

Impact of Medical Assistance in Dying on palliative care: A qualitative study

Palliative Medicine

1–8

© The Author(s) 2020

Article reuse guidelines:

sagepub.com/journals-permissions

DOI: 10.1177/0269216320968517

journals.sagepub.com/home/pmj

Jean Jacob Mathews^{1*}, David Hausner^{2*}, Jonathan Avery¹,
Breffni Hannon^{1,3,4} , Camilla Zimmermann^{1,3,4}
and Ahmed al-Awamer^{1,3,5} 

Abstract

Background: Medical Assistance in Dying comprises interventions that can be provided by medical practitioners to cause death of a person at their request if they meet predefined criteria. In June 2016, Medical Assistance in Dying became legal in Canada, sparking intense debate in the palliative care community.

Aim: This study aims to explore the experience of frontline palliative care providers about the impact of Medical Assistance in Dying on palliative care practice.

Design: Qualitative descriptive design using semi-structured interviews and thematic analysis

Settings/participants: We interviewed palliative care physicians and nurses who practiced in settings where patients could access Medical Assistance in Dying for at least 6 months before and after its legalization. Purposeful sampling was used to recruit participants with diverse personal views and experiences with assisted death. Conceptual saturation was achieved after interviewing 23 palliative care providers (13 physicians and 10 nurses) in Southern Ontario.

Results: Themes identified included a new dying experience with assisted death; challenges with symptom control; challenges with communication; impact on palliative care providers personally and on their relationships with patients; and consumption of palliative care resources to support assisted death.

Conclusion: Medical Assistance in Dying has had a profound impact on palliative care providers and their practice. Communication training with access to resources for ethical decision-making and a review of legislation may help address new challenges. Further research is needed to understand palliative care provider distress around Medical Assistance in Dying, and additional resources are necessary to support palliative care delivery.

Keywords

Assisted suicide, euthanasia, palliative care, qualitative research, terminal care, Medical Assistance in Dying

What is already known about the topic?

- Medical Assistance in Dying is a globally polarizing topic, and several national and international palliative care associations have held the position that palliative care practice should remain separate from assisted death.
- The specific role of palliative care providers in discussing, assessing, and providing Medical Assistance in Dying for patients remains unclear.
- Three years after the legalization of Medical Assistance in Dying in Canada, its impact on palliative care practice remains unexplored.

¹Department of Supportive Care, Princess Margaret Cancer Centre, University Health Network, Toronto, ON, Canada

²Palliative Care Service, Oncology Institute, Sheba Medical Center, Ramat Gan, Israel

³Division of Palliative Medicine, University of Toronto, Toronto, ON, Canada

⁴Division of Medical Oncology, Department of Medicine, University of Toronto, Toronto, ON, Canada

⁵Division of Palliative Care, Department of Family and Community Medicine, University of Toronto, Toronto, ON, Canada

*These authors contributed equally to the work.

Corresponding author:

Ahmed al-Awamer, Department of Supportive Care, Princess Margaret Cancer Centre, University Health Network, 620 University Ave., 12th floor, Toronto, Canada ON M5G 2C1.

Email: ahmed.al.awamer@utoronto.ca

What this paper adds?

- Through qualitative interviews with palliative care physicians and nurses having diverse views on Medical Assistance in Dying, we have identified several ways in which it has impacted palliative care practice.
- Medical Assistance in Dying has provided an alternative dying experience and challenged symptom control strategies because of the need to maintain lucidity for eligibility for assisted death.
- A significant amount of support for Medical Assistance in Dying was indirectly provided by palliative care providers and this created additional challenges for already strained palliative care resources.

Implications for practice, theory or policy

- Communication training around Medical Assistance in Dying with access to resources for ethical decision-making may be needed to adequately support palliative care providers.
- Findings regarding the challenge to symptom control may have implications for the Canadian government's proposal to revise the existing Medical Assistance in Dying legislation.
- Further studies are needed to examine measures to support palliative care providers who experience moral distress around Medical Assistance in Dying.

Background

Medical Assistance in Dying is defined as the administration of a lethal substance by a medical practitioner to a consenting person to intentionally cause their death, or prescribing a substance that the eligible person takes themselves, in order to bring about their own death.¹ On June 17th, 2016, Medical Assistance in Dying became legal in Canada for adult patients with irremediable and grievous illnesses. Patients who make requests for assisted death are required to undergo two independent assessments for eligibility by either physicians or nurse practitioners; there is usually a 10 day reflection period from the day of request's approval by assessors to receipt of assisted death. The federal legislation allows physicians and nurse practitioners in Canada to directly administer Medical Assistance in Dying or prescribe drugs that the patient can self-administer. The Canadian legislation requires that the patient has to expressly consent to Medical Assistance in Dying immediately before it is provided, and does not permit advance directives. The federal legislation provided a broad national framework and allowed the provincial and territorial governments and health professional regulatory bodies to develop local policies and procedures for Medical Assistance in Dying specific to their jurisdiction.² While physicians are not required to participate in Medical Assistance in Dying, most provincial regulatory authorities, including those in Ontario, require objecting physicians to make an effective referral for Medical Assistance in Dying requests.³ Palliative care providers play an important role in exploring and facilitating end of life wishes⁴; this now includes conversations about Medical Assistance in Dying for interested patients. However, Medical Assistance in Dying is a globally polarizing topic, and its introduction in Canada has sparked an intense debate about the relationship between palliative care and assisted death.^{5,6} The specific

role of palliative care providers in discussing, assessing and providing Medical Assistance in Dying for patients remains unclear.⁷⁻⁹ A survey of Canadian palliative care physicians before its legalization found that 75% of participants felt Medical Assistance in Dying should not be provided by palliative care providers.¹⁰ Several national and international palliative care associations have held the position that palliative care practice should remain completely separate from Medical Assistance in Dying.¹¹⁻¹⁴ On the other hand, some countries, such as Belgium, have created an integrated model where euthanasia is embedded in palliative care practice.^{15,16} Research exploring how Medical Assistance in Dying has impacted palliative care practice is limited, however.^{5,7,17-19}

Three years after the legalization of Medical Assistance in Dying in Canada, its impact on palliative care practice remains unexplored. The purpose of this study was to understand how Medical Assistance in Dying has impacted palliative care practice for physicians and nurses.

Methods*Research question*

How has Medical Assistance in Dying impacted palliative care practice for physicians and nurses in Canada?

Study design

A qualitative descriptive design using semi-structured interviews and thematic analysis,²⁰ was used to explore the experiences of palliative care providers who cared for patients who requested Medical Assistance in Dying. In contrast to other qualitative methods such as grounded theory or interpretive description that go beyond the words used by participants to interpret meaning, qualitative description is less interpretive and does not require

researchers “to move as far from or into their data.”²¹ The authors chose qualitative description to stay as close as possible to the words used by participants when analyzing the data. In this way, a specific theoretical lens was not required and none was chosen to assign meaning to the data. This article follows the criteria for reporting qualitative research from the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.²²

Population and setting

We recruited palliative care physicians and nurses who practiced for 6 months or more before and after the introduction of Medical Assistance in Dying, in inpatient and community-based settings that supported assisted death.

Recruitment

We used a combination of purposive and snowball sampling to include participants who had varying opinions about Medical Assistance in Dying. We invited palliative care leaders and frontline providers with publicly known opinions, either published or articulated, about Medical Assistance in Dying. We also asked participants to recommend potential interviewees with known and diverse opinions about Medical Assistance in Dying. Introductory emails were sent to potential participants. Recruitment was suspended when wide representation and saturation of themes was attained. All participants practiced palliative care in Southern Ontario, Canada.

Data collection

Semi-structured interviews based on a predefined interview guide were used as the primary means of data collection. Given the reflective nature of the interview questions, the participants received the interview guide by email a week before the interview to allow for deeper reflection on the subject matter. Each participant provided written informed consent prior to starting the interview. Participants were informed that they can withdraw at any time point or choose not to answer any of the questions. The interviews were conducted and audio-recorded between February 2018 and September 2019 by three investigators (A.A., J.J.M., D.H.). Some of the participants were known to the investigators from common professional circles and work settings, while others were not. Interviews occurred in person or over the phone, and a professional transcription service was used to transcribe the recordings verbatim. Physician participants were coded as P1, P2, etc. Nurses were coded as N1, N2, etc.

Qualitative analysis

Transcripts were analyzed by two investigators (D.H., J.J.M.) using Braun and Clarke’s²⁰ version of thematic

Table 1. Participants’ demographics.

	Physicians	Nurses
<i>N</i>	10	13
Mean age (range)	43 (33–64)	42.6 (27–59)
Gender (% female)	54%	90%
Years of practice (median, range)	7 (2–35)	9.5 (2.5–30)

analysis as a flexible guide for data analysis. All the researches are palliative care physicians (except J.A. who is a qualitative researcher) and come from diverse social and cultural backgrounds and held different views on Medical Assistance in Dying. The first four interviews were analyzed independently by D.H. and J.J.M. and then discussed to develop an agreed upon coding framework. After establishing the coding framework, the remaining transcripts were divided between D.H. and J.M. to analyze. Weekly meetings between D.H., J.M., J.A., and A.A. were used to review the coding framework and the analysis process to ensure emerging findings remained as close as possible to the words used by participants. During these meetings, researchers’ subjectivities and views about Medical Assistance in Dying were discussed and made explicit, and points of difference were examined and understood to improve validity before finalizing the findings.

Ethics approval

The study was approved by The University Health Network Research Ethics Board on Jan 19, 2018 (Ethics ID No. 17-5917.0.1).

Results

Demographics

The final sample consisted of 23 palliative care providers from Southern Ontario, Canada: 13 physicians and 10 nurses (Table 1). The median number of years of palliative care practice was 8 years, ranging from 2 to 35 years. Participants worked in various settings, including inpatient consult services, inpatient palliative care units, outpatient clinics, home-based palliative care, and residential hospices, with several participants working in more than one setting. All of the participants described having discussions with patients regarding Medical Assistance in Dying and seven of the 23 participants (four nurses and three physicians) described directly witnessing assisted death. Of the 13 physicians, eight made referrals for Medical Assistance in Dying, four conducted assessments, and three physicians were Medical Assistance in Dying providers as well as being palliative care providers; three physicians identified as conscientious objectors (who made or were willing to make referrals for Medical Assistance in Dying). None of

the nurses identified themselves as conscientious objectors, although some expressed moral or religious conflict around Medical Assistance in Dying.

Findings

Overall, participants described how the implementation of Medical Assistance in Dying had impacted palliative care practice. Six main themes emerged: (1) Medical Assistance in Dying offers an alternative dying experience to natural death; (2) The laws around Medical Assistance in Dying may pose challenges to traditional symptom control strategies; (3) Medical Assistance in Dying creates new “difficult conversations”; (4) Medical Assistance in Dying had an emotional and personal impact on palliative care providers; (5) Medical Assistance in Dying changes the patient-palliative care provider relationship; (6) Palliative care resources are consumed by Medical Assistance in Dying requests:

1. Medical Assistance in Dying offers an alternative dying experience to natural death

Participants reflected on their experience as palliative care providers with Medical Assistance in Dying in comparison to natural death and offered contrasting views that were partially influenced by their personal views on Medical Assistance in Dying before its legalization. P10, a palliative care physician who provides Medical Assistance in Dying, said: *“they [family] are so pleased with how things went. . .in contrast often to natural deaths, to be honest. Lots of times natural deaths are grim and lots of unpleasant symptoms. . .even though we’re trying everything. . .maybe that’s what scares me a bit is that it is [Medical Assistance in Dying] so positive.”*

In contrast, other participants drew a different conclusion and felt that Medical Assistance in Dying negatively impacted the quality of death from their perspective as palliative care providers. These participants recounted that assisted death created relational strains between patients and their families who struggled with the concept of intentional death and failed to empathize and accept it. They felt that Medical Assistance in Dying was isolating for some patients and excluded dissenting family. P2, a conscientious objector, said: *“I’m usually so invested in making [dying experience] . . .a warm and supportive thing and . . .[Medical Assistance in Dying] just felt like the opposite of that. . .this sort of cold, isolated way to leave the world and. . .I found that sad.”* Overall, Medical Assistance in Dying offers a new and controversial dying experience.

2. The laws around Medical Assistance in Dying may pose challenges to traditional symptom control strategies:

All participants spoke about the conflict between maintaining Medical Assistance in Dying eligibility and effective symptom control. One of the ways this conflict manifested was in withholding symptom control medications that could cause sedation or confusion and could jeopardize eligibility, as patients needed to be capable of consent at the time Medical Assistance in Dying is delivered. P10 said: *“I worry about inadvertently affecting their ability to access MAID [Medical Assistance in Dying] . . .[there is] a reluctance towards using benzos [benzodiazepines] or opioids, because of the fear that they’ll get sedated. . . Sometimes from them [patients], but sometimes it’s from me.”* This difficulty in providing optimal symptoms management created by the Medical Assistance in Dying legislation resulted in increased providers and patients’ distress.

3. Medical Assistance in Dying creates new “difficult conversations”:

Medical Assistance in Dying introduced new communication challenges in palliative care practice, including determining the optimal timing for assisted death. Most patients wanted to delay Medical Assistance in Dying and spend more time with their families but worried about cognitive decline and ceasing to qualify for assisted death. P7 said: *“There’s a lot of uncertainty about her [the patient’s] prognosis and. . . the evolution of her disease and she’s not sure when to set the date [for MAID] nor can I give her very clear guidance on that either. All we know is that one day things will change.”*

Many participants did not feel confident about discussing Medical Assistance in Dying. They described ethical and moral dilemmas regarding the appropriateness of certain discussions, such as introducing Medical Assistance in Dying to patients who did not initiate these requests. Participants were concerned that introducing the topic of Medical Assistance in Dying might be misinterpreted as an invitation to request for it, and may add to the burden of vulnerable patients and erode families’ trust. It is important to mention that there is no mandatory or standard training related to responding to requests for Medical Assistance in Dying in Canada at this time. N4 said: *“I wonder if I should speak to Ethics about [bringing up MAID with patients] because maybe they can tell me, “No, you’re allowed to say this,” or “You’re not allowed to say that,” but . . . I feel like I’m walking quite a tightrope because I don’t want to be encouraging or discouraging in any way.”*

Palliative care providers deliver a substantial amount of indirect support for Medical Assistance in Dying, even if they are not involved in it. Participants described challenging conversations around supporting patients and resolving tension with families around Medical Assistance in Dying. N7 said: *“They [patients considering Medical Assistance in Dying] struggle. . . [Medical Assistance in*

Dying patients say] I love my kids, how can I choose to leave them, you know. Those are big words. . . it's hard to know how to respond to some of that."

4. Medical Assistance in Dying had an emotional and personal impact on palliative care providers

Participants in this study described how Medical Assistance in Dying personally impacted them as they try to determine where they stood in regard to assisted death. Many of the participants described a large emotional toll created by exposure to Medical Assistance in Dying.

"I was as prepared as I could be for our first MAID [Medical Assistance in Dying] case here, but I recall that morning, I went outside and felt like I was about to throw up" (N7)

Participants also described uncertainty and fear of social stigma around their involvement in Medical Assistance in Dying and fear that they may be perceived negatively as a consequence of working in a setting where assisted death is provided.

"What would my family think that I'm working on a unit that does that [Medical Assistance in Dying]? Do I hide it from them. . . what if people find out that we do it? Are people going to come up here and start protesting? People will see that as evil." (N5)

On the other hand, some of the participants described a sense of personal and professional satisfaction for supporting the patient's wishes. P9, a Medical Assistance in Dying provider, spoke about their experience: *"I'm not going to tell you I look forward to them [providing MAID], but when they happen, I actually find them. . . they're such beautiful experiences with family. It's the shared experience with the family that you're with that you have an opportunity to help."*

Over time, participants described a change in attitude and increased tolerance among palliative care providers towards assisted death. P12, a conscientious objector, said: *"Initially there was a very strong opposition from palliative care providers to MAID [Medical Assistance in Dying]. . . just the very idea that MAID [Medical Assistance in Dying] would be considered an end of life option. Now those same physicians who were so strongly opposed. . . are understanding. . . they see a separate parallel system that exists for MAID [Medical Assistance in Dying] and so they [palliative care] could exist with it."*

5. Medical Assistance in Dying changes the patient-palliative care provider relationship

Participants reflected on how Medical Assistance in Dying had affected their relationship with their patients. They

described how patients thought that palliative care included assisted death, which complicated their relationships with these patients. P1, who worked in a setting where Medical Assistance in Dying was provided by the palliative care team, said: *"There was one family who was very concerned that we were also the MAID [Medical Assistance in Dying] team. . . they had a huge fear of what was palliative care and that we were somehow going to do something to facilitate his death."*

Despite their desire to provide optimal palliative care for all patients, participants with moral or religious objections to Medical Assistance in Dying described substantial challenges with building trust with patients pursuing assisted death. Despite their reservations about Medical Assistance in Dying, many of these participants hesitated or declined to be identified as conscientious objectors. P2 spoke about how identifying as a conscientious objector complicated the relationship with a patient:

"I told her. . . as soon the topic [Medical Assistance in Dying] came up, that I was a conscientious objector and the person said that you're not on my side, even though she was getting the service [MAID]. . . I was seen as somebody who was not helping her"

6. Palliative care resources are consumed by Medical Assistance in Dying requests

Participants described that Medical Assistance in Dying heightened public awareness about the importance of palliative care. However, participants felt that it also led to more palliative care resources being dedicated to specifically to assisted death, which would have otherwise been allocated to palliative care.

"Good palliative care takes a lot of time and interdisciplinary resources. . . when a patient is requesting MAID [Medical Assistance in Dying], most of the resources have been sucked up by that one case and it's all everyone's talking about and they're rushing to get stuff done. . . everyone from admin down to the bedside nurse is focusing on MAID [Medical Assistance in Dying]. And all of the high-quality palliative care that we do falls by the wayside for the other patients." (P6)

N7 spoke about the practical preparation for a Medical Assistance in Dying intervention and how it indirectly consumed nursing resources: *"the last [Medical Assistance in Dying] intervention, it was in the morning, and it was a struggle around getting this individual [MAID patient] prepared [for Medical Assistance in Dying]. . . a bath, a shower, whatever he needed, dressed, in terms of his dignity and then doing the rest of the care. . . we [palliative care nurses] need to be thinking about what the timeliness of it is for the team. . . we need to bring in a second nurse to be present, to be there before and after for the family. . . there's certainly practical stuff [to provide*

Medical Assistance in Dying] . . . that's like two [palliative care] staff, and then the family wanted breakfast. So, there were like ten people [family and friends] here, and the [palliative care] volunteer provided breakfast for everyone. . . there's a sense of ceremony [before Medical Assistance in Dying], So, those all have impacts in terms of resources."

P8 spoke about how Medical Assistance in Dying requests may be left to palliative care teams to deal with adding to their load: *"Yeah, they [oncologists and other specialists] just don't really want to be engaged in the [Medical Assistance in Dying] process at all. They want us to do that. . . I think we are taking on more of this because other people won't. . . 'Let palliative care deal with that'"*

Discussion

In this study, we found that the implementation of Medical Assistance in Dying has impacted palliative care practice in several ways, including offering an alternative dying experience, challenging traditional symptom control approaches, impacting palliative care providers personally and emotionally, and changing their relationship with patients, and consuming palliative care resources. Participants also discussed new challenges in communication around Medical Assistance in Dying, describing ethical dilemmas around bringing it up and the uncertainty around setting a date for assisted death. Participants described a large emotional and psychological toll created by Medical Assistance in Dying cases. Participants felt that assisted death heightened public awareness about the importance of palliative care, but palliative care resources were used to indirectly support Medical Assistance in Dying, adding further burden to an already stretched practice.

One of the themes that emerged from this study was that Medical Assistance in Dying offers an alternative dying experience. Before the legalization of assisted death, palliative care providers aimed to help terminally ill patients achieve non-hastened "good death" free from pain and other symptoms, in a place of the dying person's choosing, surrounded by people of their choosing.^{23,24} For terminally-ill cancer patients, freedom from suffering, maintaining autonomy, and preparation have been described as important aspects of a "good death."²⁵ A recent study of family caregivers of terminally ill patients has reported that they also endorse similar attributes of a "good death" for their loved ones.²⁶ However, ideas of "good death" vary between individuals; terminally-ill patients in support of euthanasia described fear of anticipatory suffering at the end of life, while patients opposing euthanasia said they placed trust in healthcare services to address future suffering.²⁷ Some participants in our study felt that Medical Assistance in Dying offers an alternative dying experience that redefined the meaning of a "good death."

In describing the challenges to traditional symptom control strategies, participants described that maintaining lucidity and eligibility for assisted death, by avoiding sedative medications, took priority over achieving good symptom control for some patients. This contrasts with some pre-Medical Assistance in Dying studies that reported that patients prioritized symptom control at the end-of-life.²⁸⁻³⁰ This discrepancy could be explained by the idea that Medical Assistance in Dying may provide patients with choices to avoid perceived future suffering,³¹ and so a patient may prioritize keeping their choices open and maintaining eligibility for assisted death over symptom control. All participants in our study felt dissatisfied with the barriers to optimal symptom control presented by current Medical Assistance in Dying eligibility criteria. Further review of these eligibility criteria is needed to avoid these unintended consequences. The Canadian government is currently holding consultation on the need to revise the Medical Assistance in Dying legislation.³²

Participants in our study described ethical and professional dilemmas around communication, especially around broaching the topic of Medical Assistance in Dying and determining the optimal timing of assisted death. A qualitative study of Swiss palliative care physicians reported that they didn't receive specific training to handle assisted suicide requests and that they struggled to reconcile their understanding of palliative care principles with the patient's right to autonomy.³³ In another study, general practitioners described barriers to communication about euthanasia due to ethical concerns.³⁴ Enhanced communication teaching with specific emphasis on conversations around Medical Assistance in Dying for palliative care providers may help to address these challenges. Models from the Netherlands and Belgium, where specialized consultation services and support for ethical decision-making from trained physicians are available in case of requests for euthanasia, may be helpful in this regard.³⁵

Our study also highlighted how Medical Assistance in Dying has impacted palliative care providers personally and created new barriers to their relationship with patients; participants described how Medical Assistance in Dying has contributed to further stigmatization of palliative care and increased distress of individual palliative care providers around assisted death. Education of the general public and patients about the role of palliative care and its benefits is paramount to reduce the stigma surrounding palliative care and to improve access to palliative care services for patients and their family members. An observational study described a home palliative care program in Canada that was able to provide Medical Assistance in Dying by integrating it into palliative care provision.³⁶ The authors concluded that their program was able to accommodate palliative care providers with diverse perspectives, including those that provided Medical Assistance in Dying and conscientious objectors. However, in our study, some participants expressing moral

or religious objections to Medical Assistance in Dying nevertheless hesitated or declined to identify as conscientious objectors. This suggests there may be a spectrum of objection beyond the label of “conscientious objector” and that there may be a stigma around identifying as an objector.

Participants in our study, including those with moral and religious objections, described a journey of learning and adaptation to Medical Assistance in Dying. This active process of sense-making overtime was described in another study exploring provider experiences around assisted death.³⁷ Further studies are needed to examine measures to support palliative care providers who experience moral distress around Medical Assistance in Dying.

Participants in our study also reported that Medical Assistance in Dying had consumed limited resources that would otherwise be used to provide palliative care. Concerns have been reported previously about the limited access to palliative care for vulnerable populations, especially in rural and underserved areas, and the need to protect access to palliative care while making provision for Medical Assistance in Dying.³⁸ Consideration should be given to the workforce required to provide palliative care and Medical Assistance in Dying moving forward, to ensure that palliative care can be provided effectively and universally, alongside the provision of assisted death.

Strengths and limitations

This is one of the first studies, to our knowledge, to directly explore the experiences of frontline palliative care providers following the legalization of Medical Assistance in Dying in Canada. We interviewed participants from a diverse range of palliative care clinical settings and covering the full spectrum of involvement with Medical Assistance in Dying, from providers to conscientious objectors. The study also has a few limitations. Member checking was not completed due to participants’ busy work schedule and the contentious nature of the topic where different participants may have different opinions on the data. Participant received the interview questions in advance and this may have resulted in unintentional self-censoring; however, those participants who did so stated that this helped them to formulate more in-depth responses. The participants were limited geographically to urban areas in Southern Ontario and working in relatively highly resourced settings. These results may not be generalizable to less-resourced rural settings. In this study, we chose to focus on the opinions of physicians and nurses because of their direct contact with Medical Assistance in Dying; however, the experiences of other healthcare providers such as social workers, and spiritual counselors, as well as patients and caregivers should also be explored.

Conclusion

We explored the perspectives of palliative care providers regarding the impact of Medical Assistance in Dying on their clinical practice. Communication training with access to expert resources for ethical decision-making and a review of eligibility criteria for Medical Assistance in Dying may help to address new challenges related to communication and symptom control, respectively. Resource allocation should ensure that palliative care can be provided effectively and universally, alongside the provision of assisted death.

Acknowledgements

We would like to thank the study’s participants for their thoughtful quotes and valuable contributions.

Author contributions

A.A., D.H., and C.Z. designed the concept. D.H. and J.J.M. conducted literature searches. The interview guide was developed by D.H., A.A. and critically revised by B.H. A.A., D.H., and J.J.M. conducted the interviews. D.H. and J.J.M. analyzed the transcripts. A.A. and J.A. revised the analysis codebook critically. J.J.M. drafted the initial draft of the manuscript, and all authors revised the initial manuscript critically and approved the final version of the manuscript.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Breffni Hannon  <https://orcid.org/0000-0002-0881-555X>

Ahmed al-Awamer  <https://orcid.org/0000-0003-2839-7460>

References

1. Bill C. 14. An act to amend the criminal code and to make related amendments to other acts, (medical assistance in dying). In: *1st session, 32nd Parliament, Ontario, 2016*, <https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/LegislativeSummaries/PDF/42-1/c14-e.pdf> (2016, accessed 21 October 2020).
2. 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.
3. College of Physicians and Surgeons of Ontario. Medical assistance in dying, <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying#Endnotes> (2016, accessed 16 August 2020).
4. Lorenz KA, Lynn J, Dy SM, et al. Evidence for improving palliative care at the end of life: a systematic review. *Ann Intern Med* 2008; 148: 147–159.

5. Gerson SM, Koksvik GH, Richards N, et al. The relationship of palliative care with assisted dying where assisted dying is lawful: a systematic scoping review of the literature. *J Pain Symptom Manage* 2020; 59: 1287–1303.e1281.
6. Al-Awamer A. [Physician-assisted suicide is not a failure of palliative care]. *Can Fam Physician* 2015; 61: 1045–1047.
7. 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.e1569.
8. Banner D, Schiller CJ and Freeman S. Medical assistance in dying: a political issue for nurses and nursing in Canada. *Nurs Philos* 2019; 20: e12281.
9. Upshur R. Unresolved issues in Canada's law on physician-assisted dying. *Lancet* 2016; 388: 545–547.
10. Eggertson L. Most palliative physicians want no role in assisted death. *CMAJ* 2015; 187: E177.
11. Radbruch L, Leget C, Bahr P, et al. Euthanasia and physician-assisted suicide: a white paper from the European Association for Palliative Care. *Palliat Med* 2016; 30: 104–116.
12. De Lima L, Woodruff R, Pettus K, et al. International association for hospice and palliative care position statement: Euthanasia and physician-assisted suicide. *J Palliat Med* 2017; 20: 8–14.
13. Canadian Society of Palliative Care Physicians. Key messages: palliative care and medical assistance in dying (MAID), <https://www.cspcp.ca/updated-key-messages-palliative-care-and-medical-assistance-in-dying-maid/> (2019 May, accessed 16 October 2019).
14. Inbadas H, Zaman S, Whitelaw S, et al. Declarations on euthanasia and assisted dying. *Death Stud* 2017; 41: 574–584.
15. Berghe PV, Mullie A, Desmet M, et al. Assisted dying-the current situation in Flanders: euthanasia embedded in palliative care. *Eur J Palliat Care* 2013; 20: 266–272.
16. Bernheim JL and Raus K. Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care. *J Med Ethics* 2017; 43: 489–494.
17. Downar J, Bailey TM, Kagan J, et al. Physician-assisted death: time to move beyond yes or no. *CMAJ* 2014; 186: 567–568.
18. Khoshnood N, Hopwood M-C, Lokuge B, et al. Exploring Canadian physicians' experiences providing medical assistance in dying: a qualitative study. *J Pain Symptom Manage* 2018; 56: 222–229.e221.
19. MacDonald S, LeBlanc S, Dalgarno N, et al. Exploring family medicine preceptor and resident perceptions of medical assistance in dying and desires for education. *Can Fam Physician* 2018; 64: e400–e406.
20. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
21. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000; 23: 334–340.
22. Tong A, Sainsbury P and Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007; 19: 349–357.
23. De Jong JD and Clarke LE. What is a good death? stories from palliative care. *J Palliat Care* 2009; 25: 61–67.
24. Meier EA, Gallegos JV, Thomas LPM, et al. Defining a good death (successful dying): literature review and a call for research and public dialogue. *Am J Geriatr Psychiatry* 2016; 24: 261–271.
25. Kastbom L, Milberg A and Karlsson M. A good death from the perspective of palliative cancer patients. *Support Care Cancer* 2017; 25: 933–939.
26. Bovero A, Gottardo F, Botto R, et al. Definition of a good death, attitudes toward death, and feelings of interconnectedness among people taking care of terminally ill patients with cancer: an exploratory study. *Am J Hosp Palliat Care* 2020; 37: 343–349.
27. Karlsson M, Milberg A and Strang P. Suffering and euthanasia: a qualitative study of dying cancer patients' perspectives. *Support Care Cancer* 2012; 20: 1065–1071.
28. Guo Q and Jacelon CS. An integrative review of dignity in end-of-life care. *Palliat Med* 2014; 28: 931–940.
29. Pringle J, Johnston B and Buchanan D. Dignity and patient-centred care for people with palliative care needs in the acute hospital setting: a systematic review. *Palliat Med* 2015; 29: 675–694.
30. Robinson J, Gott M and Ingleton C. Patient and family experiences of palliative care in hospital: what do we know? an integrative review. *Palliat Med* 2014; 28: 18–33.
31. Quinn KL and Detsky AS. Medical assistance in dying: our lessons learned. *JAMA Intern Med* 2017; 177: 1251–1252.
32. Department of Justice GoC. Medical assistance in dying: January and February 2020 consultations, <https://www.justice.gc.ca/eng/cons/ad-am/index.html> (2020, accessed 12 February 2020).
33. Gamondi C, Borasio GD, Oliver P, et al. Responses to assisted suicide requests: an interview study with Swiss palliative care physicians. *BMJ Support Palliat Care* 2019; 9: e7.
34. Otte IC, Jung C, Elger B, et al. "We need to talk!" barriers to GPs' communication about the option of physician-assisted suicide and their ethical implications: results from a qualitative study. *Med Health Care Philos* 2017; 20: 249–256.
35. Van Wesemael Y, Cohen J, Onwuteaka-Philipsen BD, et al. Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium. *BMC Health Serv Res* 2009; 9: 220.
36. Wales J, Isenberg SR, Wegier P, et al. Providing medical assistance in dying within a home palliative care program in Toronto, Canada: an observational study of the first year of experience. *J Palliat Med* 2018; 21: 1573–1579.
37. Beuthin R, Bruce A and Scaia M. Medical assistance in dying (MAiD): Canadian nurses' experiences. *Nurs Forum* 2018; 53: 511–520.
38. 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.