacted by the legislation. There was also a variance in terms of exposure to death in practice, with an estimated total between 2 and 250 deaths per annum.

Data collection

One-hour-long semi-structured focus group and 18 semi-structured interviews, ranging in length from 17 to 48 minutes, were conducted. Together, the primary investigator (PI; K.K.-M.) and research assistant (RA; K.-L.D.) conducted the focus group; the PI and RA independently conducted interviews, all but one, which was conducted in person, over the telephone. A semi-structured interview guide with open-ended questions was developed to address physician reaction to the legislation, access, delivery issues, impression of impact on the communities they serve, and challenges and rewards experienced incorporating MAiD into the community health-care delivery system. The interview guide was piloted with physicians and revised before implementation. Interview guidelines were used to facilitate, but the interviews also followed an adaptive process to meet the needs of the participants and to capture the stories they wanted to share.

Data analysis

The focus group and interviews, with the consent of the participants, were electronically recorded and transcribed by the RA using *Dragon Anywhere*

mobile dictation app. The transcripts were then manually reviewed for accuracy. Transcripts were analysed using an inductive thematic analysis approach,^{25,26} a process that entails lengthy engagement with the raw data and results in the identification of themes. First, the research team scanned the data, and initial codes were thus generated. During the second phase, members met to identify themes through the collaborative analysis process. A constant comparison process guided the coding, categorizing and theoretical sampling. In the final analysis phase, both researchers reread the data, extracting samples that most accurately illustrated the identified themes. All coding was reviewed to ensure agreement and accuracy within both the coding process and thematic analysis. Thus, it was through the aforementioned rigour that the four themes emerged.

Findings

Distinct but interconnected themes emerged from thematic analysis of the transcripts of the focus group and interviews. These themes included patient perception; challenges providing choice at end of life; integrating palliative care and MAiD; and needs to be addressed. These themes will be explained here to develop a snapshot of physician experience with MAiD in Northwestern Ontario.

Theme 1: physician perception of patient awareness, appreciation and understanding of MAiD

Patient (public) understanding of MAiD and their awareness of the process by which to obtain MAiD was a strong theme in the data. Many participants shared stories about discussing the new legislation with members of their communities; the majority of physician participants in this study felt that said legislation had been well-received by their patients. One participant shared that

in general, people are happy that patients have autonomous choice.

A rural physician shared a story that demonstrates this general appreciation of patients and their wider communities to be able to exercise some autonomy and choice at the end of life:

I attended the funeral of a patient who chose MAiD at the end of his life and the reception at the community

of people who was there and heard that, as part of his story, was very positive. I think positive because they felt like he was the master of his destiny his whole life and so I think people responded positively because they saw that as being so consistent with who he is, he made his choices, every step of the way.

Another rural physician shared the following encounter with a family member of a patient with a terminal diagnosis who appreciated the work done by many advocates and individuals over the years to allow this legislation to come to fruition:

... as we wrapped up our office visit a man said to me in passing how grateful he was to the lady out in BC who fought so hard for her right to die ... and because of this his wife would have the opportunity to ask for it (MAiD) ... he wanted me to know that he was aware it was legal and that she [Sue Rodriguez] had laid the groundwork for it.

While the participants reported that the general response to MAiD in Northwestern Ontario has been positive, the physician participants appear to have mixed opinions and experiences on what the general population that they serve know and understand about MAiD. Overall, they report that while their patients generally understand what MAiD is, confusion lies in the process and procedures required to access it. A physician working in a more urban setting shared,

I often find that the patient has done quite a bit of legwork on their own, to kind of see what MAiD is. They don't know the specifics of how it happens, but they know that there's this ability to end your life early if you have a certain illness.

This was emphasized by a physician in a rural setting:

I think people know that it is available. I don't think they get the process ... I mean people don't know about the processes of surgery and chemo and stuff like that until they get there right?

The waiting period appears to be the area in which most patients' comprehension is lacking:

In most cases, I don't think they know the parameters of what MAiD speaks to. You know, the most common encounter I've had would be a very elderly patient frustrated in their current level of care or their current situation, 'oh, I want a medically

assisted death'. And they think they get it today or get it tomorrow.

This was echoed by a physician in a rural setting:

So, I think a lot of them think it's like something very immediate, like, you know, 'I want the Tylenol, I want a medically assisted death'; they want it to be quick and expedient.

Confusion regarding the waiting period also appears to be influencing the care decisions patients make. Sometimes a request is made, the waiting period ensues, and the patient changes their mind. A physician working in a more urban context stated,

I've seen it in the very elderly – you know, they break their hip or they break their arm and, you know, they say, 'I want MAiD', and then they get their cast on and they get pain control, they feel better, and they say, 'ok, I don't, you know, I was just kind of distraught or overwhelmed', and things like that.

The need for capacity at the time of administering MAiD has also proven a challenge for the participants in this study, here described by a physician working in a rural community:

I've had one patient who lost capacity and we missed the window simply coming down to the difficult job of trying to predict when [the patient would be capable], so we missed that one by probably about a day, which was very, very sad, and very, very sad for the family.

In addition, a physician participant reported the requirement that a patient demonstrate capacity for decision-making at the time of the MAiD intervention as challenging her ability to provide good care. She described situations in which patients are sometimes fearful that the proposed pain and symptom management plan will reduce their capacity and ultimately result in loss of their eligibility for MAiD. A participant noted,

Some patients have chosen not to accept good palliative care and in particular good pharmaceutical treatment because they are worried about losing capacities so their patients will avoid opioids or benzodiazepines or drugs that we would use to treat their symptoms. They're very afraid that that would result in loss of capacity.

Of vital importance in Northwestern Ontario is the large number of Indigenous people, with whom many of the physicians in this study work. Participants were in agreement that there appears to be a difference in the understanding and general perception of MAiD from the perspective of Indigenous people. Some physicians shared that, from their vantage point, there generally appeared to be less awareness of MAiD and less discussion occurring than in more urban areas. A number of physicians recognized that culture plays an important role in healthcare in Northwestern Ontario and that perhaps MAiD is incongruent with some of the Indigenous beliefs, which results in fewer discussions and requests for MAiD. One non-Indigenous physician in a rural community recognized this as a challenge impacting her care of Indigenous patients:

... this (MAiD) is against common spiritual beliefs of Indigenous Canadians and that's caught me a little bit in not knowing how because it's a very comfortable place for me to discuss individually with somebody about MAiD as an option in end-of-life planning, but I've been noticing I'm holding back at this point. ... with opening that conversations with my First Nations patients because I don't feel grounded or educated in the underlying beliefs.

Most participants in this study shared that they did not speak of MAiD with their Indigenous patients because of cultural concerns. In addition, there were practicalities of accessibility regarding the intervention of MAiD, such as availability of a practitioner in rural and remote areas. One physician acknowledged that this presented a 'double-edged sword':

Northern doctors who go up north, they're not sure it will be received well in the community and it's something that they feel is not able to be provided in northern First Nation communities.

In addition, one physician shared,

I have only ever had one possibly two patients who were Indigenous and they made the choice (for MAiD), but they were highly urbanized.

Finally, a physician in a remote setting described the issue and implementation of MAiD as perhaps the least item on his physician radar:

At the moment, I have 25 new cases of Hepatitis C in a community of 550 since I started, so my energies

are focused on other things other than MAiD for the time being.

The same physician also described cross-cultural issues regarding the implementation of MAiD practices on northern reserves. His concern, as a non-Indigenous physician, involved bringing MAiD provision into a community emphatically opposed to, feeling that this was akin to the perpetuation of colonial practices, such as forced sterilization:

[We must be] incredibly delicate around the situation and the system in which largely non-Indigenous people are providing these services.

Theme 2: challenges providing true choice at end of life

A strong recurring theme in the data involved navigating the challenges resulting from providing healthcare in the region of Northwestern Ontario. In its broadest sense, this theme encompasses physician concerns regarding provider motivation, the geographical inequities of living in northwestern Ontario and the lack of community home healthcare and nursing supports. However, advantages were also revealed during the study, particularly in terms of physician autonomy and the role of mentorship in the education and subsequent provision of MAiD.

An overwhelming sense that the lack of a fee code at the outset of legislation, and subsequent concern regarding fee codes already used by palliative care physicians, came to light in this study. Physicians shared that the lack of billing created a barrier to building capacity of providers willing to perform MAiD, articulated by a physician in a rural community:

But if we want to increase capacity ... (we need to) get past those early adopters who are willing to engage because they believe it's the right thing to do.

This subtheme of altruistic motivation, that it's the 'right thing to do', was voiced by many physicians in the region in this study. One participant in particular who felt that the Ontario Medical Association had not made compensation a priority because there would always be physicians willing to provide the service without much complaint:

It's another thing that I think they see on the backs of family physicians, who are generally a pretty quiet group.

Subsequent to the introduction of billing codes (November 2018), there was additional concern that compensation was not appropriately addressed. One palliative care physician in the region felt that using codes already in place that afforded MAiD providers more opportunities to bill was inequitable practice:

(MAiD providers) basically use the same billing codes as we do in palliative care, but they are able to bill all their indirect time so it's they're chatting with the family doctor, if they're talking to the second assessor, they need to speak to the pharmacy, etc., that's all paid time.

This appeared to lend MAiD providers the option to bill for what is stipulated as *indirect* patient care, while palliative care physicians are allowed to bill only for what is considered *direct* patient care, regardless of amount of time and energy spent on aforementioned activities.

The lack of remuneration in a general sense and the subsequent confusion experienced on how and for what to bill appeared to generate a lack of uptake in terms of physicians in the region willing to become involved, in whatever capacity, in direct MAiD provision.

While these compensatory issues are in themselves a challenge to MAiD provision, physicians in the region, especially in rural and remote areas, were also apprehensive that the lack of adequate remuneration was symptomatic of the greater issue of recruitment and retention. With fee codes and billing structures now in place, the new legislation stipulates that physicians are also responsible for reporting requests for MAiD, providing any information or facts about the medically assisted death, whether carried out or not,²⁷ lest face recrimination. One physician in the region assessed the information, arriving to physicians *via* email, as potentially the antithesis to retention of current and recruitment of new providers:

This email might as well have been entitled: Why You Shouldn't Do MAiD.

And he was not alone. Several physicians in the region, whether provider or not, shared that the choice to act as a provider carried less and less appeal. As one participant expressed,

This new legislation came in with a stick rather than a carrot and the stick being if you don't report this, you're liable to two years in jail for refusing to report

it, which kind of puts a barrier up for recruiting new people, getting new people involved, so this is one less thing that they want to be involved in and it's one more barrier.

As such, it was felt that the opportunity to rectify any gaps in the legislation as well as offer solutions to billing issues was obliterated by the increased demands on physicians. One physician claimed that while she understood the necessity for data collection, she felt that the expectations were onerous and put providers on the defensive:

The way they rushed it in, threatening physicians with lawsuits and time in prison if they don't report, I don't think that's going to go over particularly well. And I think that's going to deter a lot of people from providing a service that's very sought after.

This perception of rushed legislation and offensive tactics led physicians to note that much of what was being learned and practiced was *ad hoc* and not based on clear directives. As a result, physicians in the region declared the role that collegial mentorship plays in MAiD provision as vital to recruitment and retention. Several providers expressed reliance on older practitioners willing to take the first steps; one seasoned professional in a leadership position decided that he would have to set the precedent for MAiD provision:

Well, I thought if I'm going to ask people to be involved, I'd better be involved as well, so I started doing it and then it's gradually been building up ... We have a couple of others who are looking to be mentored and maybe get into it, so it's slowly growing as a group.

Those willing to pursue MAiD provision shared that without someone to demonstrate expectations and practices, the information and education resources from the governing bodies would have been grossly inadequate. As one provider suggested,

I have to say that without their support in a mentoring role, it wouldn't have been enough.

This sentiment was echoed across the region, with one provider feeling comfortable enough to accept an offer of support from a colleague known to her:

I took an extended offer and said, 'Okay, you show me the ropes'.

However, there was concern that those new to a community might feel intimidated or not know who to contact to even broach the topic of mentorship; therefore, the need for a more formalized approach to mentorship was declared:

I think a lot of physicians are still very anxious about it ... I think formalizing (the mentorship role) just makes it that much easier to do ... if there was a formal way to go ahead and find a mentor, then you can work to form those relationships as you get to know people. It's not as intimidating versus actually phoning up somebody and saying, 'I need help, can I follow you?'

As far as mentorship might counteract those aspects of MAiD seen as barriers to recruitment and retention, the logistics of living in Northwestern Ontario communities remain a challenge. Several physicians shared that while the assumed disconnect between the government's expectations and physicians' realities was indeed a hindrance, an issue closer to home was a geographical one. Some doctors in Northwestern Ontario do not reside in the communities in which they work, they may work as locums or choose to live in nearby, larger communities and those who do live in the community might be unwilling to provide MAiD. This inevitably creates the added burden of factoring extensive travel into an already hectic schedule. One participant, living and working in the same community, felt that while knowing a patient and his or her family well is a privilege, it also can be a disadvantage, for everyone involved:

This is a very small community ... and there are people that I've known for years and there are people where I'm going to see their families over and over again ... and rural medicine is like that to begin with but when you're talking about helping somebody end their life, it's even more ...

The challenge of being the sole provider of MAiD in a community is also a difficulty faced in the region. One physician, the sole provider in her community, shared,

I had one patient who had requested MAiD but hadn't picked a date yet and we'd gone through the process, but I was taking a holiday for a month and I was distressed on both his and my behalf that perhaps I wouldn't be available when he needed this done.

Further inequities surface as there is an understanding of people living in rural and remote parts

of Northwestern Ontario that certain speciality services have never been available to them. Several physicians across the region stated that their patients were surprised to learn that they could even ask their family physician for MAiD, and the participants in these circumstances are pleased and privileged to be able to offer that service:

And sometimes people have been surprised to know they can access it here ... I often have met with some relief about that. I'm glad to know that it is something that we can do here.

On a more general note, the expanse of Northwestern Ontario was addressed by several physicians who felt that the region's size was directly responsible for its fractured service provision. This prompted one physician to suggest a move to a more centralized service for MAiD, for both patients and providers:

I think the problem with Northwestern Ontario is that it's a huge area and information gets scattered, each little agency is probably doing their own little thing ... so something easy, accessible, and centralized with good information would be helpful.

Finally, it was well recognized by physician participants that one of the challenges preventing them from providing true choice at the end of life for their patients was the general dearth of home healthcare support and community nursing:

One of the major facts on the ground in MAiD in the nursing stations and in the communities is scarcity of nursing services ... scarcity of home care.

While one physician suggested that this is not a barrier directly associated with MAiD provision, it did not facilitate its provision and, in some cases, made the experience substantially more difficult and inequitable:

One of the things we don't have access to is community nursing, that could go and sit by the bedside for the 15, 18, 21 hours that it might take for someone to die after oral administration of medications, so that's been a barrier to me, to think about using that locally because I can't be at the bedside and families are bereaved and I don't feel like we can resource that very effectively.

This is in keeping with another physician who felt that the loss of the value of community nursing and home care is experienced across most patient trajectories, MAiD being the latest victim:

I suppose the biggest problem we have which is indirectly associated with MAiD is our home care services are very fractured ... they're really not able to provide the kind of support that at one time we would've been used to.

One physician, citing that home care and community nursing at one time was more than sufficient, called on the regional healthcare funding body (LHIN) to rise to the challenge of improvement in both arenas:

(The LHIN) really needs to do its job around home and community care. They need to empower their nurses to be able to provide the services and provide the medications.

Theme 3: burgeoning relationships between palliative care and MAiD

Family physicians and palliative care physicians interviewed shared some interesting views regarding the relationship, if any, between MAiD and palliative care. Many providers expressed gratitude to the palliative care physicians in their communities for the support regarding MAiD. As such, several physicians understood MAiD as not separate from good palliative care:

I really see (MAiD) as part of that continuum.

And others believed it to be,

very much part of the fabric of generalist care; a good wraparound service for those who would choose it should they want it;

and,

part of the palliative care discussion now.

However, physicians' strongest sentiments were regarding the concern that MAiD is precluding access to and provision of palliative care. Several comments were made regarding the lack of access in Northwestern Ontario:

There isn't really an effective way to access palliative care ... and I know I can have an assisted death so I'm going to go down that road because I don't feel confident about the access to palliative care.

and,

I can't help but feel that some people seeking MAiD are seeking it because of the system's failure

rather than their disease process and that is a concern for me.

This also contributed to the uncertainty about physician role. Palliative care physicians pointed out that one service must not preclude the other (e.g. abstaining from palliative care support in order to be eligible for MAiD), sharing that the introduction of MAiD has altered the role of the palliative care physician:

I feel like my role right at the end of life seems a little bit uncertain. I have been challenged as to whether to attend deaths both in hospital and at home.

The ideal, then, would have MAiD positioned at the end of the continuum where palliative care had already been effectively accessed and appropriately implemented:

I would have a whole palliative care program that would have multiple trained homecare providers in every community that we serve ... and if somebody did request MAiD after receiving those excellent palliative care services, then we could.

In addition, some physicians stressed that, while palliative care and MAiD may exist on the same continuum, they are indeed separate components:

The challenge is being very clear and using our words more deliberately in the difference between ... mak(ing) people comfortable to permit them to have a more peaceful and comfortable death but also to live with a terminal illness, versus MAiD which someone may choose to hasten, actively shorten their life.

For palliative care physicians, this is a difficult process to bring to fruition in practice. The parameters regarding MAiD and its set timelines contributed to further concerns that palliative care patients were opting out of treatments in order to remain *compos mentis*:

Patients will avoid ... drugs that we would use to treat their symptoms ... they're very afraid that would result in a loss of capacity ... you see patients suffering only in order to get MAiD and it seems just all backwards.

On a fiscal note, palliative care physicians commented that solving the fee code issues for MAiD providers by giving them existing palliative care codes was far from equitable practice, as providers of MAiD were able to bill for additional items. For

one, quick to state that while it's not about the money, the inequities were taking their toll in dual respects:

I think we need to incentivize good palliative care in the same way we're trying to incentivize good access to MAiD.

From a philosophical perspective, the issue of suffering arose regarding MAiD discussions, with physicians very concerned that medically assisted death was the less labour-intensive of the two options:

It's an easier shortcut than trying to deal with the complexities of someone's existential suffering,

because a request to hasten death is essentially, according to one physician,

first and foremost, a cry for help.

And this suffering is not limited to patients and their families. One physician noted that end-of-life conversations with patients are difficult and exhausting for physicians and that there needs to be additional support for MAiD providers, not necessarily all palliative care physicians, who might be fairly unused to these burdensome practices.

Theme 4: physician recommendations

Overall, this theme encompasses physician participants' recommendations to extend MAiD legislation to reflect the original content of Bill C-14 not subsequently included, more specifically a recommendation to consider the use of MAiD in cases of diminished cognitive ability, mental health and in cases of mature minors in paediatric palliative care. In addition, there were strong suggestions for more education around the many facets of MAiD implementation and patient support.

Generally, physicians in this study expressed that the legislation for MAiD was put into effect without the necessary resources and education:

I think that people believe it is positive and expanding our options to deliver end-of-life care, but it hasn't been a resourced or rolled out appropriately program, actually developed in order to make it more robust.

The concern, too, was with what was felt to be a lack of clarity about the legislation, in general terms:

I feel there is a lot of grey to MAiD,

as well as specifically regarding terminology:

'Foreseeable death' which is an unusual term – it's not stipulated – you can't get a lawyer to tell you what it is, so you're kind of left out.

This often caused confusion for the patient:

The reflection period confuses everybody, so they often don't know a lot about that, or specifics about qualifying.

This led to discussion regarding how suffering might be construed, with several comments about the need to look at the full scope of patient experience:

People are concerned that it may not be available to them and therefore asked for it far too early when, in fact, they may not be eligible because their death is not 'reasonably foreseeable'.

This situation proved not simply theoretical as in the case of Audrey Parker, a Haligonian who opted for MAiD before her end-stage cancer rendered her incapable of same-day decision-making abilities.²⁸

For some physicians, this was particularly frustrating as they felt that MAiD legislation would help provide answers in cases of intractable pain or suffering and were left without options when a patient would become *non compos mentis* and families would exasperatedly say,

Well, this is what we were trying to avoid.

As such, several physicians felt that the legislation should be altered to include advance directives:

If (the patient) had given an advance directive and they lost capacity, I think they've already shown what they wanted to do. You do not need to have capacity at the time of administration;

and,

It's an illness where you were going to do MAiD and it was part of the treatment plan and then at the last stage you become unable to do it and that's not right.

A physician shared that a change in legislation would afford people living with dementia the option of pre-choice:

I think we're missing a huge cohort of people who would all want to access the service if they could speak ahead of time so that's all of our dementia patients. I think the vast majority of people living with dementia could articulate prior to getting it: 'If I don't recognise my family, I would like to access MAiD'.

For some, this also included a reassessment of legislation regarding other areas of ineligibility:

If you speak with paediatricians, they have some disaster cases where (mature minors) are excluded from this but should be considered for it.

In response to whether there were inherent negatives to affording greater access, one physician spoke plainly:

People worry about the slippery slope – we're going to start with the elderly and then move on to the disabled. It's not like that at all. It's people facing a certain death or certain disability and they're not willing to live that kind of life.

Finally, one physician stated that the June 2016 ruling did not realize the full recommendations put forth by the Supreme Court, suggesting that the exclusions now need to be factored back into the legislation, which would directly respond to the advance directive issue:

The things that they've excluded ... was a pre-directive so somebody could say, 'Yes, I want to go ahead with this', and sign the papers now and not have to do it for six months, or something. That way you'd avoid the need for competence at the time of administering the drug.

Discussion

Since its inception, the legalization of MAiD has impacted the options and opportunities available at the end of life for people in Northwestern Ontario. Physicians have been key in rolling out this new legislation into practice and their experiences have been greatly influenced by the communities and the geographic region in which they work. This exploratory study aligns with other research findings, foremostly that, while the implementation of the legislation has not been without its challenges, physician participants found the provision of MAiD to generally be a rewarding

experience;^{26,29} in addition, several participants who had not provided referrals or direct assistance felt that provision was important as they, too, would want access to the service, for themselves and for their families.^{26,30}

The challenges put forth by participants also reflected those in the literature review. Physicians' concerns regarding affording true choice for their patients^{29–31} highlighted the need for access to more resources^{30,31} and collegial and community supports for MAiD providers. Participants echoed sentiments regarding the value of professional and informal mentorship^{29,32} and the necessity of peer and community support as vital to professional and personal well-being.^{26,31} It is reasonable to suggest that while legislation from the Supreme Court of Canada requires that physicians provide patients with complete information on all options available to them, including MAiD, and advise patients on how they can access more information, counselling and referral services, how this might be realized in practice is perhaps an area for further investigation.

Regarding relationship(s) between MAiD and palliative care, participants generally reinforced the need for relationships and communication in their provision as well as the importance of interprofessional roles and dynamics for patient-centred care at end of life.³³ Participants' eagerness to see MAiD as a component of palliative care also echoed the need for an Action Plan in order to co-exist in this new landscape,³⁴ especially in view of the predicament for palliative patients to have to cease medications to remain *compos mentis* in order to meet current MAiD criteria.

Suggestions outlined in this study for readdressing the parameters of original legislation, training and practices shared many of the issues put forth by physicians on both a national and international scale.^{29,32,33} In particular, physicians' concerns regarding ambiguity of both role and legislation,^{32,35,36} lack of interprofessional collaboration^{26,32} and community support, and the need to return to the original legislation to determine areas deemed necessary for inclusion, notably regarding eligibility and wait times³⁶ and medical student and physician education and preparation.^{29,32,35}

Provision of MAiD in rural and remote areas was one area of paucity in the literature, with one source offering a perspective of a physician

involved in rural medicine in Newfoundland³⁷ and another providing this query: as MAiD appears to present a further set of challenges to rural and remote physicians, particularly for those whose scope of practice includes the provision of high-quality palliative services, should rural and remote general practitioners in Ontario also be expected to provide access to MAiD? If so, the aforementioned issues of affording true choice through practical and culturally appropriate methods³⁷ assume a heightened urgency. If not, Ontario could look to provinces such as Manitoba, where MAiD teams have been created to specifically address and fulfil patient requests, although that approach, too, is not without its challenges.³⁷

Limitations

There are limitations of this study to note. No participants identified as conscientious objectors, and we were unable to secure representation from all the communities we attempted to reach. We began this study hoping to conduct focus groups with physicians but due to scheduling challenges we altered our methods to individual interviews. Focus groups may have provided valuable additional information and perspectives. Interviews varied in duration based on physician availability. As with all qualitative research, the findings from this study are not generalizable since the sampling strategy was purposive rather than random, and participants were self-selecting. Further studies with conscientious objectors and additional community representation might offer differing perspectives.

Conclusion

The results of this study provide a snapshot of the Northwestern physician experiences with MAiD and contribute to the work, on a national scale, of Khoshnood and colleagues^{26,29–33,35,36} MAiD is highlighted as a rewarding and challenging experience for physicians in Northwestern Ontario in this study. The logistics of healthcare delivery in Northwestern Ontario communities are complex and layered, which contribute to physician experiences as they work to provide choice at the end of life for the communities they serve. Additional research is needed to recognize the experience of individuals, families and communities alongside other healthcare professionals to better understand how this new intervention has impacted the dying experience of Canadians.

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ORCID iD

Katherine Kortés-Miller  <https://orcid.org/0000-0003-0777-890X>


References

1. Parliament of Canada. Bill C-14, <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent> (2016, accessed 10 January 2020).
2. Council of Canadian Academies. *The state of knowledge of medical assistance in dying for mature minors – MAiD in Canada: historical and current considerations* (chapter 2). Ottawa, ON, Canada: Council of Canadian Academies, 2018.
3. Cohen J, Van Landeghem P, Carpentier N, *et al.* Public acceptance of euthanasia in Europe: a survey study in 47 countries. *Int J Public Health* 2014; 59: 143–156.
4. Tiegel S. *Colombia just legalized euthanasia – here's why that's important.* Public Radio International (PRI), <https://www.pri.org/stories/2015-04-29/colombia-just-legalized-euthanasia-heres-why-thats-big-deal> (29 April 2015, accessed 11 January 2020).
5. Dignitas. Who is Dignitas, http://www.dignitas.ch/index.php?option=com_content&view=article&id=4&Itemid=44&lang=en (2020, accessed 11 January 2020).
6. NBC News – Health News. Ten years after Terri Schiavo, death debates still divide us: bioethicist, <https://www.nbcnews.com/health/health-news/bioethicist-tk-n333536> (31 March 2015, accessed 11 January 2020).
7. CNN News. Physician-assisted suicide fast facts, <https://www.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts/index.html> (1 August 2019, accessed 11 January 2020).

8. Dickens BM. Medically assisted death: Nancy B. *Mcgill Law J* 1993; 38: 1053–1070.
9. CTV News. Taylor's right-to-die fight will continue despite her death at 64, <https://www.ctvnews.ca/canada/taylor-s-right-to-die-fight-will-continue-despite-her-death-at-64-1.986000> (6 October 2012, accessed 11 January 2020).
10. CBC News. Assisted suicide ban struck down by B.C. court, <https://www.cbc.ca/news/canada/british-columbia/assisted-suicide-ban-struck-down-by-b-c-court-1.1144743> (15 June 2012, accessed 11 January 2020).
11. Government of Canada. Medical assistance in dying, <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html> (25 April 2019, accessed 26 January 2020).
12. CBC News. 'Happy to be out of the broken body': one man's journey to assisted death, <https://www.cbc.ca/news/canada/toronto/michael-micallef-assisted-death-1.5260421> (accessed 12 December 2019).
13. Palliative care and MAiD: co-existing in the new environment – Survey report, November, 2018, https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/For+Professionals/For+Professionals/Tools+for+Practice/Other/Palliative+Care+And+MAiD_+Co_Existing+In+The+New+Environment+Survey+Report.aspx
14. Ball IM, Hodge B, Jansen S, *et al.* A Canadian academic hospital's initial MAiD experience: a health-care system review. *J Palliative Care* 2019; 34: 78–84.
15. Sibbald B. Uncertainty over MAiD likely to continue. *Can Med Assoc J* 2016; 188: E417–E418.
16. Canadian Press. Ontario doctors must give referrals for services they oppose: court. *The Toronto Sun*, <https://torontosun.com/news/provincial/ruling-expected-on-doctors-giving-referrals-for-services-they-oppose> (15 May 2019, accessed 13 June 2019).
17. Her Majesty the Queen in Right of Canada. *Fourth interim report on medical assistance in dying*. Ottawa, ON, Canada: Health Canada, April 2018.
18. Bator EX, Philpott B and Costa AP. This moral coil: a cross-sectional survey of Canadian medical student attitudes toward medical assistance in dying. *BMC Med Ethics* 2017; 18: 1–7.
19. Canadian Society of Palliative Care Physicians (CSPCP). Key messages: palliative care and medical assistance in dying (MAiD), <https://www.cspcp.ca/wp-content/uploads/2019/05/CSPCP-Key-Messages-PC-and-MAiD-May-2019-FINAL.pdf> (May 2019, accessed 17 June 2019).
20. Collins A and Leier B. Can medical assistance in dying harm rural and remote palliative care in Canada. *Can Fam Physician* 2017; 63: 186–190.
21. North West LHIN. Sub-regions in the North West LHIN: the right care, when and where it's needed, <http://www.northwestlhin.on.ca/AboutOurLHIN/LHIN%20Sub-regions.aspx> (accessed 17 June 2019).
22. Charmaz K. *Constructing grounded theory: a practical guide through qualitative analysis*. Thousand Oaks, CA: SAGE, 2006.
23. Richardson V. Constructivist pedagogy. *Teach Coll Rec* 2003; 105: 1623–1640.
24. Vygotsky L. *Mind in society*. London: Harvard University Press, 1978.
25. Braun V, Clarke V, Hayfield N, *et al.* Thematic analysis. In: Liamputtong P (ed.) *Handbook of research methods in health social sciences*. Singapore: Springer Nature, 2019, pp.843–860.
26. Beuthin R, Bruce A, Hopwood M-C, *et al.* Rediscovering the art of medicine, rewards, and risks: physicians' experience of providing medical assistance in dying in Canada. *SAGE Open Med* 2020; 8: 1–9.
27. College of Physicians and Surgeons of Ontario. Medical assistance in dying, <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying> (2018, accessed 22 October 2019).
28. CBC News. Halifax woman posthumously calls for fix to Canada's assisted dying rules, <https://www.cbc.ca/news/canada/nova-scotia/audrey-parker-canada-assisted-dying-fix-halifax-1.5006445> (6 February 2019, accessed 15 May 2019).
29. Khoshnood N, Hopwood MC, Lokuge B, *et al.* Exploring Canadian physicians' experiences providing medical assistance in dying: a qualitative study. *J Pain Symptom Manage* 2018; 56: 222–229.
30. Reid T. Reflections from a provider of medical assistance in dying. *Can Fam Physician* 2018; 64: 639–640.
31. Shaw J, Wiebe ER, Nuhn A, *et al.* Providing medical assistance in dying: practice perspectives. *Can Fam Physician* 2018; 64: e394–e399.
32. Fujioka JK, Mirza RM, McDonald PL, *et al.* Implementation of medical assistance in dying: a scoping review of health care providers' perspectives. *J Pain Symptom Manage* 2018; 55: 1564–1576.

33. Brooks L. Health care provider experiences of and perspectives on medical assistance in dying: a scoping review of qualitative studies. *Can J Aging* 2019; 38: 384–396.
34. Canadian Hospice Palliative Care Association (CHPCA). Palliative care and MAiD: Co-existing in the new environment. Survey report, CHPCA, Ottawa, November 2018.
35. Li M, Watt S, Escaf M, *et al.* Medical assistance in dying – implementing a hospital-based program in Canada. *N Engl J Med* 2017; 376: 2082–2088.
36. McKee M and Sellick M. The impact on physicians of providing MAiD (Presentation to CAMAP), <https://camapcanada.ca/wp-content/uploads/2018/12/MAID2018eng1.pdf> (2018, accessed 10 August 2018).
37. Canadian Association of MAiD Assessors and Providers. Final report – 2nd annual medical assistance in dying conference, University of Ottawa, 2018, <https://uocal.uottawa.ca/en/node/20428>

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