Title.
An Entrustable Professional Activity descriptor for Medical Aid in Dying.

Authors.
1. James Downar[1,2 **]
2. Stefanie Green[3]
3. Arun Radhakrishnan[4]
4. Joshua Wales[1,2]
5. George Kim[5]
6. Dori Seccareccia[2,6]
7. Kim Wiebe[7]
8. Jeff Myers[1,2]
9. Sarah Kawaguchi[1,2]

**Corresponding Author:
200 Elizabeth St. 11PMB-195, Toronto, ON, M5G 2C4
james.downar@utoronto.ca

Affiliations.
1. Sinai Health System, Toronto, Canada.
2. University of Toronto, Toronto, Canada.
3. Canadian Association of Medical Aid in Dying Assessors and Providers, Victoria, Canada.
4. Ontario College of Family Physicians, Toronto, Canada.
5. University of Western Ontario, London, Canada.
6. Sunnybrook Health Sciences Centre, Toronto, Canada.
7. University of Manitoba, Winnipeg, Canada.

Abstract Word Count: 246
Main Text Word Count: 1796

Key Words: Suicide, Assisted; Euthanasia, Active, Voluntary; Competency-Based Education; Delphi Technique; Education, Medical

Funding Statement:
This study received funding and support from the Ontario College of Family Physicians through a program supported financially by the Ontario Ministry of Health and Long-Term Care.

Declaration of Authors' Competing Interests:
None declared.

Abstract.

Background. In jurisdictions where Medical Aid in Dying (MAID) is legal, there is an obligation to ensure the competence of those who assess eligibility and provide MAID to patients. Entrustable Professional Activities (EPAs) are one framework for incorporating competency-based training and assessment into the workplace. We convened a group of experienced MAID providers to develop an EPA descriptor for MAID.

Methods. Mixed methods sequential qualitative (focus group) and quantitative (survey) study to generate and refine a consensus descriptor using a modified Delphi approach. Participants were experienced MAID providers identified purposively from a national community of practice.

Results. We invited 22 participants to participate in the focus group, of which 13 (59%) did so. The focus group divided MAID into three component: assessment, preparation and provision of MAID. Participants identified key knowledge, skills and attitudes for each component. They also suggested teaching approaches, potential sources of information to evaluate progress, and a potential basis for evaluating progress and entrustment. Key points from this descriptor were sent via survey to 88 experienced providers, of whom 64 (73%) responded. Respondents agreed on all key points except for the conditions of entrustment. These were modified based on feedback and sent back to the respondents for a second Delphi round, when agreement was achieved.

Interpretation. Here we report on the first competency-based descriptor of MAID in the form of an EPA. This can be used to inform practice standards, curriculum development and/or assessment of competence among learners and practicing physicians alike.

Introduction.

Medical Aid in Dying (MAID) was legalized by the Quebec National Assembly (Bill 52) in June 2014[1], and by Canadian Parliament (Bill C-14)[2] in June, 2016. Although the eligibility criteria and legal safeguards were defined by law, the details of service provision were left to the medical profession, regulatory bodies, provincial ministries of health, and local healthcare organizations to determine. One important aspect of service delivery is ensuring the competence of the healthcare providers delivering the service. Courses have been developed for healthcare providers seeking training in MAID assessment and provision in Canada and Europe[3,4].

Medical education is shifting from time- and process-based training to focusing on competence and outcomes[5]. Entrustable Professional Activities (EPAs) are a framework that enables the practical application of competency-based training into the workplace. An EPA is a key responsibility that involves observable and measurable tasks, requiring a specific set of knowledge, skills and attitudes. A learner must be able to perform this activity at a level that the assessor would trust them to perform it unsupervised[6-8]. Once "entrustment" is achieved for all core activities of a specific discipline, the learner would be considered competent to practice independently. Sets of EPAs have been developed and published for many fields of medicine in Canada, including palliative medicine[9].

For the settings of both postgraduate medical education and clinical practice, a MAID EPA would be of great value to help learners identify learning needs and enable teachers to determine competence prior to independent provision. Therefore, a consensus process involving established experts was used to develop an EPA descriptor for MAID.

Methods.

Design. A mixed methods sequential qualitative and quantitative study was conducted following the model of Myers et al[9]. To describe competence in assessing a patient's request for MAiD as well as perform the procedure, the qualitative component consisted of a focus group with participants being experienced MAID providers and the aim being to establish the required knowledge, skills and attitudes; the methods of assessing progress; the proposed entrustment conditions; and the approach to arriving at an entrustment decision. This information was compiled into a brief 2-page descriptor, which was reviewed and refined by consensus of the focus group. A modified Delphi process was subsequently used to revise the draft descriptor and establish consensus about each component among a larger group of practicing MAID assessors and providers.

Participants.

Eligibility Criteria.

1. Qualitative (Focus group). Experienced providers were purposively sampled from the membership of the Canadian Association of MAID Assessors and Providers (CAMAP). Efforts were made to include representation from all provinces, and to include members who were actively involved in both MAID provision and dialogue around practice issues on the CAMAP listserv discussion forum.

2. Quantitative (modified Delphi). A survey of experienced MAID providers was conducted using the national CAMAP email listserv.

Study Procedures.

1. Focus Group. Consenting individuals participated in 2 x 60-minute semi-structured teleconferences to establish:

- The description of the MAID assessment and provision
- The knowledge, skills and attitudes required to successfully complete a MAID assessment and provision
- Suggested teaching approaches to acquire the necessary competence, including didactic, experiential and reflective components
- The means of assessing competence, including direct observation of an assessment and provision
- The point at which a learner would be expected to achieve competence (estimation)
- The basis for establishing "entrustment" to perform the task independently.

Participants were given material prior to the teleconferences that addressed the topics of competency-based assessment and EPAs, as well as an overview of the MAID related content material taught in educational courses[3,4]. Focus group sessions were audiorecorded and field notes were taken by two authors (JD and SK). Data were analyzed by open coding to identify key points within the structure above. These were then compiled into a 2 page description and fed back to focus group participants. Disagreements on content were resolved by consensus.

2. Survey. Elements of the 2-page description along with explanations of the project, competency based evaluation, and EPAs in particular were distributed electronically to all members of the CAMAP provider listserv via SurveyMonkey™. Respondents were asked to rate their agreement with each section of the EPA description using a 5-point Likert scale ranging from "strongly disagree" (1) to "strongly agree" (5). Given the controversial nature of the topic, we set the threshold for agreement at "Agree" (4), and points were accepted if 70% of respondents gave this rating[10]. Respondents assigning a score of "Neutral" (3) or less were asked to suggest changes that would result in their agreement with the point. Any section failing to achieve consensus after the first round would be modified based on participant feedback and resent to listserv members with the aim of achieving consensus. Non-respondents were sent up to 2 reminders in each round.

Ethics.

This project was approved by the Research Ethics Board at the University Health Network (17-6257).

Results.

22 experienced MAID providers were identified and invited to participate in the focus group, of which 13 were able to participate in one or both teleconferences held in March 2018. Participants were all physicians, seven (54%) were female, and their practice locations included Eastern Canada (1), Quebec (1), Ontario (5), the Prairie provinces (4), and British Columbia (2).

From the discussion, MAID related tasks were categories into three groupings: (1) assessing patient eligibility; (2) preparing for MAID provision; and (3) MAID provision. Participants identified the key knowledge, skills and attitudes required for each component. Suggestions were made on teaching approaches, potential sources of information to evaluate progress, and a potential basis for evaluating progress and entrustment. Participants also identified important differences in Quebec where only physician administered MAID (and not self-administered MAID) is permitted. After two 90-minute focus group sessions, participants did not have any further suggestions to inform the EPA description.

The quantitative survey was then sent to 88 assessors and providers across the country, of which 64 (73%) responded. Demographic information is outlined in table 1 and of note, seven individuals chose not to provide this information. The majority of respondents were family physicians with a range of clinical experience but all had assessed eligibility and performed MAID at least once.

Overall, there was a high degree of agreement for most of the key points on the survey (Table 2). Agreement ranged from 58% for one section of the entrustment conditions (see below) to 100% for "confirming capacity and consent and providing an opportunity to withdraw the request for MAID" in the description of provision of MAID. The only key point that did not achieve the 70% threshold for agreement was the entrustment conditions. Written comments for this section indicated concern that three observed assessments/provisions were too many to be realistically achieved in many settings. Concern was also expressed about the feasibility of applying this standard retroactively among experienced and expert providers.

In view of this feedback, the entrustment section was revised and resent to the same group of 88 individuals. Fifty-one responses were received (58% response rate), with 44 (86%) indicating agreement or strong agreement with the revision, and none indicating disagreement. The final version of the EPA descriptor appears in the Appendix.

Discussion.

In this project, we developed an EPA descriptor for MAID in Canada using a modified Delphi process. To our knowledge, this is the first competency-based description of MAID assessment and provision. MAID poses a unique training challenge in Canada because legalization preceded coordinated efforts to train providers. Process-based training programs have been developed for other jurisdictions, including Belgium and the Netherlands[4], but early Canadian providers had little or no access to this training, with the result that many were self-taught. After some time, communities of practice formed to discuss approaches and clinical challenges (e.g. The Canadian Association of MAiD Assessors and Providers (CAMAP)), and the Canadian Medical Association developed a workshop to teach MAID assessment and provision[3]. Still, there is no formal means of assessing or ensuring competence, even though MAID is now performed in almost 1% of deaths in Canada[11], and MAID itself is fraught with potential clinical, moral, and legal challenges.

MAID is well-suited to the EPA framework, in that MAID assessments and procedures can be scheduled and observed, and there is an identifiable group of clinicians with experience with MAID who could assess competence. Focus group participants were able to clearly describe the key concepts used in the descriptor, most of which were readily accepted by the

larger group of MAID providers. Our EPA descriptor outlines the key tasks involved in MAID, and can be used to help inform practice standards, develop curricula[12], and/or serve as the basis assessing competence among learners both in practice and still in training.

In our current educational climate, it is no longer satisfactory to consider learners as having attained the necessary knowledge, skills, and attitudes to care for patients simply because they completed a prescribed set of educational experiences. Nevertheless, as medical education transitions to a competency-based paradigm[5], some challenges can arise. An example was clearly communicated by participants who disagreed with the entrustment conditions initially proposed, feeling that they were unnecessarily onerous and impractical for many settings. Even in a training environment, learners perform many professional activities unsupervised[13]. Assessing competence is not always straightforward, and some may question the value and validity of specific competencies[14] because they are not clearly linked to outcomes. Entrustment is a complicated decision that involves many factors, and learners and supervisors may not agree on what the learner can be trusted to do independently[15]. It may be challenging to find a balance between conditions that are achievable and conditions that can guarantee exposure to sufficiently complex cases. Ten Cate et al. have suggested means of approaching competence in the context of a particular clinical environment[16]. Our EPA descriptor is one part of a competency-based approach to MAID, but many details have yet to be established.

Strengths of this study include the fact that participants were a geographically-diverse group of experienced assessors and providers, and the fact that we achieved a high response rate and a high degree of consensus around the content. A main limitation is related to the

broader issues of MAID and the fact it is still a controversial practice in evolution. MAID assessors and providers have the experience and expertise to inform key aspects of practice, but some members of the medical community, including those who are morally opposed to MAID, may not accept a competency framework established by assessors and providers.

In conclusion, we present this EPA descriptor for the practice of MAID in Canada, in the hope that it can help to inform practice standards, curriculum development and assessment of competence among learners and practicing physicians alike. Future work in this area will focus on applying this descriptor to these specific settings, in the hope of ensuring high quality MAID assessment and provision for all Canadians.

Acknowledgments.

This study received funding and support from the Ontario College of Family Physicians through a program supported financially by the Ontario Ministry of Health and Long-Term Care. The authors would like to thank the providers who participated in the focus group sessions, and the members of the CAMAP listserv who participated in the survey.

Legends.

Table 1. Demographics of survey participants.

Table 2. Participant agreement with key points on the survey.

References.

1. Bill 52: An act respecting end-of-life care.
2. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). *Criminal Code of Canada*2016.
3. https://www.cma.ca/En/Pages/advanced-course-medical-assistance-dying.aspx. Accessed December 14, 2017.

4. Van Wesemael Y, Cohen J, Onwuteaka-Philipsen BD, Bilsen J, Deliens L. Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium. *BMC Health Serv Res.* 2009;9:220.
5. What is competency-based medical education. https://knowledgeplus.nejm.org/blog/what-is-competency-based-medical-education/. Accessed May 24, 2018.
6. ten Cate O. Trust, competence, and the supervisor's role in postgraduate training. *BMJ.* 2006;333(7571):748-751.
7. ten Cate O, Scheele F. Competency-based postgraduate training: can we bridge the gap between theory and clinical practice? *Academic medicine : journal of the Association of American Medical Colleges.* 2007;82(6):542-547.
8. Mulder H, Ten Cate O, Daalder R, Berkvens J. Building a competency-based workplace curriculum around entrustable professional activities: The case of physician assistant training. *Medical teacher.* 2010;32(10):e453-459.
9. Myers J, Krueger P, Webster F, et al. Development and Validation of a Set of Palliative Medicine Entrustable Professional Activities: Findings from a Mixed Methods Study. *J Palliat Med.* 2015;18(8):682-690.
10. Downar J, Hawryluck L. What should we say when discussing "code status" and life support with a patient? A Delphi analysis. *J Palliat Med.* 2010;13(2):185-195.
11. Medical Assistance In Dying: Interim Report September 2017. https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-sep-2017/medical-assistance-dying-interim-report-sep-2017-eng.pdf. Accessed May 5, 2018.
12. Boyce P, Spratt C, Davies M, McEvoy P. Using entrustable professional activities to guide curriculum development in psychiatry training. *BMC Med Educ.* 2011;11:96.
13. Jones MD, Jr., Rosenberg AA, Gilhooly JT, Carraccio CL. Perspective: Competencies, outcomes, and controversy--linking professional activities to competencies to improve resident education and practice. *Academic medicine : journal of the Association of American Medical Colleges.* 2011;86(2):161-165.
14. Lurie SJ, Mooney CJ, Lyness JM. Commentary: pitfalls in assessment of competency-based educational objectives. *Academic medicine : journal of the Association of American Medical Colleges.* 2011;86(4):412-414.
15. Sterkenburg A, Barach P, Kalkman C, Gielen M, ten Cate O. When do supervising physicians decide to entrust residents with unsupervised tasks? *Academic medicine : journal of the Association of American Medical Colleges.* 2010;85(9):1408-1417.
16. ten Cate O, Snell L, Carraccio C. Medical competence: the interplay between individual ability and the health care environment. *Medical teacher.* 2010;32(8):669-675.

Characteristic	N (%)
Age	
30 or less	1 (2)
31-40	12 (21)
41-50	14 (25)
51-60	18 (32)
61 or more	12 (21)
Profession	
Physician	52 (91)
Nurse Practitioner	4 (7)
Specialty	
Family Medicine	40 (71)
Internal Medicine	5 (9)
Anesthesiology	7 (13)
Emergency Medicine	1 (2)
Pediatrics	1 (2)
Psychiatry	1 (2)
Surgery	1 (2)
Years in Independent Practice	
5 or less	8 (14)
6-10	9 (16)
11-20	13 (22)
21-30	14 (25)
>30	13 (23)
Estimated number of MAID eligibility assessments performed	
0	0
1-5	7 (12)
6-10	8 (14)

11-25	18 (32)
26-50	10 (18)
>50	14 (25)
Estimated number of MAID procedures performed	
0	0
1-5	18 (32)
6-10	7 (12)
11-25	14 (25)
26-50	12 (21)
>50	6 (11)

Description: Participants were asked to "indicate whether you agree that the sentence should be included and is an accurate description of the tasks performed by a competent assessor/provider"							
Part 1: Assessment for Eligibility	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total	Weighted Average
Determining that the patient is clearly expressing a desire for MAID and meets the criteria for MAID established by law.	0	2 (3)	4 (6)	9 (15)	49 (77)	64	4.64
Establishing that the patient is capable- namely that they understand their medical options, including therapeutic options for their underlying illness as well as their EOL options (including palliative care); they understand the reasonably foreseeable consequences of each of these options; and they can make a reasoned decision among these options.	1 (2)	0	0	9 (15)	54 (84)	64	4.8
Identifying the cause(s) of the patient's intolerable suffering and addressing any unmet palliative and social needs, if possible and appropriate, by engaging a palliative care or other specialized provider.	0	2 (3)	5 (8)	27 (42)	30 (47)	64	4.33
Establishing that the decision is voluntary and not coerced.	0	1 (2)	0	14 (22)	49 (77)	64	4.73
Obtaining corollary history and additional documentation as required.	1 (2)	0	2 (3)	20 (31)	41 (64)	64	4.56
Documenting findings.	1 (2)	0	0	12 (19)	50 (79)	63	4.75
Part 2: Preparation for the provision of MAID							
Communicating with multidisciplinary team to arrange provision (including pharmacy, nursing, administration, when applicable).	0	0	1 (2)	18 (28)	45 (70)	64	4.69
Determining the patient's preferred location, and making preparations appropriate for that location.	0	1 (2)	0	16 (25)	46 (73)	63	4.7
Determining the patient's preferred route of administration (if more than one route is available in your jurisdictions), and making appropriate preparations.	1 (2)	1 (2)	0	19 (30)	43 (67)	64	4.59
Responding appropriately to a rapid deterioration in the patient's patient's condition or episodes of delirium or decreased level of consciousness by expediting the provision.	2 (3)	3 (5)	6 (9)	19 (30)	34 (53)	64	4.25
Part 3: Provision of MAID							
Counseling the patient and family about what to expect during MAID provision.	0	0	1 (2)	12 (19)	51 (80)	64	4.78
Confirming capacity and consent, and providing an opportunity to withdraw	0	0	0	11	53 (83)	64	4.83

the request for MAID.				(17)			
Administering medication while ensuring a caring and supportive environment.	0	0	1 (2)	12 (19)	50 (79)	63	4.78
Attending to post-death tasks including documentation of the provision, discussing next steps with family/caregivers, contacting the coroner when necessary, and debriefing with team members. Assuring appropriate paperwork and reporting to relevant oversight authorities.	0	0	2 (3)	12 (19)	50 (78)	64	4.75
Knowledge, Skills and Attitudes: Participants were asked to "indicate whether you agree that the sentence should be included and is an accurate description of the knowledge, skills or attitudes required by a competent assessor/provider"							
Knowledge: The learner should be aware of...						Total	Weighted Average
The eligibility criteria established by law and reasonable interpretations of these criteria.	0	0	0	10 (16)	54 (84)	64	4.84
Areas of controversy in interpreting these criteria, and the basis of the controversies.	0	0	2 (3)	24 (38)	38 (59)	64	4.56
Regional/institutional requirements such as standard protocols, reporting requirements, institutional procedures, and referral mechanisms.	0	0	0	18 (28)	46 (72)	64	4.72
The range of medications and equipment used during MAID.	0	0	1 (2)	18 (28)	45 (70)	64	4.69
Considerations that arise when providing MAID in the home vs. in an institution.	0	0	2 (3)	24 (38)	38 (59)	64	4.56
Common events that occur and signs that patient may display during the provision of MAID.	0	0	2 (3)	21 (33)	41 (64)	64	4.61
Regulations regarding organ and tissue donation.	0	1 (2)	6 (9)	36 (56)	21 (33)	64	4.2
Skills: The learner should be able to...							
Understand and assess the patient's understanding of treatment alternatives relevant to the patient's condition, in keeping with the expertise of the assessor.	0	0	4 (6)	25 (39)	35 (55)	64	4.48
Assess and facilitate the patient's understanding of information and ability to reason between options, particularly in patients with neurological disease, mental illness and cognitive impairment.	0	0	1 (2)	29 (45)	34 (53)	64	4.52

Recognize when additional medical information or assessments are required from other sources.	0	0	0	19 (30)	45 (70)	64	4.7
Prognosticate when appropriate, and to appreciate how prognosis might affect the eligibility or timing of MAID.	1 (2)	2 (3)	2 (3)	30 (47)	29 (45)	64	4.31
Document and communicate findings accurately.	0	0	0	18 (28)	46 (72)	64	4.72
Develop a therapeutic relationship with new patients/family members in a short timeframe.	0	0	0	20 (31)	44 (69)	64	4.69
Assess and manage the range of emotions that can arise from the family and health care team either in respect to MAiD in general or to a particular MAiD provision.	0	1 (2)	3 (5)	20 (31)	40 (63)	64	4.55
Manage enteral or intravenous access, and anticipate and troubleshoot problems that may arise during the provision of MAID.	1 (2)	6 (9)	6 (9)	16 (25)	35 (55)	64	4.22
Support family through acute grief around the time of MAID provision.	0	1 (2)	6 (9)	18 (28)	39 (61)	64	4.48
Attitudes: The learner should...							
Demonstrate a non-judgmental approach to patients'/families' responses to MAID (either positive or negative)	0	0	0	17 (27)	46 (73)	63	4.73
Not allow personal views on MAID to influence an eligibility assessment, or influence a patient's decision to proceed with MAID or not.	1 (2)	0	1 (2)	16 (25)	45 (71)	63	4.65
Advocate for access to MAID when an eligible patient has requested MAID.	0	0	2 (3)	21 (33)	40 (63)	63	4.6
Show humility by acknowleding limitations of personal knowledge, and consult experts regarding medical, legal or ethical issues outside their training and experience.	0	0	2 (3)	15 (24)	46 (73)	63	4.7
Adapt their approach (by providing extra documentation or consultation) when medicolegal consequences seem more likely.	0	3 (5)	4 (6)	18 (28)	38 (60)	63	4.44
Demonstrate a commitment to self-care and emotional support for other members of allied health team who may be struggling with MAID.	0	2 (3)	1 (2)	20 (32)	40 (63)	63	4.56
Demonstrate a commitment to maintain the competence of self and others by participating in a community of practice to share experience and learn from the experience of others as the practice of MAID and eligibility and reporting requirements evolve.	0	3 (5)	3 (5)	20 (32)	37 (59)	63	4.44

Teaching, progress and entrustment: Participants were asked to "indicate whether you agree that the sentence should be included and is an accurate description of the teaching approaches and entrustment decisions that should be used to determine competence"							
The following teaching approaches can be used.						Total	Weighted Average
Didactic sessions/lectures.	0	0	2 (3)	39 (63)	21 (34)	62	4.31
Witnessed assessments and provisions, including remote witnessing via telemedicine.	0	0	1 (2)	21 (34)	39 (64)	61	4.62
Optional: Simulated encounters with standardized patients.	0	1 (2)	9 (15)	34 (55)	18 (29)	62	4.11
Optional: Procedural simulation for vascular access.	0	2 (3)	7 (11)	34 (55)	19 (31)	62	4.13
The following sources of information can be used to evaluate progress							
Direct observation	0	0	2 (3)	23 (37)	37 (60)	62	4.56
Reviewing documentation of assessments	0	0	0	24 (39)	38 (61)	62	4.61
Multi-source feedback	0	3 (5)	1 (2)	26 (42)	32 (52)	62	4.4
Formal entrustment decisions (i.e. that the learner can be trusted to perform an assessment and provision of MAID without supervision) can be made on the following bases:							
Entrustment for assessment requires more observation with varying complexity than entrustment for provision.	0	8 (13)	6 (9)	32 (52)	15 (25)	61	3.89
Entrustment should occur after observation (in person or remotely) of 3 assessments+provisions where the observer felt the learner demonstrated appropriate competence for unsupervised practice. Ideally, one of these assessments should involve a patient of high complexity.	1 (2)	12 (20)	13 (21)	23 (38)	12 (20)	61	3.54
Most assessments are straightforward and even several of these might not prepare the learner for challenging cases. Experience with different types of scenarios (e.g. neurological illness, mental illness, and other conditions that may affect capacity) would be ideal. For entrustment, the learner should demonstrate the ability to distinguish between straightforward and complex cases, and demonstrate a willingness to ask for help with complex cases.	0	3 (5)	5 (8)	23 (38)	30 (49)	61	4.31

Title: Assessment and provision of Medical Aid in Dying (MAID).

Description:

This activity includes 3 components:

1. *Assessment* for eligibility, which includes:
   - Determining that the patient is clearly expressing a desire for hastened death (as opposed to a desire to die) and meets the criteria for MAID established by law.
   - Establishing that the patient is capable- namely that they understand their medical options, including therapeutic options for their underlying illness as well as their EOL options (including palliative care); they understand the reasonably foreseeable consequences of each of these options; and they can make a reasoned decision among these options.
   - Identifying the cause(s) of the patient's intolerable suffering and addressing any unmet palliative and social needs, if possible and appropriate, by engaging a palliative care or other specialized provider.
   - Establishing that the decision is voluntary and not coerced.
   - Obtaining corollary history and additional documentation as required.
   - Documenting findings.

2. *Preparation* for the provision of MAID:
   - Communicating with multidisciplinary team to arrange provision (including pharmacy, nursing, administration, when applicable).
   - Determining the patient's preferred location, and making preparations appropriate for that location.
   - Determining the patient's preferred route of administration (if applicable), and making appropriate preparations**.
   - Responding appropriately to a rapid deterioration in the patient's patient's condition or episodes of delirium or decreased level of consciousness by expediting the provision.

3. *Provision* of MAID:
   - Counseling the patient and family about what to expect during MAID provision.
   - Confirming capacity and consent, and providing an opportunity to withdraw the request for MAID.
   - Administering medication while ensuring a caring and supportive environment.
   - Attending to post-death tasks including documentation of the provision, discussing next steps with family/caregivers, contacting the coroner when necessary, and debriefing with team members. Assuring appropriate paperwork and reporting to relevant oversight authorities.

Link with Competency Framework:

Knowledge: The learner should be aware of…

- The eligibility criteria established by law and reasonable interpretations of these criteria.
- Areas of controversy in interpreting these criteria, and the basis of the controversies.

- Regional/institutional requirements such as standard protocols, reporting requirements, institutional procedures, and referral mechanisms.
- The range of medications and equipment used during MAID.
- Considerations that arise when providing MAID in the home vs. in an institution.
- Common events that occur and signs that patient may display during the provision of MAID.
- Regulations regarding organ and tissue donation.

Skills: The learner should be able to…

- Understand and assess the patient's understanding of treatment alternatives relevant to the patient's condition, in keeping with the expertise of the assessor.
- Assess and facilitate the patient's understanding of information and ability to reason between options, particularly in patients with neurological disease, mental illness and cognitive impairment.
- Recognize when additional medical information or assessments are required from other sources.
- Prognosticate when appropriate, and to appreciate how prognosis might affect the eligibility or timing of MAID.
- Document and communicate findings accurately.
- Develop a therapeutic relationship with new patients/family members in a short timeframe.
- Assess and manage the range of emotions that can arise from the family and health care team either in respect to MAiD in general or to a particular MAiD provision.
- Manage enteral** or intravenous access, and anticipate and troubleshoot problems that may arise during the provision of MAID.
- Support family through acute grief around the time of MAID provision.

Attitudes: The learner should…

- Demonstrate a non-judgmental approach to patients'/families' responses to MAID (either positive or negative)
- Not allow personal views on MAID to influence an eligibility assessment, or influence a patient's decision to proceed with MAID or not.
- Advocate for access to MAID when an eligible patient has requested MAID.
- Show humility by acknowleding limitations of personal knowledge, and consult experts regarding medical, legal or ethical issues outside their training and experience.
- Adapt their approach (by providing extra documentation or consultation) when medicolegal consequences seem more likely.
- Demonstrate a commitment to self-care and emotional support for other members of allied health team who may be struggling with MAID.
- Demonstrate a commitment to maintain the competence of self and others by participating in a community of practice to share experience and learn from the experience of others as the practice of MAID and eligibility and reporting requirements evolve.

Teaching Approaches may include:

- Didactic sessions
- Witnessed assessments and provisions, including remote witnessing via telemedicine
- Optional: Simulated encounters with standardized patients.
- Optional: Procedural simulation for vascular access.

Sources of Information to evaluate progress may include:

- Direct observation
- Reviewing documentation of assessments.
- Multi-source feedback.

Potential basis for formal entrustment decisions:

Entrustment indicates that in the opinion of the assessor, the learner can be trusted to perform the task independently. We suggest that in order to be able to make this entrustment decision, a minimum of two assessments for and provisions of MAiD be directly observed and completed at a level compatible with unsupervised practice. Ideally, one of these assessments should involve a patient with a higher degree of complexity (illness that may affect capacity, complex family dynamics, lack of clarity in interpretation of the law). This is, however, a guideline and we recognize that from a logistical standpoint this may be challenging, especially for those working in remote areas. In some circumstances telemedicine may prove helpful. We suggest that for entrustment, the learner should at least be able to demonstrate the ability to distinguish between straightforward and complex cases, and demonstrate a willingness to ask for help from colleagues when appropriate. This definition of entrustment is also not meant to limit the functioning of existing MAiD providers, but rather to provide a more robust way of verifying competence for those seeking to become assessors and/or providers.

**Not applicable to Quebec