

New Brunswick Physicians' Perspectives Towards Medical Assistance in  
Dying (MAiD)

by

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## **Abstract**

Medical assistance in dying (MAiD) is an important policy and practice issue, and physicians play an instrumental role in accessing this service, therefore, it is vital to understand the factors that influence their decision regarding the provision of MAiD. This project aimed to understand what is shaping the views of New Brunswick physicians surrounding MAiD. Through one-on-one interviews with 15 New Brunswick physicians and using Straussian grounded theory methodology, three main categories were identified: 1) personal worldview and ethics, 2) role as a physician, and 3) autonomy and choice. From these findings, the physician's identity emerged as the primary factor that impacted their views on this topic. It was found that their personal, social, and professional identities were all important contributors shaping their views towards MAiD. Understanding what shapes these views helps us better understand these physicians and could potentially help mitigate any barriers to access for patients.

*Keywords: Medical assistance in dying, assisted suicide, euthanasia, physician perspectives, Canada*

## **Dedication**

I dedicate this work to my father, Peter Robertson, and my stepfather, Peter Saab.

“Thanks, Petes!”

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## **Chapter I - Introduction**

Although it has been argued in court for over 30 years, medical assistance in dying (MAiD), colloquially known as physician-assisted suicide, only became legal in Canada less than eight years ago. In June 2016, MAiD assented to law in Canada. This law allows physicians and nurse practitioners (NPs) to end the lives of patients at the patient's explicit request (Government of Canada, 2016a; 2016b).

The novelty of this law poses a challenge for these practitioners, who must decide if a patient qualifies for a medically assisted death. Since this decision falls to the discretion of individual physicians and NPs, it is especially important to understand their beliefs and how that might be impacting access. This is especially true in a small province like New Brunswick, Canada, where there are only a handful of physicians willing to participate and no NPs, with most practicing in the three major cities (Saint John, Fredericton, and Moncton) (J.W., personal communication, July 15, 2018; E.H., personal communication, August 24, 2018). Although there are physicians who may be willing to provide a referral to someone who is willing to provide an assisted death, there may still be barriers to access MAiD based on the availability of providers where the patient is living (i.e., outside of the cities mentioned above, patients in Catholic institutions etc.).

### **Objectives and Purpose**

The objective of this research project was to gain a richer understanding of the views of New Brunswick physicians towards MAiD and what is shaping their views.

Therefore, the research questions for this project were: (1) What are the views of New Brunswick physicians towards MAiD? and (2) What is shaping these views?

### **Research Significance**

Since MAiD is relatively new in Canada, it is important to better understand this service in the Canadian context. This research project aimed to better understand the views of physicians in New Brunswick. From the *Fourth Annual Report on Medical Assistance in Dying in Canada*, New Brunswick showed low rates of MAiD provided in the first partial year of the law being created (2016), with only nine patients accessing the service (Government of Canada, 2023). In the following years, New Brunswick saw a slow increase from year to year in the number of patients accessing this service; from 49 accessing in 2017 (first full year of the law being enacted) to 247 accessing in 2022 (the most recent year reported). In 2022, 4.1% of all deaths in Canada were due to MAiD, compared to 2.9% in New Brunswick, which could point to potential issues with access.

This project will add to the literature in the Canadian context on this subject, which is currently sparse, and hopefully can help inform future studies. Since uptake has been slow in New Brunswick relative to the entire country, I hoped that the findings of the project would have the potential to help shape policy and practices in the province. This would be of most importance to patients who may be having issues accessing this service in New Brunswick. Additionally, the findings from this research may be transferrable to other Canadian settings and inform future studies examining physicians' perspectives on MAiD and access to this service.

## Chapter II – Literature Review

### Introduction

In this chapter, I will outline the history of assisted dying in detail, starting at the decriminalization of suicide, up until the creation of Bill C-14, as well as the newest change to the law. Then I will explore how the law defines an assisted death as well as some confusion surrounding the terminology. I will then explore access to this service in Canada, and New Brunswick. A scoping review of the literature surrounding international views of physicians on assisted dying was performed prior to the start of this study. The findings of this review will be outlined at the end of this chapter.

### History leading to MAiD in Canada

#### *Suicide*

Suicide has always been a stigmatized topic in Canada, and up until the early 1970s it was a crime to commit suicide (Parliament of Canada, 1995). In 1972, the law prohibiting suicide was deemed unconstitutional, and was removed from the *Criminal Code* (Parliament of Canada, 1995). However, section 241(b) of the *Criminal Code*, which stated that one person cannot help another commit suicide, remained until decades later (Government of Canada, 2016a). Additionally, section 14 of the *Criminal Code* stated that people cannot consent to have death inflicted upon them, and that anyone who killed someone with their explicit request was still committing a crime (Butler & Tiedemann, 2015).

### *Sue Rodriguez*

One of the most notable legal battles for assisted death in Canada was the Sue Rodriguez case which was argued before the Supreme Court of Canada in 1993 (Browne & Russell, 2016; Butler & Tiedemann, 2015). Suffering from Amyotrophic Lateral Sclerosis (ALS), Rodriguez sought to end her life with the help of a physician, at some point in the future when she would deem that her quality of life decreased to a point that she could no longer bear. Her legal team argued that by not allowing her to access a legal assisted death in Canada, she would be forced to travel to the U.S. and end her life early. This is because their specific law required her to take the drug herself, rather than be injected with a legal medication, meaning she would have to end her life much earlier in her disease progression. Her legal team pointed to sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*, saying that her rights were being infringed upon by not allowing a physician to end her life (Browne & Russell, 2016). Section 7 says that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice” (Butler & Tiedemann, 2015; Government of Canada, 2018, p. 49). Section 15 states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and in particular, without discrimination based on race, national or ethnic origin, colour, religious, sex, age or mental or physical disability. (Butler & Tiedemann, 2015; Government of Canada, 2018, p. 50)

Ultimately, Rodriguez was denied an assisted death, and the law went unchanged for another two decades.

### ***Carter v. Canada***

In 2015, a claim was brought to the Supreme Court of Canada (*Carter v. Canada*) asking for the right for Gloria Taylor to have a physician end her life on her behalf, due to her devastating diagnosis of ALS (Butler & Tiedemann, 2015). Along with a supportive physician and the family members of Kay Carter, who sought an assisted death in Switzerland, they argued for the right to an assisted death in Canada. Much like the Rodriguez case, they argued that sections 7 and 15 of the *Charter* were being infringed upon by not allowing this service. The Supreme Court unanimously held that section 7 of the *Charter* was infringed by section 241(b) of the *Criminal Code* and ruled that provision of the *Criminal Code* unconstitutional (Browne & Russell, 2016). From there, Bill C-14 came to be, and the *Criminal Code* was amended to include MAiD.

### ***Bill C-14: Amending section 241(b) of the Criminal Code of Canada***

MAiD has always been a controversial topic, and still is even though it is now legal in Canada. Many who reject the idea of MAiD fear the “slippery slope” that it may lead the country down; these individuals believe that MAiD could lead to people being killed against their will (Browne & Russell, 2016). Therefore, the law and policies surrounding this topic are of paramount importance: to ease the mind of those who fear it (Browne & Russell, 2016; Health Law Institute, n.d.). One of the main concerns of those who opposed MAiD was that it would not be accompanied by sufficient

safeguards, potentially putting vulnerable individuals at risk. This concern prompted Parliament to take extra time in drafting legislation (Browne & Russell, 2016). The resulting legislation amended section 241(b) of the Criminal Code (aiding someone to die by suicide), to exempt those providing MAiD. Section 241.2 outlines the eligibility for those seeking MAiD and contains very distinct rules about who can and cannot access a medically assisted death, which was discussed above (Government of Canada, 2016b). The 2016 version of section 241.2 of the Criminal Code is included in Appendix A.

### ***Bill C-7: Recent amendment to MAiD law in Canada***

In the fall of 2020, Bill C-7 was submitted to parliament with the hope of changing the law surrounding MAiD (Minister of Justice, 2020). The goal of this bill was to tackle the “reasonably foreseeable” death requirement of the law, as well as address issues with those who lose capacity to provide consent before MAiD is provided (discussed in depth below). In March 2021 the bill was passed and the new legislation regarding MAiD eligibility is now in place (Department of Justice Canada, 2021). These changes will be outlined in the next section.

### **MAiD Law – Legal vs. Not Legal**

The term MAiD refers to a medical practitioner administering or prescribing a substance, upon a person’s explicit request, which will cause that person’s death (Government of Canada, 2016a). MAiD became legal in Canada on June 17, 2016, after the assent of Bill C-14 (Government of Canada, 2016b). The main objective of this legislation was to respect the autonomy of people with “grievous and irremediable”



medical conditions who want to end their life with the aid of a medical professional, while also ensuring the protection of these people through the implementation of appropriate safety measures (Government of Canada, 2016b). There are many strict safeguards in place to protect patients because this is a life-or-death decision. For the purposes of this research study, the 2016 iteration of the law was used to outline what was legal at the time the interviews were conducted. This version of the law can be found in Appendix A.

In 2016, the eligibility to access MAiD included: being eligible for publicly funded health services in Canada, being at least 18 years old and capable of decision-making (as determined by a healthcare professional), having a “grievous and irremediable medical condition” with their death being “reasonably foreseeable”, making a completely voluntary request for MAiD, and giving informed consent at the time of the procedure (Government of Canada, 2016a).

As mentioned above, there was a recent amendment to the law in 2021. This change removed the need for the patient’s death to be reasonably foreseeable, making it easier for those with neurodegenerative diseases to access an assisted death should they choose to. It also allows someone whose death *is* reasonably foreseeable to waive the final consent requirement on the day of the procedure which is meant to protect those who could potentially lose capacity to consent prior to the date of the procedure. The 2021 safeguards and practices are outlined in section 241.2 of the Criminal Code, which is included in Appendix B. Additionally, in 2023 there was discourse surrounding changing the law again to include those with a sole diagnosis of a mental illness to be eligible for MAiD. Currently, the exclusion of mental illness has been extended to 2024

to allow more time for appropriate safeguards to be put in place (Government of Canada, 2023).

### *Confusion of terminology*

For the purposes of understanding MAiD from a broader perspective, I reviewed the international literature on this topic. Early on, it became clear that there was a pattern of confusion regarding the terminology surrounding assisted dying and other end-of-life practices. In Canada, the MAiD law incorporates what is called “voluntary euthanasia” (VE) and “physician assisted suicide” (PAS); where VE is the injecting of a lethal substance at the explicit request of a patient and PAS is the prescription of a lethal substance for a patient to take on their own or with a physician present (Emanuel et al., 2016; NHS, 2017). Other confusing terminology used internationally includes non-voluntary or involuntary euthanasia, which is not legal in Canada. “Non-voluntary” refers to patients who cannot give their explicit permission for euthanasia, such as babies and people who are in a coma (Emanuel et al., 2016). “Involuntary” means that the patient did not give their consent for euthanasia; this is what a lot of people who are against assisted dying fear – the “slippery slope” into performing this act against a patient’s will (Browne & Russell, 2016; Emanuel et al., 2016). Finally, there was reference to acts that would be considered “passive” euthanasia, which is not the topic of concern here. Passive euthanasia refers to doing something that would eventually lead to someone dying naturally, but not actively giving something to end the person’s life (NHS, 2017). Examples of this are withdrawing treatment and voluntary stopping eating and drinking. For the purposes of this study, I only wanted to identify research related to

medical assisted dying practices that were considered legal in Canada at the time, following the law as set out by the Criminal Code of Canada.

### **Jurisdictional Responsibility for Health Services Delivery in Canada**

Canada is made up of ten provinces and three territories and is the second largest country in the world (Villeneuve, 2017a). The country is made up of both densely populated cities and large rural areas which are far less populated, which can make the delivery of healthcare quite complex nation-wide. While health services delivery (i.e., Medicare) and legislation is primarily the responsibility of each provincial government, the Federal government also plays a role in providing health services to Canadians (e.g., Indigenous Canadians, Canadian Armed Forces, Correctional Services Canada, etc.) and supporting provincial Medicare through funding agreements with each province.

At a national level, the Senate of Canada is appointed to review Federal legislation, and importantly in this context, investigate health care issues (Villeneuve, 2017a). The senate is equally split to represent the different areas in Canada, so that the most populous provinces are not the only ones being represented (i.e., more populated Ontario doesn't have more say than the significantly less populated maritime provinces). When Bill C-14 was being proposed, the Senate was included to review the proposed legislation and provide feedback (Villeneuve, 2017a). Most of that feedback was included or investigated further; however, the House of Commons ignored their suggestion that only terminally ill people should be allowed to access a medically assisted death and maintained that those who are suffering without a terminal illness can request MAiD as well.

## **Access to MAiD in Canada**

As previously mentioned, physicians and NPs can provide a medically assisted death in Canada (Government of Canada, 2016a). Two independent practitioners are required to determine if the patient meets all the criteria set out in the law, including their mental competency to make that decision. It could potentially be difficult for patients to find two practitioners willing to conduct the eligibility assessment, let alone actually provide the lethal dose of medication. This points to the importance of understanding the perspective of physicians and NPs on MAiD; since they can decide whether to participate in any capacity, their views on MAiD may inadvertently create a barrier to access for eligible patients seeking this service.

One of the main issues regarding a medically assisted death is gaining access for patients. If you look to the news, you hear various stories from Canadian patients seeking a medically assisted death who are unsure where to turn when their own physician says they will not provide it, or when they live in remote areas and there are no MAiD providers in the area (Gerein, 2018; MacPhee, 2018; Taylor, 2018).

## **Access to MAiD in New Brunswick**

When looking specifically to New Brunswick, at the time this research study was conducted there were no known NPs performing this service within the two health authorities in the province (Government of Canada, 2021), which is why I chose to focus on the physician's perspective. Without any NPs providing MAiD, I would not have access to the same range of experience and views towards MAiD in this population. In 2018 there were approximately 10 physicians willing to provide MAiD in

New Brunswick and they are mainly located in New Brunswick's largest cities (Saint John, Moncton, and Fredericton) (E.H., personal communication, August 24, 2018; J.W., personal communication, July 15, 2018). This is only an estimation, as there is no public record of this information and currently there is no known list to seek out and identify practitioners willing to provide MAiD in the province.

For New Brunswickers seeking more information on MAiD or wanting to access this service there are two likely routes to seek information: searching the internet or asking their physician directly. When you look at the Government of New Brunswick's (GNB) MAiD webpage, it provides general information on the current MAiD law, and then directs the public to other sources of information: Bill C-14, the Supreme Court ruling on MAiD, the advisory report, and links to the Horizon and Vitalité health networks' individual webpages on MAiD (GNB, n.d.). If you look at the "patient brochure" that is available on both the Horizon and Vitalité webpages, the first step that they suggest is to ask your physician or NP (Vitalité, n.d.a.; Horizon, 2018). Thus, the physician or NP would be the first point of contact for most patients as a starting point, highlighting why it is important to try to gain an understanding of their position. For those who do not want to discuss MAiD as an option with their physician or NP or those who do not have a primary healthcare provider, the two regional health authorities (Horizon and Vitalité) offer the contact information to a "Patient Representative" who can help them as well; although this could also be a challenging obstacle for a patient who may not want to share this sensitive information with many people.

## **Conscientious Objection**

Conscientious objection refers to the physician's right to refuse offering a medical service that they do not agree with. For the purposes of this study, it refers specifically to physicians who do not want to provide MAiD and will not refer their patients to a physician who would. Historically, there are other services that physicians have been able to object to providing patients. This includes the prescription of birth control, which was debated decades ago, and more recently, the prescription of the "morning after pill" (or "plan B") (Showalter, 2017). Another highly controversial procedure is that of abortion, which has been legal since 1988 in Canada but is still not widely performed, largely due to conscientious objection (Norman & Downie, 2017). In New Brunswick, there are still issues with access to abortion services. For example, the closure of Clinic 554 in Fredericton in 2020 (Walker & Kaiser, 2020) left New Brunswick with only three hospital locations (in only two cities) where a person could access an abortion (Vitalité Health Network, n.d.).

We cannot begin to address the potential issue of conscientious objection without a full picture of the MAiD landscape in Canada; understanding the reasoning behind physicians who do not provide MAiD or why some physicians would refuse to refer their patients on to someone else. The Canadian Medical Association (CMA) policy on MAiD states that they support "the right of all physicians to follow their conscience" when it comes to participating or objecting to MAiD (CMA, 2017, pp. 1-2). However, the CMA position is that physicians are required to respond to these requests even if they disagree with the service so that their patients are not left abandoned and to prevent delays for the patient. To address this, they also suggest that the health care

system should “implement an easily accessible mechanism to which patients can have direct access” so that patients can have timely and unimpeded access to MAiD (CMA, 2017, p. 3).

Some physicians are conscientiously objecting to providing MAiD in Canada based on religious beliefs, and some physicians refuse to refer patients to someone who will provide the service. (Glauser, 2018). When this occurs, it has the potential to create a barrier to patients exercising their legal right to choose MAiD at the end of life. The Canadian Medical Association *Code of Ethics and Professionalism* lays out the standard they expect physicians to abide by; it highlights the importance of communicating with patients if the physician has a moral conflict that might impact their care, and the importance of not abandoning their patients even if their beliefs do not align (2018). However, this is just a professional guideline and they are to follow the legal requirements of their own province (Canadian Medical Association, 2018) Ontario was one of the first provinces who attempted to address the issue of non-referral by implementing a new regulation that requires physicians to refer patients to known MAiD providers if they are not willing to provide this service in order to uphold their duty to not abandon their patients (Fine, 2018; Glauser, 2018; Ontario Ministry of Health, 2021). This was implemented by the College of Physicians and Surgeons of Ontario and is not applicable across the rest of Canada since healthcare is provincially regulated. There is no similar regulation or recommendation by the College of Physicians and Surgeons of New Brunswick. There is, however, one line on the GNB’s MAiD page that states, “The government of New Brunswick respects the rights of health care providers to decline to participate in medical assistance in dying for moral or

religious reasons” (GNB, n.d., para. 8). There is no mention of any duty for physicians to refer patients on to someone who would provide MAiD for them, should they disagree. Currently in New Brunswick, physicians ultimately make the decision about whether a patient will have access to MAiD. This could potentially be a barrier to access for some patients, especially those located in more rural areas with fewer healthcare providers.

### **MAiD Statistics in Canada and New Brunswick**

Since the law came into place in 2016, MAiD cases have been steadily increasing. In the first full year of implementation (2017) there were 2838 cases in Canada; In 2022 this number rose to 7611 cases (Government of Canada, 2023). Although there has been an uptick in cases since MAiD became legal, it only accounted for 4.1% of the deaths in 2022, which is relatively small. Following a similar trajectory, New Brunswick had 49 cases in the first full year (2017) and rose to 247 cases in 2022, accounting for 2.9% of all deaths in New Brunswick that year, however, it still remained below the Canadian average.

Across Canada in 2022, the main cause for seeking MAiD was cancer (63.0%); the same was found in New Brunswick with a slightly higher percentage (66.5%). Men received MAiD at a slightly higher rate than women: 51.4% nationally and 53.6% in New Brunswick. When looking at age, 85.0% of MAiD deaths in Canada and 83.5% of MAiD deaths in New Brunswick occurred in those who were 65 or older, with an average age of 77.0 years nationally and 74.1 years in New Brunswick. In New Brunswick, those who received MAiD in 2022 were mostly urban residents (53.6%),



with 39.3% of deaths happening in a personal residence and 31.7% of deaths happening in a hospital setting. The only two specialties that provided MAiD in New Brunswick in 2022 were family medicine (70.1%) and palliative medicine (29.9%), with no MAiD services provided by a NP (compared to 9.4% in 2022 for all of Canada) (Government of Canada, 2023).

### **Literature Review of Physicians' Perspectives towards MAiD**

Prior to starting this project, I conducted a scoping review of the literature using the methods as set out by Levac, Colquhoun, and O'Brien (2010). The goal of this review was to map out the current literature relevant to the Canadian context, as well as gain insight into international physicians' perspectives on this topic. An important note is that I only included studies that assessed assisted deaths that would be considered legal under Canadian law (i.e., exclusion of studies regarding people under 18, those who have not consented, those with mental illness as a sole diagnosis), as I did not want to muddle the results with studies that were not relevant to the Canadian context. The initial search took place in 2017 and was updated in 2018 and 2023.

The search was conducted in four databases (PubMed, Cochrane Reviews, Scopus and ProQuest Nursing and Allied Health. A research librarian helped to select keywords to use for this search; they can be found in Table 1.

Inclusion criteria for these searches were articles had to focus on the perspective of physicians, the act of assisted dying had to fit the legal definition of MAiD in Canada and be written in English. Quantitative, qualitative, and mixed method studies were included, as well as any opinion pieces that were found to be relevant; review papers

were excluded. Exclusion criteria were studies that focused on different health care practitioners, patients, or the general public, acts of assisted dying that were illegal at the time in Canada (e.g., patients under the age of 18, those with dementia, those with depression), if it explored non-voluntary euthanasia, or was written in a language other than English.

**Table 1**

*Databases and search terms used.*

Databases	Search Terms (all databases)
PubMed	Physician* OR doctor*
Cochrane Reviews	AND
Scopus	Attitud* OR perspective* OR belie*
ProQuest Nursing and Allied Health	AND
	“medical assistance in dying” OR “physician assisted suicide” OR “suicide, assisted” OR euthana* OR “death with dignity” OR “right to die”

In the initial search, of the 70 articles that were found to be relevant, 23 articles were published in Canada (Appendix C). Of these, 20 were opinion pieces, news articles, or replies to other articles. While this gave some colourful commentary on the

topic, it also highlighted that more primary research studies were needed from the Canadian lens to better understand this topic. In an updated search of the literature (2023), there were two more primary research papers found from Canada (which will be discussed below), but there were still no papers coming out of New Brunswick. This points to the fact that more research is required in Canada, as well as New Brunswick, to better understand the physician perspective on this topic. Through thematic analysis ten overarching themes emerged. These were: 1) patient autonomy and suffering, 2) Hippocratic oath and the physician's role, 3) religion and the sanctity of life, 4) importance of doctor-patient relationships, 5) physician autonomy and conscientious objection, 6) MAiD as distanced from palliative care, 7) protecting the vulnerable and the slippery slope, 8) patient and physician emotions, 9) education or exposure to assisted dying, and 10) professional stigma. These articles provided information regarding some of the reasons a physician may or may not provide an assisted death in an international context; each topic will be explored briefly below.

### ***Patient autonomy and suffering***

The results highlighted the importance of patient-centered care to the physicians that were in support of an assisted death. The most frequent theme to come out of the included articles centered on the patient and their decisions. Patient autonomy, or the patient's right to decide what they want to do with their body, has been one of the pillars of the assisted dying support arguments. It was even cited in the two major assisted dying cases in support of their seeking an assisted death: *Rodriguez v. British Columbia* and *Carter v. Canada* (Supreme Court of Canada 1993, 2015). Many physicians in the

included articles believed that it wasn't their right to make decisions for their patients; that ultimately it was the patient's choice (Bernheim et al., 2014; Brauer et al., 2015; British Medical Association, 2015; Cohen et al., 2012; Elliott, 2014; Ilvemark et al., 2016; Jylhänkangas et al., 2014; Kouwenhoven et al., 2014; Kranidiotis et al., 2015; Quill et al., 2016a; Trankle, 2014; Voorhees et al., 2014). However, one article stated that the patient shouldn't have that right to decide to end their life (Rathor et al., 2014). Additionally, patient suffering was brought up frequently by physicians as a reason that an assisted death should be allowed because these patients are suffering in pain and are usually terminal anyway (Brauer et al., 2015; Elliott, 2014; Hébert, 2017; Hurley, 2015b; Kouwenhoven et al., 2014; Oliver et al., 2017; Quill et al., 2016a; Rowe, 2015; Trankle, 2014).

Patient dignity was also cited by several studies as a reason to provide an assisted death. This is consistent with the logic of patient advocacy groups that support assisted dying and usually point to dignity and autonomy as their main driving force (e.g., Death With Dignity) (Beaulieu-Volk, 2014; Death With Dignity, n.d.; Hébert, 2017; Oliver et al., 2017). This dignity argument points to a patient being able to have control at the end of life, so they can experience a good death (British Medical Association, 2015; Eggertson, 2014; English & Ribeiro, 2018; Jylhänkangas et al., 2014; Nicholl, 2017; Quill et al., 2016b; Trankle, 2014; Young, 2016). Death is frightening for everyone, but especially for those who are at the end of life and know that it is quickly approaching; controlling how and when you die allows a patient to feel more at ease with that unknown. One paper pointed to the idea that a good quality of life also includes a good quality of dying, or a positive dying experience (Booij et al., 2014).

### ***Hippocratic oath and the physician's role***

A topic cited by multiple studies and articles was the Hippocratic oath, the oath physicians take to “do no harm” when entering the profession. Most included papers suggested that to “do no harm” means to not kill your patients, and therefore, not to provide an assisted death (Beaulieu-Volk, 2014; Elliott, 2014; Fletcher, 2015; Galishoff, 2016; Sheahan, 2016; Voorhees et al., 2014). Conversely, in one of the articles, the author suggested that it was against the Hippocratic oath to *not* provide an assisted death, because to “do no harm” would mean to not let your patients suffer (Rowe, 2015). Some physicians were adamant that providing an assisted death would be against the role of a physician or against the reason they became physicians in the first place (to help and heal patients) (British Medical Association, 2015; English & Ribeiro, 2018; George, 2014; Jylhäkangas et al., 2014; MacCormick, 2014; MacLeod, 2012; Oliver et al., 2017; Simon, 2014). Yet, the opposite position was provided in two other articles; that providing an assisted death *is* the role of a physician (British Medical Association, 2015; Wright et al., 2015). In one opinion paper, a family medicine physician wrote about his first experience with an assisted death, and ultimately settles at the conclusions that a physician's calling is to attend to your patients as they approach death (Ardman, 2023). Conversely, Gale and Barak (two psychiatrists) argued that physicians should not be facilitating death for their patients, and that psychiatrists should be saying no to assisted deaths as a profession (2020). Kaye had a similar position in his reply to Anfang (which will be discussed later): he believed that physicians should not be helping patients to “commit suicide” because they are often incorrect when it comes to predicting when death will happen (2021, pp. 459). He linked this back to the

Hippocratic oath when he says, “we are trained to heal, not harm, and certainly not to kill (as is done in veterinary school)” (Kaye, 2021, pp. 459). This suggests that the interpretation of the Hippocratic oath and the role of being a physician is varied and deeply personal for each physician.

### ***Religion and the sanctity of life***

The findings suggested that personal religious beliefs are still an important factor influencing some physicians’ perspectives on MAiD. This was a topic that was expected to come up, particularly because “the sanctity of life” was cited in the literature of the Supreme Court of Canada case against Sue Rodriguez in 1996 (Supreme Court of Canada, 1993). The sanctity of life, or the importance of not ending a life, has been cited in the past as being an important factor for those who are against assisted dying, and this is usually rooted in religion. In some of the quantitative results, religion or the importance of religion were found to be oppositional to MAiD (Abela, 2015; Abela & Mallia, 2016; Bülow et al., 2012; Doron et al., 2014; Galishoff, 2016; Rathor et al., 2014; Thomas et al., 2014; Voorhees et al., 2014). Additionally, some papers pointed to the sanctity and value of human life and the need to preserve life, which aligns with many religious beliefs (Abela, 2015; Abela & Mallia, 2016; Cohen et al., 2012; Elliott, 2014; Jylhäkangas et al., 2014; Kussmaul, 2017; Sheahan, 2016; Trankle, 2014). Interestingly, in a sample of 170 French physicians, the opposite was found; that the individual’s belief in God was linked to having a positive opinion of euthanasia (Dany et al., 2015). The most prominent finding was that religion was still closely linked to physician’s opinions on MAiD. Heltzer et al. performed a survey of American

physicians (n = 188); participants who identified that they were unwilling to perform an assisted death were asked to write in an answer to why they made that decision, and 11% of those respondents stated religion as the reason (2019). In a 2019 study of Canadian family medicine residents (n = 247), it was found that when asked about providing MAiD by lethal prescription, those who didn't practice a religion were more supportive (34.6%) than those who didn't strictly practice their religion (27.8% supportive) and those who did strictly adhere to a religious ideology (6.7% supportive) (Wong et al., 2019). Similar results were found when it came to MAiD by lethal injection, with those who were non-religious being more supportive (31.6%) than those who were non-practicing (26.9%) and those who did strictly adhere (3.3%) (Wong et al., 2019). A study of Norway physicians (n = 1605) found a significant inverse correlation between permitting physician assisted suicide (lethal prescription) or euthanasia (lethal injection) and religious conviction (Gaasø et al, 2019). A similar finding was also seen in a 2021 study of Israeli physicians (n = 135): with an inverse relationship found between religiosity and support of euthanasia (Dopelt et al., 2021). Finally, in a qualitative study of Quebec physicians (n = 22), the authors wanted to seek to understand why there was support for MAiD in a survey pre-legalization, but 18 months after the survey they were seeing a lot of conscientious objectors (Bouthillier & Opatrny, 2019). One of the two major categories of themes emerged, with one being "refusal on moral or religious grounds" (Bouthillier & Opatrny, 2019). This all points to personal religious beliefs having an impact on MAiD decisions for practitioners.

### ***Importance of doctor-patient relationships***

Like previous themes, the doctor-patient relationship was used as a justification for both not providing MAiD and providing it. Many physicians cited the perceived harm to the doctor-patient relationship that MAiD can cause; that patients won't be able to trust their doctors if they are willingly ending the lives of their patients (Abela, 2015; Brauer et al., 2015; Breen, 2018; British Medical Association, 2015; English & Ribeiro, 2018; Fletcher, 2015; Ilvemark et al., 2016; Louhiala et al., 2015; Sheahan, 2016; Simon, 2014; Wright et al., 2015). One paper inferred that allowing assisted dying would lead to a decreased confidence in the medical profession (Kranidiotis et al., 2015). Interestingly, some palliative care physicians have wanted to distance themselves from MAiD to maintain trust in their specialty. The Canadian Hospice and Palliative Care Association and the Canadian Society of Palliative Care Physicians (CSPCP) created a joint statement distancing palliative care from MAiD because hospice and palliative care “does not seek to hasten death or intentionally end life”, although individual palliative care physicians can and do provide MAiD (Baxter & Herx, 2019, para. 3). On the other side of the argument, some physicians felt that providing MAiD was an important part of the doctor-patient relationship. In one of the included news articles from the Canadian Medical Association Journal, one physician suggested that by *not* providing an assisted death, they would be violating the doctor-patient relationship (Eggertson, 2014). Additionally, in one of the qualitative studies, participants pointed to the fact that a strong doctor-patient relationship could foster better assisted dying conversations because of the trust a patient has in their physician (Voorhees et al., 2014). This suggests that personal interpretations by the physicians of what will make



their patients trust them, has an impact on MAiD decision making.

### ***Physician autonomy and conscientious objection***

The importance of physician autonomy also emerged as an important theme. Physician autonomy, the right for them to decide what they want to do, and the importance of being allowed to conscientiously object (the right to decline the provision of MAiD for personal moral or religious reasons) were very important to many physicians (Brauer et al., 2015; Buchman, 2012; Downar et al. 2014a; Downar et al., 2014b; Eggertson, 2014; Goligher et al., 2016; Kelsall, 2018; Kermode-Scott, 2016; Voorhees et al., 2014). Some physicians also felt that they shouldn't have to refer their patients to a MAiD provider if they were unwilling to provide the service themselves (Fletcher, 2015; Goligher et al., 2016; Kelsall, 2018). As previously mentioned, Ontario has attempted to address any issues of non-referrals by creating a new regulation requiring physicians to not abandon patients seeking MAiD (Ontario Ministry of Health, 2021). Although this isn't Canada-wide yet, it is an important precedent for the rest of the country. As a way to combat this, there were some suggestions about how to eliminate the need for physicians with MAiD, so they did not have to participate: these ideas were creating a new profession to perform this service (Simon, 2014; Trankle, 2014), or the creation of an information service for these patients to access (Vogel, 2015). However, Downar et al. believed that there was no need for another profession to perform MAiD because physicians do not unanimously oppose the service (2014a).

### ***MAiD as distanced from palliative care***

Discussions of MAiD in relation to palliative care services was found in the

literature as well. First and foremost, the need for better palliative care and the need to focus on improving palliative care came up numerous times (Eggertson, 2014, 2015; Francescutti, 2014; Johnston, 2014; Sheahan, 2016; Wright et al., 2015). In line with that, there was a belief that providing patients with better palliative care will result in decreased requests for MAiD (Abela, 2015; Abela & Mallia, 2016; Cohen et al., 2012; Wright et al., 2015). Some physicians also didn't want MAiD to be seen as an alternative to palliative care or for it to lead to decreased palliative services (Bright, 2014; Downar et al., 2014b; Ilvemark et al., 2016; Sheahan, 2016). One paper even mentioned a fear that MAiD would be seen as an alternative to *good* care (Vogel, 2015). Finally, some physicians expressed concern with a decreased trust in palliative care, even though MAiD is outside the scope of palliative care, and that it might deter people from using palliative care services (Eggertson, 2015; Sheahan, 2016). As mentioned above, the palliative care speciality has been distancing itself from assisted death, mainly for the reasons just listed. Ideally, both services could work together to give options to patients at the end of life. One paper was found during the updated literature scan that discussed this topic. Through qualitative interviews with Swiss palliative care providers (n = 23), some participants believed that palliative care should be distanced from assisted death, while others saw assisted death as a tool to be used by palliative care providers in conjunction with their other training (Gamondi et al., 2019). This points to interpretations of the goal of palliative care as being important in MAiD opinions as well.

### *Protecting the vulnerable and the slippery slope*

Many included articles pointed to the need to protect vulnerable patients because of the fear that these vulnerable people could be forced into an assisted death when they don't actually want one (Breen, 2018; Bright, 2014; Downar et al., 2014a; Downar et al., 2014b; George, 2014; Jylhäkangas et al., 2014; MacCormick, 2014; Noble, 2013; Trankle, 2014; Wright et al., 2015). In addition, a few papers cited the slippery slope argument that has been used for decades (Abela, 2015; Jylhäkangas et al., 2014; Kussmaul, 2017). This argument suggests that even allowing only voluntary euthanasia will eventually lead to non-voluntary and involuntary euthanasia to those who are most vulnerable (Browne & Russell, 2016). The need to protect vulnerable patients from the “slippery slope” was also found in the updated scan of the literature. Like in the opinion paper written by Gale and Barak (2020). They suggest that when assisted death is legalized it adds pressure to allow access for those who might think they are a burden to those around them (like the elderly, disabled and poor) (Gale & Barak, 2020). Anfang argues that this could be remedied by psychiatrists being involved in assisted death as evaluators, because then they can ensure that these patients are truly seeking it for a humane death and identify those who might fear becoming a burden to their families (2021). Additionally, he covered conscientious objection and those who do wish to participate in assisted dying, noting that he believed everyone should be able to decide to participate, while also providing reasoning for why he believes the speciality of psychiatry should be involved (Anfang, 2021).

### *Physician and patient emotions*

Some articles pointed to the different emotions experienced related to MAiD, both from the perspective of the physician and the patient. One physician expressed anxiety about providing an assisted death (Buchman, 2012). Hébert talked about conflicting emotions: expressing nightmares about performing assisted deaths and guilt, but also that he provides a peaceful dignified death, and knows that this is a needed service (Hébert, 2017). In one article, the providing physician did it out of duty to their patient, but later expressed that it was upsetting (Hurley, 2015a). In the study by Voorhees *et al.* (2014), participants described their emotions becoming more intense when they considered performing an assisted death (Voorhees *et al.*, 2014). Along the same line, another article discussed some intense emotions after an assisted death such as being moved, drained, relieved, and satisfied (Bernheim *et al.*, 2014). Some other positive emotions brought up were being moved, and the death being “poignant and peaceful” (Li & Kain, 2018). Additionally, two physicians believed that they would feel awful before performing an assisted death, but afterwards they described it as being peaceful (Quinn & Detsky, 2017). Physicians also expressed that the patient’s acceptance and peace with their decision would greatly influence whether they would provide an assisted death (Ten Cate *et al.*, 2017). Physician emotions were also noted in was the paper written by Ardman which appeared in the updated scan, about his first experience with an assisted death (2023). He spoke about how the patient put him at ease because she was not afraid of death, he spoke about the laughter experienced in the house as they were preparing the patient for the procedure, and he spoke about the empathy he felt for the patient because of her prognosis (Ardman, 2023). In the study of

Quebec physicians who conscientiously objected participating in MAiD (n = 22), another of the major themes involved emotions, fear, and the emotional burden that might happen (Bouthillier & Opatrny, 2019).

As for patient emotions, some believed that MAiD offers hope and peace of mind (Brewer, 2012). One physician said that they could see the relief on their father's face when he realized he could receive an assisted death (Hurley, 2015a). Death With Dignity reports that many people don't go through with taking the medication after they know that they have been approved for it because just having the option gives them comfort (Death With Dignity, n.d.).

### ***Education or exposure to assisted dying***

A handful of articles pointed to the importance of or need for education around MAiD, or more professional experience with dying, as reasons to support MAiD. In a study of Quebec conscientious objectors (n = 22), another of the sub-themes talked about inadequate expertise; 36% of individuals felt they didn't have enough clinical experience and didn't have enough familiarity with the medications to be able to provide an assisted death (Bouthillier & Opatrny, 2019). In a survey of American physicians (n = 37), when asked whether they had the information they needed to be able to provide assisted deaths, 43% said they have all the information they need to counsel a patient asking for an assisted death, and 34% said they have all of the information they need to complete the paperwork associated with an assisted death and prescribe the medication involved (Landry et al., 2020). In a survey of family medicine residents (n = 247), Wong et al. (2019) found that those with increased clinical exposure to death and dying (e.g.

declaring a patient dead, completing a death certificate, speaking with families after a family member died) would be more likely to participate in MAiD by lethal prescription. Specifically, they found a statistically significant correlation between speaking with families after the death of a loved one and willingness to participate in MAiD (Wong et al., 2019). This shows that providing more education around MAiD, or clinical exposure to dying, will allow practitioners to feel more comfortable with MAiD as a service.

### ***Professional stigma***

Finally, an important topic in the updated scan of the literature was around professional stigma as it relates to MAiD. In interviews with Quebec conscientious objectors (n = 22), one of the sub-themes pointed to a fear of stigmatization from participating in MAiD (Bouthillier & Opatrny, 2019). This was also similarly seen in the interviews with Swiss palliative care physicians (n = 23), who feared being stigmatized as a palliative care physician if they supported assisted dying (Gamondi et al., 2019). This shows that although MAiD is a legal service (in both Canada and Switzerland), there is still a fear of stigma that prevents practitioners from providing this service.

### **Summary**

MAiD has been a decades-long debate in Canada; before the Sue Rodriguez case in 1993 to the landmark Carter case in 2015, advocates for assisted death have been fighting for the right to access this service. Even after the legalization of MAiD in 2016, it seems to be a topic of conversation with respect to policies surrounding physician's

conscientiously objecting and the recent change to the law (removing a “reasonably foreseeable death”).

The topics found in the literature review revealed a wide variety of reasons that a physician may support or oppose MAiD. The findings were enlightening, however, most of the studies came from countries outside of Canada and may not fully encompass this issue within the Canadian context. Although two more Canadian studies were found in the updated literature scan in 2023, there were few studies examining what shapes the views of physicians, with most focused on the surface-level question of: do they support MAiD? What the findings did point to, were that physicians have a range of personal principles that shape their views (e.g. religion or what they have learned as professionals). They then use these principles to justify how they approach MAiD, sometimes leading to different outcomes because of the way that they personally interpret that principle.

## **Chapter III - Methods**

### **Introduction**

In this chapter I will review grounded theory methodology and provide the rationale behind the methodology I selected for this project. A detailed outline of the methods that were implemented will be provided, including data collection, sample, rigour, and analysis. This chapter will also address ethical considerations and REB approval.

### **Methodology – Grounded Theory**

For this project, I was interested in exploring what New Brunswick physicians believe regarding MAiD and what is shaping their views, so a qualitative approach to data collection was used. I believed it would be valuable to find physicians to interview and to gain a rich understanding of their perspectives around this topic. Specifically, I selected a grounded theory methodology because it is best for understanding “beliefs and meanings that underlie action” (Corbin & Strauss, 2015b, pp. 11). It is also suggested that this is an appropriate method for novel research areas, much like the topic of this project (Corbin & Strauss, 2015b).

There are three major schools of grounded theory that evolved and changed over time, each with different methods and goals. These are: Classical Grounded Theory (Glaser), Straussian Grounded Theory (Strauss), and Constructivist Grounded Theory (Charmaz) (Apramian et al., 2017). There are other types of grounded theory mentioned in the literature as well, however, for the purposes of brevity, I will discuss the three that appear most often. Although different in their stance on the use of literature reviews,



coding processes, and theory generation, they are still similar in their use of iteration or constant comparison of data (Corbin & Strauss, 2015d; Evans, 2013).

### ***Classical grounded theory (Glaser)***

With classical grounded theory the most important aspect is induction; Glaser would draw conclusions from the data that is collected and then create a theory from that data (Evans, 2013). This methodology generally does not begin with a research question, just an idea of what the researcher would like to study (Evans, 2013). Additionally, the information that classical grounded theorist would use isn't entirely qualitative; Glaser would use other sources of information as data for his theory building, such as surveys and the literature review; using the approach that "all is data" (Evans, 2013). Glaser did not support the researcher performing a literature search before data collection began, and but would rather look into the literature and use it as data after the data collection had begun (Evans, 2013). This was so the researcher would not be shaped by the literature review, or choose codes or categories based on what the literature said. Finally, Glaser did not support the use of reflexivity, which is the act of reflecting on your own personal opinions and biases as the researcher, as he contended that the researcher should not be influencing the emerging theory (Evans, 2013).

### ***Straussian (Strauss)***

Similarly to classical grounded theory, Straussian grounded theory focuses on induction and theory development, and is supportive of a broad research question (Corbin & Strauss, 2015a). Additionally, Strauss (and Corbin) have set out clear methods to follow when using this form of data collection, to make it easier for novel

researchers to use (Corbin & Strauss, 2015a; Evans, 2013). Straussian grounded theory allows the use of reflexivity, unlike Glaser mentioned above, and suggests that the researcher keep a research journal and document their feelings before the beginning of the study as well as after each interview (Evans, 2013; Corbin & Strauss, 2015). Finally, this methodology allows the researcher to perform a literature review before data collection (Evans, 2013; Corbin & Strauss, 2015).

### ***Constructivist (Charmaz)***

Constructivist grounded theory also focuses on theory-building but allows for qualitative description as well; unlike with classical grounded theory, a constructivist believes “concepts are constructed, not discovered” (Charmaz, 2006a; Evans, 2013, pp.45). This allows for the “co-construction” of theory between the researcher and research participants (Charmaz, 2006b). The constructivist believes that knowledge is created through the interaction of the researcher and participants’ perspectives and considers the research setting. For this reason, reflexivity is also important with this methodology, to keep track of the researcher’s perspective. Finally, there is a clear focus on “story building” or telling the stories of the participants (Apramian et al., 2017).

### ***Justification for using Straussian grounded theory***

For my thesis project, I decided to use the Corbin and Strauss’ approach to grounded theory (Straussian). When looking at the textbook written by Corbin and Strauss, I found their methodology easy to follow. It felt more methodical and accessible for a first-time qualitative researcher (Corbin & Strauss, 2015b; Evans, 2013).

As mentioned above, both the Straussian and Constructivist methodologies allow for a researcher to perform the literature review before data collection begins (Evans, 2013). Glaser, on the other hand, is staunchly against a literature review being performed in advance because he believes it has the potential to mislead the direction of the interviews (Apramian et al., 2017; Corbin & Strauss, 2015b; Evans, 2013). Going into this project as a blank slate, as Glaser would prefer, would have been impossible, since this is a service that I had already done extensive readings on prior to choosing a topic. Additionally, a literature review could not be avoided at this stage of my learning (and had to be performed for my research proposal).

As described by Evans, there is often “method slurring” found among grounded theory researchers, and thus, we should attempt to stick to only the one method that we chose as rigidly as possible (2013). To be able to adhere to grounded theory as described by Anselm Strauss, I used the method textbook, *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, written by Corbin and Strauss as a guide for my research protocol (2015a).

## **Methods**

### ***Data collection***

I conducted one-on-one semi-structured interviews with all participants. Although Corbin and Strauss recommend the use of unstructured interviews for grounded theory, they suggested that a novice researcher choose a semi-structured approach to interviews, as it is easier to perform than an unstructured interview (Corbin & Strauss, 2015d). Each interview ranged between approximately 15 and 45 minutes to

complete, and they were audio-recorded. These interviews took place at mutually agreed upon times and locations; the majority took place in the physician's office or at the hospital. Two of the fifteen interviews took place in the participant's home. Since the interview was semi-structured, the guide was subject to change over the course of the interviews. A sample interview guide is attached in Appendix D. As the interviews progressed, there were certain topics that continued to come up naturally, and thus they were added to the original interview guide so that the topics could be explored. These questions were: "do you think MAiD could be an element of good palliative care?", and "do you think you would choose MAiD for yourself?"

### ***Sample and sampling***

The study population I was trying to identify was licensed New Brunswick physicians. This was a decision made because physicians were at the time the only practitioners who were choosing to participate in MAiD in New Brunswick. Although we were not sampling for only physicians who were choosing to provide MAiD or assess patients for MAiD eligibility, we felt it would be better to aim for a purposive sample of physicians who were in support of MAiD (providers and assessors) and physicians who were against, rather than muddle the sample. It is unknown whether NPs would have different reasons and motives for not participating in MAiD than physicians, so we wanted to isolate the physician experience in this study, to ensure we're understanding the view of the practitioners who were (and still are) completely involved in the process.

I excluded physicians who were not currently working in a clinical setting such as those working exclusively in research or recently retired. This was meant to identify practitioners who were currently working with patients, rather than removed from that setting. We also excluded medical students and residents, as they likely hadn't had enough clinical practice to start forming a true opinion on MAiD outside of their preconceived ideas. As mentioned previously, we also excluded NPs and other healthcare providers from this study, because we wanted to identify the group that was providing MAiD in the province at the time of the study, which was and continues to be, solely physicians (E.H., personal communication, August 24, 2018; Government of Canada, 2021; Government of Canada, 2023; J.W., personal communication, July 15, 2018). Finally, we did not exclude any participants based on specialty.

The initial plan was for participants to be recruited using snowball sampling because it was thought that it may be challenging to recruit them through other methods. This was due to the sensitive nature of the topic in question, as well as the perceived difficulty in recruiting physicians to agree to an hour-long interview. Sampling began with a personal contact that I had, of a physician who was interested in speaking about MAiD. Snowball sampling was then attempted by sending the Email for Recruitment, with the Letter of Information and Consent attached (Appendix E; Appendix F) to the participant who was just interviewed. That participant would then forward my email to people that they thought would be interested in participating, so that I was not the person contacting the potential participants. This however, proved to be quite unsuccessful at recruiting physicians, and so we also put a small advertisement in the New Brunswick Medical Society (NBMS) eBulletin in June of 2019 (Appendix G). Additionally, since

MAiD can be a sensitive and controversial topic, I went over a debriefing protocol with each participant which was created to ensure the utmost safety for our participants (Appendix H).

Although there is no set sample size for grounded theory methodology, I had assumed that the sample size would be relatively small due to the target population (physicians) and the sensitive subject matter. There is some debate in the grounded theory community regarding “data saturation”, versus ‘theoretical sufficiency’ of the data collected, we will be using the term saturation as is described in the methodological handbook written by Corbin and Strauss (Corbin & Strauss, 2015a; Charmaz, 2006b). Corbin and Strauss define this as the “point in the research when all major categories are fully developed, show variation and, are integrated” (Corbin & Strauss, 2015e, pp. 135). Data collection continued until I believed that I had reached a saturation point in the information I was receiving from the participants, seeing the same common topics arise.

### ***Reflexivity***

An important aspect of performing qualitative interviews is to consider that I, the interviewer, would be present in the interview with the research participant, requiring me to examine my assumptions and biases and reflect on how that might impact the research process or participants (Corbin & Strauss, 2015d). For this reason, it was important that I recognized and documented my own perspectives on this topic. My general feelings are that patients should have autonomy over their lives, and in this context, death. Since MAiD is a legal act in Canada, I believe qualifying patients should be able to access the service if they wish to. I believe that nobody should be able to

prevent a patient from accessing MAiD because of their personal beliefs, but I also believe that physicians who do not wish to participate in MAiD shouldn't be forced to partake. Since the question was asked of my participants as well, I reflected on whether I would choose an assisted death for myself. I honestly don't know. I can see merits to not wanting to suffer from an incurable disease, but I also think it would be too anxiety-inducing to know exactly when you are going to die.

I can clearly see that there are two opposing sides to the debate and respect both sides of it, especially because it is a life-or-death decision. I believe I was engaged, interested, and impartial throughout the interview process; especially with my one participant (participant 15) who had a vastly different view than my own. I believe they and I had a good rapport and I remained non-judgmental throughout, eager to listen and hear what they were saying.

In addition to listing my personal beliefs at the start of my research project, Corbin and Strauss recommend that the interviewer (myself) keep a research journal to keep track of everything that happens during the research process, as well as reflecting on my own beliefs and biases to maintain self-awareness through the process (2015d). After each interview, I sat for fifteen to twenty minutes (either in the hospital, or in my car) and wrote out my initial interpretations of what the participant said, as well as any notes on rapport or environmental distractions (such as a participant's dog sitting on my lap). These notes were referenced back to as I was coding the interviews, so that I was constantly reflecting on myself as a presence in the research setting and anything that I may have personally brought into the interview.

## **Data Analysis**

As mentioned above, the interviews were audio-recorded, and then transcribed verbatim. I coded the interviews by organizing the data into similar concepts (themes), and then eventually into a core category. I used a constant comparison method, where the data collection (i.e., the interviews) occurred concurrently with the data analysis and coding (Corbin & Strauss, 2015b).

The coding process started by coding the interviews line-by-line, looking for the main ideas that were expressed. These line-level codes were then coded again section-by-section (generally, by each answer the participant gave), writing a memo of what was interpreted in that section, creating a larger concept (theme). If those concepts were repeated in another interview, it confirmed what was seen, and the main concepts (themes) arose from the interviews. It was important that I remain open to the process of data analysis, and not pre-emptively choose a core category before sufficient information is collected (Corbin & Strauss, 2015b). This is why reflexivity and keeping a research journal throughout data collection and analysis was imperative.

The core category is what is discovered as being the main theme that appears during the interview process (Corbin & Strauss, 2015b). It is meant to summarize the main idea found in the study by encompassing the other categories found, and thus, forming a theory (Corbin & Strauss, 2015f). From Corbin and Strauss (2015f), it is meant to be an “overarching explanatory concept”, that appears frequently in the interview data (pp. 189). For this project, I referred to my research journal, and the memos that I had created while coding, and tried to find an overarching theme that



explained each of the main categories and was able to show how they were connected to each other.

### **Ethical Considerations**

This project had been approved for ethics at the University of New Brunswick (UNB REB#2018-118). I provided written letters of information, and informed consent forms to the participants, which were explained verbally, and then were signed by the participants prior to the start of the interview (Appendix F). All participants were informed that they may terminate the interview at any point. However, to remain cautious of the participant's mental health, there was a debriefing protocol that was given at the end of all interviews (Appendix H).

Confidentiality has been maintained by not providing any identifiable information of the participant in any of the written work; this includes names, ages, and locations of any of the participants, or others that the participants mentioned during the interviews. Additionally, if the participant mentioned another practitioner or patient by name, that information was de-identified to protect the confidentiality of those people as well. Only the PI (me) had access to the recordings taken during the interviews, and these were saved in a password protected folder on a password-protected laptop. All confidentiality forms have been saved in a locked cabinet.

## **Chapter IV – Results**

### **Introduction**

Fifteen interviews were conducted across New Brunswick between March 26<sup>th</sup> and November 1<sup>st</sup>, 2019. Each interview was performed by a graduate student (me) and took place one-on-one with a physician in the setting of their choice; some were conducted in the physician's office, some in the physician's home, and one took place in a room rented at a hospital. Most of the interviews (n = 13) took place within the three major city centers in New Brunswick, but there were two interviews in rural locations. City names have been removed to maintain anonymity of the physicians interviewed.

### **Sample Demographics**

The average age of the participants was 47, with a range from 30 to 67 years old. There were more female physicians (n = 11) than male physicians (n = 4) in this study (Table 2). Partway through the interviews, it was realized that asking the participants "how long have you been practicing medicine?" can receive varying degrees of replies (some counted medical school graduation, and some residency). To ensure that we were collecting the same information from all physicians, their graduation year was searched in the New Brunswick College of Physicians and Surgeons database. As such, the medical school graduation years for the participants was found to range from 1978 to 2015. In terms of specialty areas, most of my participants were family physicians (n = 11). The rest of the sample was made up of four specialists. The specialties have been omitted to protect the anonymity of our sample since New Brunswick is a very small province. The group was quite varied with the setting of their work, with the majority (n

= 13) of participants working in more than one clinical setting (e.g., outpatient clinic, in-patient hospital, nursing homes, home visits, etc.).

### **Participation in MAiD**

Five of my participants were experienced MAiD providers and the other ten had not at the time participated in MAiD. Of the fifteen participants, eleven said that they are MAiD assessors (or that they would be, given the opportunity), three said that they would not assess but would refer their patient to someone who could help them, and one participant said that they would not assess and would prefer if there was a self-referral system for patients so that physicians were not involved. Ten of the participants held supporting views of MAiD, while four expressed themselves as having mixed opinions on the topic, and one participant fully opposed MAiD.

Finally, when asked if they would choose MAiD for themselves, eight of the participants said they would, four said they would not, and three said that they were unsure, and that they might not know unless they were in the situation.

**Table 2***Participant characteristics (n = 15)*

<i>Characteristic</i>	<i>Mean (SD)</i>	<i>Range</i>
Age (years)	46.6 (11)	30 - 67
	<i>n</i>	<i>%</i>
Sex		
Female	11	73
Male	4	27
Location Type		
Urban	13	87
Rural	2	13
Specialty		
Family Medicine	11	73
Specialists	4	27
Willingness to participate in MAiD		
MAiD Provider	5	33
MAiD Assessor	11	73
Would not participate, but would refer	3	20
Would not participate, would not refer	1	6

**Qualitative Findings**

Through the interviews with these physicians, I found that physicians' perspectives on MAiD were an intersection of their personal, social and role identities. These identities were shaped by their personal worldview, by the pain and suffering they have witnessed in their role as physicians, and the value they placed on personal autonomy. Below, I will expand on each of these concepts, drawing on quotes from my participants to illustrate how deeply personal these views can be. From this, it will show that the physician's identity is a major factor that shapes their view on MAiD.

### *Personal Worldview and Ethics*

The participants drew on their ethical, moral, religious, and political values when describing their perspectives on MAiD. Some participants explained that it was the way they were brought up – whether that be their religion, their political affiliations, or the way their parents taught them, that first shaped their views, and had a long-lasting impact on them when it came to their opinion on assisted dying.

**Religion.** The link between religious background and MAiD was described by participants either outright by stating their religious beliefs were the reason for their opinion, or sometimes linked to ‘the sanctity of life’ argument that is sometimes discussed with regards to protecting human life. Additionally, there were nuanced conversations, with some participants sharing the opposite opinion. Either way, this finding points to something that is ingrained in a person’s identity and is deeply personal.

For instance, Participant 2 (who expressed mixed beliefs surrounding MAiD) believed that their views were based on their belief in God, “I don’t think it’s just religious beliefs, but it’s certainly my belief in *God*. And I just think that God is [the] entity or the being that, sometimes makes us suffer when we don’t want to, and we don’t understand that.” They explained complex feelings surrounding MAiD, and their belief that we should not interfere in other people’s lives but ultimately decide that it’s outside of their control, falling back on their religious beliefs: “and you think ‘oh, like, why are you still alive? Like what is the reason for you to be here?’ And somehow inside I think that that’s like God’s job...I don’t think that it’s my job to decide” (participant 2).

Another participant who expressed mixed views (participant 7) stated that their opinion was likely initially based on the religious household that they were raised in: “When it first came out, I didn’t really agree with it [...]. I was raised in a religious household. Even though I wouldn’t say I actively practice a lot of religion today. Probably those core beliefs are still there.” Participant 12 expressed similar hesitations based on religion: “I don’t know, that’s really tricky...It’s new, and I’m religious.” This points to their early reactions to the service being strongly impacted by their core religious values (even if no longer practicing).

The one participant who was in opposition to MAiD focused on their religious background and the ‘sanctity of life’: “I think that primarily for me, MAiD goes against this sanctity of life principle. That all life is valuable.” (participant 15). Additionally, they pointed to the messaging from their religious leaders regarding suicide and murder, so this participant inferred that MAiD would also be inexcusable:

There seems to be a fairly strong press from our religious leaders and also our religious texts that suggest that *suicide* is wrong. And murder is wrong which creates a bit of pressure for saying that helping somebody to end their life could be right.

This individual took the teachings from their religious background and applied it to the way they view the world, and specifically, MAiD.

Conversely, there were conversations about religion from the participants who supported MAiD as well; they believed that MAiD did not stand in opposition to religion, and that even some religious patients will still seek an assisted death. Participant 3 said “I mean if there’s no heaven, it doesn’t matter. If there is – I believe

they're going there too." Participant 10, who identified as "culturally Christian" talked about how they personally look at God:

I don't really think God is micromanaging Mr. Smith and insisting that he suffer through the last three weeks of his life. You know, I don't view God as this puppeteer. Right, that it's—I prefer sort of the New Testament idea that "God is love." And if we're doing things that move towards love and acceptance, and supporting people, then that's what it's really supposed to be about.

They continued regarding their beliefs, "Any God that I believe in, wouldn't think that's a sin. Right?" and explained how sometimes even religious figureheads are supportive: "Interestingly, two of the medical assistance dying I've been at, the ministers have been present."

Some participants had religious upbringings but did not feel that influenced their opinion on MAiD now. Participant 8 said:

I may be Catholic and everything else - they say suicide could potentially be a sin, I don't believe that. I think it's a medical procedure, it's done for medical reasons, it's done to relieve pain and suffering, therefore, I think it's a reasonable procedure to have done if necessary.

Those that were in support of MAiD tended to believe that these perspectives can operate together rather than in opposition, showing that even if their beliefs are ingrained in religion, they will interpret those beliefs to fit what it is that is important to them (in this case, to relieve pain and suffering).

**Political Leanings** There were other influences outside of religion that also linked to the family unit and the participant's upbringing, things that end up embedded in a person's identity. For example, some participants stated which way they and their family leaned politically, beliefs that were instilled in them by their family while growing up, and other notes about their family that they believe shaped their view.

A few of the participants linked their viewpoint to being "liberal", and how it shaped their support of MAiD. When asked if there was anything that shaped their views towards assisted death, participant 5 outright stated "Open-mindedness [laughs]. Being liberal. Being compassionate.... There was not gestalt moment. This is something I have always believed in." Participant 8 stated, "I'm fairly liberal [laughs]. I've kind of figured eventually it would be a legal right." Participant 11 linked their viewpoint to their parents being more liberal, and that shaped their viewpoint on MAiD as well: "It's interesting, I have always thought that was something that should be allowed. I have really liberal parents." Linking their personal identity, or the ways in which their family brought them up shows how deeply engrained beliefs regarding this topic can be.

Similarly, Participant 10 (who is a MAiD provider) discussed a more overt way that their parents raised them, instilling ideas of what is right: "I grew up in a family where we'd been – where I was raised pro-choice, right? And women in particular are um, entitled to make decisions that pertain to their body and their health and family planning and whatever else, right." They took these teachings and now provide MAiD as a part of their practice.

I found that participants were trying to reconcile various aspects of their worldview and personal upbringing when discussing the concept of MAiD. They all



interpreted these influences in different ways, which affected not only their stance on MAiD as a physician, but how they might feel about MAiD as an end-of-life option for themselves (should they find themselves ill). Interestingly, those in support of MAiD and MAiD providers didn't always believe they would choose it for themselves at the end of life.

### ***Role as a Physician***

The participants also drew on their very unique perspective, from their role as physicians, MAiD assessors and MAiD providers to explain what shaped their view on MAiD. A lot of these discussions surrounded things that they often witnessed while working as physicians, like the pain and suffering of dying patients, the good deaths that they have witnessed, aspects of palliative care, and the importance of protecting vulnerable patients. This important role identity (as physicians) shaped how they viewed MAiD.

**Nature of a physician's job.** The participants spoke about the experiences they had as physicians, and what they personally believe this job entails. Some expressed that the role of a physician is to help suffering by providing MAiD, and others believed it was to mitigate that suffering without ending a life.

For some, their job as a physician reinforced their support of MAiD. From their experiences, participant 6 said "I've seen people in pain. I've seen them suffer – needlessly. And you know what's the point of suffering through another few days or few weeks to reach the same end point? I don't think there's any reason to suffer." When asked what they think shapes their opinion towards MAiD they also said, "I think just

experiences with patients—with dying patients or suffering patients.” Participant 10, who is now a MAiD provider, said “I’ve seen some—I don’t want to say bad deaths in quotations, but deaths where people suffer through their last breaths, their last hours, their last days.” Participant 9 parroted this sentiment, “it’s difficult, it’s painful. It’s painful for the patient, it’s painful for the family. Sometimes it can be quite long, uncomfortable, being in the hospital is not comfortable.”

When talking about the dying process, participant 11 questioned whether the public had a skewed view on what dying entails:

And having experienced people dying *horrific* deaths...I think the hard thing is when we picture someone dying, we picture a little granny in bed, comfortable, you know? Just at peace. I don’t think that the vast majority of people would really appreciate what actual dying can look like and the level of suffering people can have.”

Similarly, participant 13 stated, “You just see people with just like poorly controlled symptoms that you know, they may just you know – it really affects their quality of life. Um, and they may choose that they don’t want to you know, have that be their end of life”.

Another talked about how helpless they felt when helping participants at the end of life because they were unable to help their suffering: “I see patients at the end of life a lot. So, I see some patients that just have very bad symptoms, that despite all of our attempts, aren’t very well controlled” (participant 13). Similarly, participant 14 stated: “but there are times that I’ve seen people suffer in the end despite my best efforts. And

wondered if there were ways of speeding up the process so they didn't have to go through that."

Participant 10 explained their beliefs regarding what it is to be in the role of someone who provides MAiD "with medical assistance in dying, you're not changing the ultimate destination for these folks. They are dying. What you're influencing is the *route* that they take *to* death." Conversely, participant 2 who expressed hesitation with regards to MAiD as an option for patients based on their religion, drew on the Hippocratic Oath of 'do no harm' and interpreted it to mean that a physician should not kill a patient:

There's that thing in medicine that says, 'do no harm', and that we're supposed to be helping people in whatever way we can. And I just can't get my head around the idea of me deciding that somebody should die as being the way that I'm going to help them.

The participants explained how they interpret their role as physicians in relation to MAiD and still took opposing views. This shows how interpretation of this topic is very individual, based off an interaction of multiple principles and identities; it's what is most important to the physician that really justifies their decision (e.g. if ending suffering is more important, then they will use their professional identity to justify supporting MAiD).

Most participants drew on their background and professional role as a physician to explain their perspective on MAiD. There were surprisingly few participants who spoke about the education they may have received on this topic. When education was discussed, it was regarding a lack of education and resources for them to draw on, and

not fully understanding the eligibility criteria. They felt they didn't have the tools or information to be able to direct their patients in the right direction should they ask for MAiD. Participant 5 explained it perfectly by saying: "I think there needs to be way better education out there for both the doctors and the public. People still don't understand.", and participant 11 noted that when a participant reached out asking about MAiD, they "felt like a dumbass." I think this is an important note to keep in mind, because education and exposure to topics and help inform how physicians interact with their professional role.

**Pain and Suffering.** Participants cited the physical and mental anguish that can often be experienced at the end of life as a reason to support MAiD (from either their experience with patients or family members). But those who were unsure, or against it, talked about other means of pain control, and one participant who was strongly opposed to MAiD expressed that it was important to walk with patients through their suffering, and to really be there for them at the end of life. In these examples, one sees that the importance placed on certain aspects of the physician's identity shaped how they looked at the pain and suffering of these patients; some looked at MAiD as a way to help patients who were suffering based on their personal and professional experiences, some pointed to other ways to help suffering, and the last taking a more religious view of this topic. Quotes to illustrate these points will be explored below.

Participant 5, who is a MAiD provider, believed that what they do is end suffering: "If somebody is dying of cancer, I'm not killing them. The death sentence is already there. I'm easing suffering." They then expressed how the families thank them

after the MAiD procedure: “it’s hard for me to accept it. But I know what they’re saying. ‘Thank you for helping them and putting them out of their suffering.’”

Participant 1 expressed how they have been in situations as a palliative care physician where they haven’t been able to relieve that suffering at the end of life: “I haven’t been able to do anymore to help people, or what I can do to help people is not acceptable to them and there’s a lot of suffering that happens for multiple reasons.”

Some participants made a comparison between MAiD, and the ‘humane’ way to care for pets at the end of life. Participant 5 said: “you put your dog’s down when they’re suffering.” Participant 6 agreed by saying: “I think it’s humane. Um, I always say... ‘it’s inhumane to let an animal suffer, so why is it humane to let a human suffer?’”

Some participants looked at the issue of suffering as something that can be controlled, such as through comfort care. One such participant (2) said:

I’m more interested in palliative care than I am in MAiD. Cause the principles of palliative care say that as a person is dying, that you should provide them comfort care, so that they don’t suffer. And I think MAiD’s idea is that so many people suffer at the end of life, that once it gets to the point that there’s a lot of suffering, why not just end the life there, and not continue on with the unnecessary suffering until they die.

Participant 15, who was opposed to MAiD, used their religious lens to talk about the importance of walking alongside someone who is suffering, rather than allowing them to access an assisted death:

So, as I walk side by side with somebody who suffering, I can learn empathy, I can learn compassion, I can learn how to assist one who is no longer able to do whatever it is. And those would be the kinds of lessons I think a society needs to learn.

These all show how these practitioners framed how they felt based on their personal experiences and can closely be linked to aspects of their identity. Another example of this is how some physicians framed their opinion on suffering and MAiD specifically through the lens of their clinical experiences.

**Good death.** Conversely, some physicians talked about the idea of a “good death” or what they perceived as a good death, which generally involved having the opportunity to say goodbye to family members, and not experience prolonged suffering. Although this does overlap with the idea of pain and suffering, these ideas presented as opposite sides of the same coin, and thus I wanted to separate these two very important experiences. Additionally, one participant (15) who was very much in opposition to MAiD understood that the idea of a good death is a frequent reason that patients do choose this option for themselves.

Some participants believed that patients should have the option to have a good death for themselves. Participant 4 states as such: “I just think that if people wanted the option, that I feel that they should really have that option for a good death they could have for themselves.” Participant 14 placed a high value “living well and dying well”, while participant 10 (a MAiD provider) described MAiD as “humane and dignified”, which would also signal a ‘good death’. Participant 4 cited their mother’s death as an example of a good death, and the reason why they want to help patients at the end of

their lives, “I thought everyone should be able to have a really good death. And my mom’s death was as good, in a way, as it could be...That’s what everyone wants.”

Some talked about the benefit of an assisted death as a way of having a good death for the patients. Participant 3 (a MAiD provider) said, “it’s generally some of the best deaths I’ve ever seen. [...] Well, they have a chance to say goodbye to people or say certain things to people who are there.” Similarly, participant 10 talked about a patient who died by MAiD: “I think to then contrast that to some of the other deaths that I’ve observed, and I just thought, ‘if we could all be so lucky.’ To be surrounded by love, the people that we want to be there, and to not suffer.”

Finally, when talking about why someone would decide to choose an assisted death, participant 15 (who was against MAiD) said,

I think a desire to end on a strong note, would be there for a lot of people. [...]  
“I have lived my life, and I have lived it well, and I want to be done before I suffer, or before I have to suffer, before I have to lose any sense of self-accomplishment or pride that I have in what I have lived.

Although this participant was correct in noting that that is why patients would choose MAiD, they still did not support that decision due to their personal and religious identities.

**Palliative Care.** Palliative care was brought up among the participants, likely due to palliative care and MAiD both dealing with end-of-life issues. It is important to note again that within the discipline of palliative care, there has been some push to separate MAiD from their service. This distinction was also touched on by some of the participants.

Participant 15 expressed how good palliative care would mitigate the need for MAiD: “I think that with *appropriate* palliative care, you can meet the needs of the vast majority of patients, *both* on a biomedical level, but also in kind of this spiritual level.” Conversely, when asked if MAiD can be an element of good palliative care, participant 10 said “It absolutely is. Right? I think just the optics of people trying to be separate from it...so, there’s sort of the—the *field* of palliative care, and then you’ve got the personal feelings of the physicians currently practicing palliative care.” Some of the participants who support MAiD also discussed how MAiD should be able to work with palliative care, and even be discussed as an end-of-life option with patients in palliative care and before they’re ever admitted. Participant 8 stated: “in palliative care, your job is to keep patients comfortable, as happy as possible. And if they come to the point where they’re just suffering to the point - for no end, why would you make someone continue to suffer if you knew you could help them?” Participant 5 stated: “when somebody is facing end of life, they should be presented with all their options. Which now, *includes* assisted death. We don’t make any suggestions which one.”

Another example of the participants looking at situations through their own personal identity would be how participants 12 and 6 view the services that palliative care can and cannot offer at the end of life. Participant 12 looked at MAiD as a “failing” of palliative care “if people want to die - end their life - you know, we haven’t found a cure for the disease, we haven’t been good at palliating them, improving their depression. Yeah, I feel like maybe we failed, and this is an easier solution.” Participant 6 (a MAiD provider), however, offers a contrasting opinion, suggesting that MAiD could complement palliative care: “Palliative care, it’s good. We do all we can to



alleviate suffering. However, we can't do everything. And essentially, palliative care is pain management. And you know, taking care of agitation, and difficulties breathing, but what that does, is puts your patient in a comatose state. So, then we don't know if the patient is suffering or not." Participant 6 used this as a reason to provide MAiD to requesting patients, whereas participant 12 looked at it through the perspective that maybe physicians are not attempting to properly palliating patients because MAiD is an 'easier' option.

**Burden and the vulnerable.** A fear of patients feeling like a burden and a potential 'slippery slope' was also expressed. This is the idea that once we allow MAiD for a select group of people, it will start expanding to include more people and then unfairly target those who are seen as different or as burdens on their families or the healthcare system (often listed as those who are disabled or elderly). Participant 15 believed that the idea of being a burden would be the reason that someone would choose an assisted death: "I think a lot of people might choose to end their life early because they don't want to be a burden on somebody else." Participant 1, who is a MAiD provider, cited family burden and being dependent on others as a reason a patient might choose an assisted death: "you know they would *literally* really rather be dead." The fear of the slippery slope was expressed by participant 2 "I worry that if we put too much emphasis on MAiD rather than on palliative care, we're going to be thinking about medical diagnoses that are uncomfortable for *us*, and not necessarily uncomfortable for other people, and putting our viewpoint on whether their life has value."

Participant 4 was worried that there would be pressure placed on those with disabilities to access MAiD: “I know there are concerns from the disability community, that there might be pressure.” Participant 15 explores the idea of discrimination of patients with disabilities a little bit further by discussing the fact that when a lot of able-bodied people are talking about how they might want MAiD as an option, they are citing the losses of their bodily functions, which they think implies that those with disabilities might be living lives that aren’t worth living. This participant worried that those with disabilities will ultimately have that choice taken from them: “you’ll have MAiD advocates who are constantly pushing towards this kind of - “it is the choice of *self*”, but at a certain point you can lose your self-choice amid all of the externals”.

Participant 10, as a MAiD provider, explained how they make MAiD eligibility decisions based on what the patient values in life, not them making the decision for the patient based on what they can and cannot do:

I don’t mean that I’m assigning value to someone else’s life and saying “okay, you can’t walk anymore, you’re less valuable.” No, no, no that’s not what it is. But if you’re coming to me and saying, “*my* life has no more value. I’m suffering not doing the things I love. I’m in pain constantly. I’ve lost weight, I feel nauseous continuously.” I’m going to hear you out. Right? But I’m not [sic] gonna come in and say, “oh here are the criteria, you’re no longer contributing to the universe, we’re [sic] gonna off you.” No, to me those are two very different things, and I think sometimes people kind of worry you’re going to end up on the slippery slope.

### *Autonomy and Choice*

Frequently cited by those who support MAiD was the idea of patient autonomy, and choice at the end of life. There was overlap in conversations with the participants surrounding suffering. However, autonomy focused more on the right of patients to make decisions for themselves, and suffering was more about what physicians had witnessed as patients or family members.

When asked to define MAiD, some participants included control or autonomy in their definition, as an inherent part of the service. Participant 5 stated, “Have control over their death [...] they choose the time and place and setting—able to say their goodbyes, and then they are given medications to end their life in a peaceful manner.” Another participant (11) when defining MAiD said it is to “Enact a means of allowing people to have a control over their process of dying.”

Many believed that autonomy and control were big reasons why someone should be able to choose MAiD as an option. When asked if there was anything that shaped their view on MAiD participant 10 said, “that genuine belief that we’re entitled to autonomy.” Participant 9 said, “I think people worry about losing their independence, being in pain, not being able to be in control.” And along the same lines, “I think sometimes the notion of controlling this one last aspect is something that people want” (participant 13).

Frequently, participants emphasized the importance of choice for their patients, and the need to respect those choices. Participant 5 said, “The patients have autonomy, they should have some control...And it should not be a dictatorial, [hitting hand on table] ‘this is what you’re going to do’, they need some choices, especially in end of

life.” When asked what shapes their view towards MAiD, participant 1 stated: “I think basically it comes down to my belief that that people should be able to make their own decisions about their health.” Participant 7, who was still unsure on their thoughts towards MAiD stated that: “I think it really is up to the individual. If they meet the conditions, and that’s something that they really want, I’m beginning - my view is shifting a little bit in that I think that maybe that should be their choice.” And participant 8 discussed the importance of choice in any medical situation: “I still think that in the end, a person—whether it’s this, or reproductive rights, whatever – the patient in the end, had the right to make their own decision, as long as they have the information available, the capacity to make that decision.”

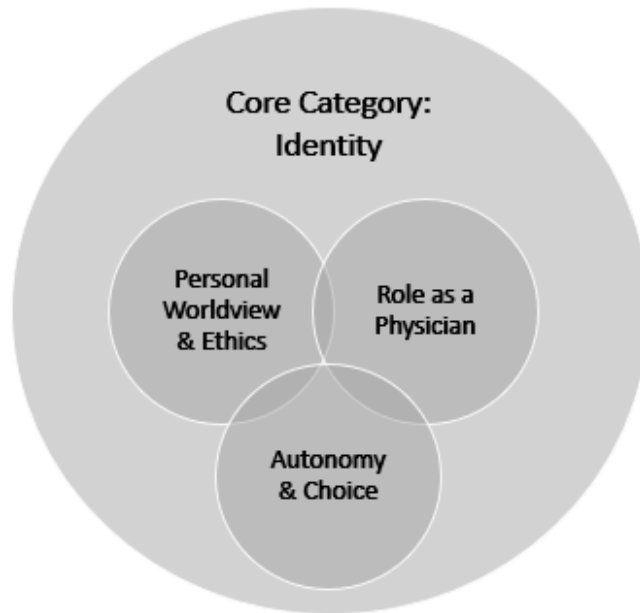
Two participants discussed not allowing the physician to make the decision for the patient; that the patient should have the right to decide for themselves whether they agree or not. Participant 1 said:

I remember hearing this a few times in medical school, ‘people can make stupid decisions, as long as they’re competent to make those decisions.’ They don’t have to make the decisions that we would make for ourselves or we think is the right decision... I feel like there has to be a point where we just respect what the patient says is right for them. And believe that they’re right.

Participant 11 discussed when they were still in residency and they had a preceptor that believed that palliative care did not expedite death, so they shaped their own views in the opposite way: “[it] really made me realize how strongly I felt myself that it should be an individual’s choice and not some random person deciding on my behalf.”

## Figure 1

*Categories and core category*



### **Core Category: Identity**

As depicted in Figure 1, each of the three main findings from the interviews were deeply intertwined and had the possibility of influencing each other. For example, “autonomy and choice” was heavily influenced by the experiences of participants witnessing “pain and suffering” while working looking at it through their “role as a physician” or sometimes in their personal life experiences with family members. Moreover, participants’ justification for supporting autonomy was frequently linked with their “role as a physician” and choosing when a person could no longer bear the pain. Similarly, the categories of “role as a physician” and “autonomy and choice” were

both viewed through the lens of the participant's "personal worldview and ethics", as well as reinforcing factors in those worldviews and ethics (e.g., seeing pain in their "role as a physician" reinforced their already held views).

I believe that the core category that brings these three categories together is the participant's identity. This is because a lot of their opinions come from their personal and deep-rooted beliefs, and sometimes is linked to other identifying factors. When looking specifically at the "personal worldview and ethics" category, a lot of the participants described their viewpoint on MAiD as linked heavily to their beliefs and the way they were raised (e.g., religion, politics etc.). Frequently, the participants stated that their views were shaped because they self-identified as something (e.g., liberal, religious, compassionate). I also believe that through their identity as a physician, they had their views further reinforced through their experiences (whether that be for or against MAiD). These experiences in their "role as a physician" were strongly linked to the categories of "autonomy and choice" and "pain and suffering". This is not to say that people cannot change, of course they can; there were participants who discussed that their perspective has slowly changed over time, especially due to their experiences within their role as a physician. Those with stronger viewpoints (like the MAiD providers, and participant 15 who was strongly against MAiD) held their opinion as part of their identity and viewed everything through that specific lens.

### **Summary of Findings**

Fifteen New Brunswick physicians (n = 11 family medicine, n = 4 specialists) were interviewed regarding their views towards MAiD, and what might be shaping

those views. Five participants identified themselves as MAiD providers, eleven as MAiD assessors (or would be if asked), and three would not assess but would refer to someone who would help them. There was only one participant who would not assess or refer a patient, and who identified themselves as being against MAiD.

From these interviews, three main categories were found. “Personal worldview and ethics” which touched on the participant’s religion, political leanings and upbringing. “Role as a physician” included topics such as pain and suffering they have witnessed, the idea of a “good death”, the nature of a physician’s job, palliative care, and burden and the vulnerable. The final category was “autonomy and choice”. These were all important aspects of a physician’s decision to support or oppose MAiD.

When analyzing all the information, the core category of “identity” was found. This core category explains all the other categories that were found and shows how each of the three categories relate to each other. This was seen through how deeply rooted these beliefs seemed to be, and how closely linked they were to aspects of the participant’s identity (such as religion, politics, their profession). This shows the physician’s identity is a major aspect shaping their viewpoint towards this service.

## **Chapter V – Discussion**

### **Introduction**

This research project aimed to explore what was shaping the views of New Brunswick physicians towards MAiD. The findings provide a rich understanding of the views and opinions of the participants and insights into why these physicians believe what they do about this service. Through these interviews three key categories emerged from the data: Personal worldview and ethics, role as a physician, and autonomy and choice. These three categories are linked together by the concept of identity as the overarching core category that explains what shapes the view of New Brunswick physicians towards MAiD (Figure 1).

In this chapter I will explore identity, the main types of identity and how it relates to these findings, and then discuss any relevant identity theories. Additionally, I will discuss how identity influences MAiD perspectives and decisions for these physicians. Finally, I will outline the strengths and limitations of this study, potential implications, and areas for future research.

### **Identity**

Identity refers to the traits that define who a person is. It represents a person's self-concept, or how they view themselves (Oyserman et al., 2012). Identity formation is a lifelong process and there are many theories about how identity is formed, influenced and sustained.

Erik Erikson believed that identity is something that develops during adolescence (Erikson, 1970). At this time in a person's life, there are a number of



biological and psychological phenomena happening due to puberty and the social aspect of being a teenager; so frequently, there is a “moratorium” of the commitment to an identity, while they test out different things to see what works for them (Erikson, 1970; Erikson, 2000; Marcia, 1966; Oyserman et al., 2012). The “conflict” that happens during this stage of development leads the person to either “confirm” the identity that they had prior to this period, or that identity will be “weakened” which will lead them to evolve into something different and new (Erikson, 1967; Erikson, 1970, pp. 732). Marcia expanded on Erikson’s idea of identity by proposing that identity was formed through “exploration and commitment” in adolescence, where a person explores different identities from their role models and social group, experiments with those options, and then commits to those identities by making decisions related to that identity (Oyserman et al., 2012; Marcia, 1966; Topolewska-Soedzok & Ciecuch, 2018).

### **Types of Identity**

There are three main types of identity: social identity, role identity and personal identity (Owens et al. 2010; Oyserman et al., 2012). Social identity are the characteristics of a group that the person belongs to and accepts as part of their identity (e.g., religion). Role identity speaks of the characteristics one has from being in a particular role, such as a person’s profession. Personal identity refers to “a person’s traits, characteristics, attributes, goals and values, and ways of being” (Oyserman et al., 2012, pp. 94). Each will be discussed more in depth below, and how it applies to a physician’s view on MAiD.

### ***Social Identity***

Social identity is the part of a person that is formed by the social groups that they belong to (Oyserman et al., 2012). This includes both religious identity and political identity, which both emerged from the interviews.

**Religious identity.** Religious identity is the degree to which an individual links their self-concept to their belief in a religion or deity and the set of rules laid out in that religion (Oyserman et al., 2012). Religion and religious identity were mentioned in several of my participant interviews as being an important factor influencing their views towards MAiD, whether for or against. There were those who said they were raised religious, or are practicing a religion, but didn't believe that MAiD went against those teachings (participants 8 & 10). In a recent study looking at MAiD providers (Oliphant & Frolic, 2021), they found that participants were able to support MAiD despite their religion's belief on the topic. Conversely, the one participant who was against MAiD entirely (participant 15), cited religion as one of the main reasons that they did not or might not support it. Inverse relationships between support for assisted deaths and adherence to a religion, or high levels of religiosity have been identified in past studies (Dopelt et al., 2021; Gaasø et al., 2019; Wong et al., 2019)

**Political identity.** Political identity refers to the degree to which a person links their belief system to a political party or viewpoint (Oyserman et al., 2012). This is like religious identity mentioned above and was also mentioned in a handful of interviews conducted. Two of our participants linked their positive views towards MAiD to identifying as "liberal", and another participant attributed their positive opinion on this subject to having "really liberal parents" (participant 11). In the context of these quotes,

it is hard to decipher if they mean the Liberal party of Canada, or the more abstract idea of being socially liberal in their opinions. Historically, MAiD has been supported by the Liberal, New Democrat and Green parties of Canada, and unsupported by the Conservative Party of Canada (Martin, 2015).

### ***Role Identity***

Role identity was one of the main types of identity discussed within these interviews. Role identity is seen through the lens of a particular role that someone inhabits, such as their profession. The physician participants in this study commonly linked their beliefs to scenarios that they had seen while working as a physician (e.g., extreme pain and suffering at the end of life), their “professional identity”. Both professional identity and the formation of that identity through education will be expanded upon below.

**Professional identity.** Pain and suffering were seen as influential on a person’s decision to support MAiD and was strongly linked to their role as a physician. Many of those who cited pain and suffering also mentioned the things that they have seen in their years as a physician (e.g., negative dying experiences) and how that shaped their views over time.

The idea of autonomy and choice could also be included within professional identity, as many participants expressed that from the things they have seen as a physician, they would want their patients to be able to choose what they do at the end of life. Oliphant and Frolic found that professional values and identity were a main contributor to conscientious participation in MAiD (2021). Within this theme they found

that the patient's right to choose, their personal value on compassionate care, facilitating access to care, and a "good death" were important reasons why these practitioners choose to participate in MAiD (Oliphant & Frolic, 2021). In the current research, similar sub-themes were seen within conversations with participants who supported and participated in MAiD, such as pain and suffering, a good death, and patient autonomy. These important aspects of what a physician sees within their professional role seems to play a major part in their personal opinions on MAiD, and their decision to participate in this service (or not). Findings from a cross-Canada survey of family medicine residents found that increased clinical exposure to end-of-life processes, led to more support of assisted death via lethal prescription and lethal injection (Wong et al., 2019). They also found that one of the more intimate aspects of a physician's job, talking with families after the death of their loved one, had a significant impact on willingness to partake in MAiD (Wong et al., 2019).

**Education and clinical experience.** An important aspect of professional identity development is the education people receive. In the context of this study, some participants highlighted that there wasn't enough education or knowledge about MAiD. Although this lack of knowledge didn't directly influence how they felt about MAiD, it did influence whether they would provide or perform the second assessment, with those citing a lack of knowledge as the reason for not feeling comfortable performing or assessing. One participant even stated that they "felt like a dumbass" for not knowing about the process when a patient asked them about MAiD, showing that this person internalized their lack of knowledge and incorporated it into their self-concept by describing themselves negatively (participant 11). Since what is learned and what is

experienced within societal roles has an impact on professional identity, it could be believed that this lack of knowledge would influence the professional identity of these physicians in some way (Owens et al. 2010; Oyserman et al., 2012). Other studies have noted that some physicians do not want to provide MAiD because they are lacking the education or clinical exposure that is needed to feel comfortable with these services (Bouthillier & Opatrny, 2019; Landry et al., 2022; Wong et al., 2019).

### ***Personal Identity***

Personal identity refers to the personal characteristics or traits that a person believes they have, and often are described as a person's "self-concept" – the things that a person believes about themselves (Owens et al. 2010; Oyserman et al., 2012). Additionally, Oyserman et al. (2012) note that these characteristics are those found outside of an individual's social and role identities but can be influenced by them. Someone's self-concept can often be shaped by the groups they belong to or the roles that they inhabit in the world.

You can see through the interviews I conducted that these personal identities are closely and strongly linked to the participant's beliefs on MAiD due to the way the physicians were self-describing (e.g., using "I am" statements), when asked what shapes their views on this service (Owens et al. 2010; Stryker, 1968). The "I am" statements that the participants used were heavily influenced by their social and role identities, showing that they have taken these aspects and included them in their own self-concept (e.g. "I am religious", "I am liberal", "as a physician...").

## **Stryker's Identity Theory and Identity Saliency**

Stryker's identity theory posits that a person can have multiple identities at the same time, and the most dominant identities are based on the number of interactions with that identity and the person's emotional investment to the role of the identity (Owens et al. 2010). Thus, how invested these participants were in their role (as a physician) or social (religious, political) identities could determine how they make clinical decisions, like with MAiD.

They described people being created of "diverse parts", such as political and occupational identities as discussed above (Stryker, 1968). Additionally, they believed that these different identities had different levels of saliency, and that there is a hierarchy of how behaviours present based on how salient each of these identities are (Stryker, 1968). So, if a situation presents itself, and the identity is higher on that person's hierarchy (because of more interactions with that identity, or they are emotionally committed they are to that role), then they will make decisions based on the more salient identity (Owens et al., 2010). An important note is that the interviews took place in in the middle of 2019, where MAiD had only been legal for about three years. Therefore, the participants might not have had enough exposure with this service to move these issues higher up their hierarchy of importance.

One of the participants (participant 7) who was unsure about where she stood on the topic, also was unsure about why she felt the way she did. She claimed that she was raised religious but is no longer practicing, but still thinks that maybe the core of her beliefs was being impacted by that upbringing. This suggests that although religious identity can be a key influencing factor for some providers, it's likely saliency of that

religious identity that is required for it to really make an impact on the person's opinion on MAiD; those with religious identity higher on the hierarchy of saliency will use that lens to influence their decision. But if another identity is higher, they may ignore or be uncertain of what their religion might value.

### **Core Category: How Identity Influences MAiD Perspectives**

It has been highlighted above, that the different types of identity (social, role and personal) as well as how important those identities are to the individual (saliency) impact how physicians feel about MAiD, and how it can impact their decision to participate in the service. An Ontario study looking at assessors and providers of MAiD (physicians, nurses, allied health, leaders), found a similar theme through interviews and focus groups (Oliphant & Frolic, 2021). Themes found included personal values and identity, professional values and identity, experience with death and dying, and organizational context. Although this study did not appear in the scoping review of the literature (due to the inclusion of non-physicians), the overlap in themes surrounding personal identity and professional identity shows that identity is key to shaping the views towards MAiD, and work in tandem to influence professional decision-making towards this service. Specifically, this overlap is seen in their group of MAiD supporters (including non-physician healthcare providers), and within the participants of my study who were MAiD providers and/or assessors (n = 11). Many of the participants in my study answered questions regarding what is shaping their views towards MAiD by listing their social and role identities (such as religion, politics, and things they have seen within their role as a physician) as reasons to support or not support this service.

Additionally, there has been research that focuses on the different types of identity (specifically, social and role identities) and how that shapes the opinion of physicians, which have been discussed above. I believe this shows that decisions surrounding MAiD are inextricably linked with the physician's many identities and is seen in the way that they self-describe (e.g. "I am religious") when asked why or why not they support this service; it is deeply entwined with who they are.

### **Strengths**

The timing of the present study was advantageous due to the addition of the new legislation on MAiD in 2016. This led to participants who were very excited to speak on this new topic, and who willingly shared their opinions on the topic at hand. This likely also aided in recruitment for a project with no budget for participant compensation. Due to the methodology of one-on-one interviews, the study also provided a rich understanding of the views of New Brunswick physicians towards MAiD, allowing lots of time to explore their views on this topic.

### **Limitations**

This project involved a small sample size ( $n = 15$ ), that took place in the small province of New Brunswick. Additionally, those who responded to our sampling efforts were focused mainly in the three largest urban centres of the province, with only two of the participants residing in a rural area. Thus, the findings may not be entirely transferrable to practitioners of the whole province or the rest of Canada. However, this is typical of qualitative research, and the information gleaned from these interviews still gives a rich understanding of physicians' perspectives about this important topic.



Additionally, NPs were not included in this study because initially, we had wanted to focus on who was providing MAiD at the time. It may have been beneficial to include this group in our sampling to understand why they were not participating in MAiD at the time (or currently) in New Brunswick.

Another sampling limitation that was found was that I did not find a purposeful sample with equal numbers of physicians in support of and opposed to MAiD. The final breakdown of our participants were supporters (n = 10), opposed (n = 1) and those who had ‘mixed feelings’ (n = 4). It is unclear if this is indicative of those who are opposed to MAiD being fewer in New Brunswick, or if it because those who are opposed weren’t as willing to participate in the study as those who are in support and those who provide the service. Despite these sampling limitations, I was able to explore a range of nuanced perspectives on MAiD; even those who were not supporters of MAiD still reinforced our analysis that physicians’ decisions were shaped by their social, role, and personal identities.

The interviews were conducted between March and November 2019, and therefore this is a dated study. Since that time, MAiD laws in Canada have been changed by removing the need for the patient to have a “reasonably foreseeable” death. In addition, MAiD has become a more popular option since this study was conducted. Therefore, it is likely that physicians’ views have also change in that timeframe. However, the findings still provide valuable insights into what shapes physicians’ views on MAiD, as well as what those views are during a specific timeframe, providing an opportunity to explore how these views change over time, should another study be conducted in the future.

## **Potential Implications**

The hope is that this research will advance knowledge about what shapes the views of New Brunswick physicians on this topic. This study isn't transferrable to other Canadian settings, but I believe it provides a good starting point to someone who may want to do further research in this area. Since it is a novel service, it benefits everyone to have a better understanding of different ideas and worldviews that affect access to MAiD in Canada, since MAiD is growing in popularity across Canada, the need to understand the physician perspective is growing as well (Government of Canada, 2023).

I found that physicians base their decisions on provision of legal medical services on their deeply personal beliefs. This could potentially have negative consequences for patients, such as issues with accessing MAiD, as well as negative experiences with their physician (e.g. a sense of judgement). This is an important balancing act, between timely access for patients, as well as respecting the professional boundaries of physicians. One way to remedy this could be by the New Brunswick College of Physicians and Surgeons following the lead of Ontario by implementing a requirement to refer patients on to a physician who can help them with their request for MAiD. Alternatively, the province could implement some form of 'hub' where patients can call and put in a request, and then be put in touch with a physician who is willing to assess and provide this service.

Additionally, there needs to be more education for medical students, residents, and staff physicians about MAiD. When looking at professional identity development, we know that this important aspect of identity is closely tied to education and exposure, so the hope is more education potentially could increase those who wish to participate in

MAiD and create more providers (Owens et al. 2010; Oyserman et al. 2012). Even if it does not increase the number of MAiD providers, this exposure could also lead to physicians feeling comfortable with what to do if they receive a MAiD request and decrease negative biases that the physician may have.

### **Future Research**

Future research involving quantitative and/or qualitative studies could expand on and verify my theory that identity is what is shaping the view of physicians towards MAiD. Research in other provinces and territories or a national study would be beneficial to explore the views of physicians in Canada more broadly. Additionally, should anyone choose to make policy changes regarding education at the medical school, residency, or regional health authority level, there could be an opportunity for program evaluation studies to examine the impact on physicians' knowledge of MAiD and willingness to provide this important service. Additionally, studies on what is shaping the views of other healthcare workers, MAiD patients, or MAiD patient family members/caregivers could be valuable as well.

### **Summary**

Physician identity was found to influence the decision to support or object MAiD in my sample of New Brunswick physicians. There are many types of identities that can play into this, such as the person's personal identity or self-concept; the person's social identities like religion or political affiliation; and the person's role identity, such as their professional identity of being a physician. All of these identities shape who a person is, and the decisions that they make. Future research on the topic of identity and MAiD in

Canada is recommended to further validate the findings of this study and learn more about this relatively new service in Canada.

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## Section 241.2 of the Criminal Code (2016)

### Appendix A

(Justice Laws Website, 2016)

#### Eligibility for medical assistance in dying

- **241.2** (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
  - (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
  - (b) they are at least 18 years of age and capable of making decisions with respect to their health;
  - (c) they have a grievous and irremediable medical condition;
  - (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
  - (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.
- Grievous and irremediable medical condition

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
  - (b) they are in an advanced state of irreversible decline in capability;
  - (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
  - (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.
- Safeguards

(3) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must

- (a) be of the opinion that the person meets all of the criteria set out in subsection (1);
  - (b) ensure that the person's request for medical assistance in dying was
    - (i) made in writing and signed and dated by the person or by another person under subsection (4), and
    - (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;
  - (c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before two independent witnesses who then also signed and dated the request;
  - (d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;
  - (e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);
  - (f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;
  - (g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;
  - (h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and
  - (i) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.
- Unable to sign

(4) If the person requesting medical assistance in dying is unable to sign and date the request, another person — who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death — may do so in the person's presence, on the person's behalf and under the person's express direction.

- Independent witness

(5) Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they

- (a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death;
- (b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;
- (c) are directly involved in providing health care services to the person making the request; or
- (d) directly provide personal care to the person making the request.
- Independence — medical practitioners and nurse practitioners

(6) The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the opinion referred to in paragraph (3)(e) are independent if they

- (a) are not a mentor to the other practitioner or responsible for supervising their work;
- (b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or
- (c) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.
- Reasonable knowledge, care and skill

(7) Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.

- Informing pharmacist

(8) The medical practitioner or nurse practitioner who, in providing medical assistance in dying, prescribes or obtains a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose.

- Clarification

(9) For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.

2016, c. 3, s. 3



## Section 241.2 of the Criminal Code (2021)

### Appendix B

(Justice Laws Website, 2021)

#### Eligibility for medical assistance in dying

- **241.2** (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
  - (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
  - (b) they are at least 18 years of age and capable of making decisions with respect to their health;
  - (c) they have a grievous and irremediable medical condition;
  - (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
  - (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.
- Grievous and irremediable medical condition

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability; and
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.
- (d) [Repealed, 2021, c. 2, s. 1]
- Exclusion

(2.1) For the purposes of paragraph (2)(a), a mental illness is not considered to be an illness, disease or disability.

- Safeguards — natural death foreseeable

(3) Subject to subsection (3.2), before a medical practitioner or nurse practitioner provides medical assistance in dying to a person whose natural death is reasonably foreseeable, taking into account all of their medical circumstances,

without a prognosis necessarily having been made as to the specific length of time that they have remaining, the medical practitioner or nurse practitioner must

- (a) be of the opinion that the person meets all of the criteria set out in subsection (1);
- (b) ensure that the person's request for medical assistance in dying was
  - (i) made in writing and signed and dated by the person or by another person under subsection (4), and
  - (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;
- (c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before an independent witness who then also signed and dated the request;
- (d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;
- (e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);
- (f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;
- (g) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision; and
- (h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.
- (i) [Repealed, 2021, c. 2, s. 1]
- Safeguards — natural death not foreseeable

(3.1) Before a medical practitioner or nurse practitioner provides medical assistance in dying to a person whose natural death is not reasonably foreseeable, taking into account all of their medical circumstances, the medical practitioner or nurse practitioner must

- (a) be of the opinion that the person meets all of the criteria set out in subsection (1);
- (b) ensure that the person's request for medical assistance in dying was
  - (i) made in writing and signed and dated by the person or by another person under subsection (4), and
  - (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

- (c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before an independent witness who then also signed and dated the request;
- (d) ensure that the person has been informed that the person may, at any time and in any manner, withdraw their request;
- (e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);
- (e.1) if neither they nor the other medical practitioner or nurse practitioner referred to in paragraph (e) has expertise in the condition that is causing the person's suffering, ensure that they or the medical practitioner or nurse practitioner referred to in paragraph (e) consult with a medical practitioner or nurse practitioner who has that expertise and share the results of that consultation with the other practitioner;
- (f) be satisfied that they and the medical practitioner or nurse practitioner referred to in paragraph (e) are independent;
- (g) ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care;
- (h) ensure that they and the medical practitioner or nurse practitioner referred to in paragraph (e) have discussed with the person the reasonable and available means to relieve the person's suffering and they and the medical practitioner or nurse practitioner referred to in paragraph (e) agree with the person that the person has given serious consideration to those means;
- (i) ensure that there are at least 90 clear days between the day on which the first assessment under this subsection of whether the person meets the criteria set out in subsection (1) begins and the day on which medical assistance in dying is provided to them or — if the assessments have been completed and they and the medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;
- (j) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision; and
- (k) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.
- Final consent — waiver

(3.2) For the purposes of subsection (3), the medical practitioner or nurse practitioner may administer a substance to a person to cause their death without meeting the requirement set out in paragraph (3)(h) if

- (a) before the person loses the capacity to consent to receiving medical assistance in dying,
  - (i) they met all of the criteria set out in subsection (1) and all other safeguards set out in subsection (3) were met,
  - (ii) they entered into an arrangement in writing with the medical practitioner or nurse practitioner that the medical practitioner or nurse practitioner would administer a substance to cause their death on a specified day,
  - (iii) they were informed by the medical practitioner or nurse practitioner of the risk of losing the capacity to consent to receiving medical assistance in dying prior to the day specified in the arrangement, and
  - (iv) in the written arrangement, they consented to the administration by the medical practitioner or nurse practitioner of a substance to cause their death on or before the day specified in the arrangement if they lost their capacity to consent to receiving medical assistance in dying prior to that day;
- (b) the person has lost the capacity to consent to receiving medical assistance in dying;
- (c) the person does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration; and
- (d) the substance is administered to the person in accordance with the terms of the arrangement.
- For greater certainty

(3.3) For greater certainty, involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes of paragraph (3.2)(c).

- Advance consent invalidated

(3.4) Once a person demonstrates, by words, sounds or gestures, in accordance with subsection (3.2), refusal to have the substance administered or resistance to its administration, medical assistance in dying can no longer be provided to them on the basis of the consent given by them under subparagraph (3.2)(a)(iv).

- Advance consent — self-administration

(3.5) In the case of a person who loses the capacity to consent to receiving medical assistance in dying after self-administering a substance, provided to

them under this section, so as to cause their own death, a medical practitioner or nurse practitioner may administer a substance to cause the death of that person if

- (a) before the person loses the capacity to consent to receiving medical assistance in dying, they and the medical practitioner or nurse practitioner entered into an arrangement in writing providing that the medical practitioner or nurse practitioner would
  - (i) be present at the time the person self-administered the first substance, and
  - (ii) administer a second substance to cause the person's death if, after self-administering the first substance, the person lost the capacity to consent to receiving medical assistance in dying and did not die within a specified period;
- (b) the person self-administers the first substance, does not die within the period specified in the arrangement and loses the capacity to consent to receiving medical assistance in dying; and
- (c) the second substance is administered to the person in accordance with the terms of the arrangement.
- Unable to sign

(4) If the person requesting medical assistance in dying is unable to sign and date the request, another person — who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death — may do so in the person's presence, on the person's behalf and under the person's express direction.

- Independent witness

(5) Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they

- (a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death;
- (b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;
- (c) are directly involved in providing health care services to the person making the request; or
- (d) directly provide personal care to the person making the request.
- Exception

(5.1) Despite paragraphs (5)(c) and (d), a person who provides health care services or personal care as their primary occupation and who is paid to provide that care to the person requesting medical assistance in dying is permitted to act as an independent witness, except for

- (a) the medical practitioner or nurse practitioner who will provide medical assistance in dying to the person; and
- (b) the medical practitioner or nurse practitioner who provided an opinion under paragraph (3)(e) or (3.1)(e), as the case may be, in respect of the person.
- Independence — medical practitioners and nurse practitioners

(6) The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the opinion referred to in paragraph (3)(e) or (3.1)(e) are independent if they

- (a) are not a mentor to the other practitioner or responsible for supervising their work;
- (b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; and
- (c) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.
- Reasonable knowledge, care and skill

(7) Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.

- Informing pharmacist

(8) The medical practitioner or nurse practitioner who, in providing medical assistance in dying, prescribes or obtains a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose.

- Clarification

(9) For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.

- 2016, c. 3, s. 3      2021, c. 2, s. 1

## Summary Tables from Scoping Review

### Appendix C

Author (Year)	Title	Country of Origin	Specialty of Physician(s)	Type of Article	Key Points
<b>Physician-authored commentaries, replies and opinion pieces.</b>					
<b>Breen (2018)</b>	Unbearable suffering or unbearable deceit (Reply to Verhofstadt, not included)	Ireland	Adult psychiatry	Correspondence	<ul style="list-style-type: none"> <li>- Undermines doctor-patient relationship</li> <li>- Need to protect vulnerable populations</li> <li>- Implying no hope or treatment options from the physician</li> <li>- MAiD is killing and is therefore wrong</li> </ul>
<b>Brewer (2012)</b>	All good doctors do it anyway	U.K.	Psychiatry	Last Words	<ul style="list-style-type: none"> <li>- “When palliation fails, patients shouldn’t have to travel to Switzerland”</li> <li>- Implied that good doctors will do it</li> <li>- Offers hope and peace of mind for patients to have the option</li> </ul>
<b>Bright (2014)</b>	Premature closure of the debate (Reply to Downar <i>et al.</i> )	Canada	Family Medicine	Letters	<ul style="list-style-type: none"> <li>- Downar <i>et al.</i> suggested stopping the yes or no debate, and focus on shaping policy; Bright disagreed because there is still a lot of debate among Canadian physicians on the topic</li> <li>- Inevitable coercion of vulnerable populations</li> <li>- Can’t ensure MAiD won’t be considered a low-cost alternative to palliative care</li> <li>- With difficult palliative cases it is too easy to say, ‘why bother?’</li> </ul>
<b>Buchman (2012)</b>	Physician-assisted dying: Bringing the family physician	Canada	Family Medicine	President’s Message	<ul style="list-style-type: none"> <li>- Personal anxiety about PAD as provider</li> <li>- Concern for patient autonomy</li> <li>- Importance of family physician perspective, because they provide end of life and palliative care</li> <li>- Concern for physician autonomy</li> </ul>

	perspective to the table				
<b>Chochinov (2016)</b>	Physician-Assisted Death in Canada	Canada	Psychiatric oncology	Viewpoint	<ul style="list-style-type: none"> <li>- Neither side is immune from outside motivations</li> <li>- Offering MAiD would leave the patient hopeless, or make them think their life isn't worth living</li> <li>- The right to a death with dignity</li> </ul>
<b>Clark (2016)</b>	Ellen Wiebe: Pro-choice doctor providing peaceful deaths	Canada	Family Medicine	Profile	<ul style="list-style-type: none"> <li>- At the time of publishing, Ellen Wiebe was the only MAiD provider in her health authority</li> <li>- She provides both MAiD and abortions; "doing what is best for my patients"</li> <li>- Feels like she has to help her patients; believes it's important work</li> <li>- Made her decision to provide because most of the profession wasn't ready to provide this service</li> </ul>
<b>Downar, Bailey, Kagan &amp; Librach (2014)</b>	Physician-assisted death: time to move beyond yes or no	Canada	Critical Care/Palliative Care	Letters	<ul style="list-style-type: none"> <li>- Provides a list of question to consider when thinking about making assisted dying legal</li> <li>- Points to the issue of lack of palliative/psychiatric resources to be able to protect vulnerable patients</li> <li>- Protect patients from PAD against their will</li> <li>- Make sure legalizing assisted deaths wouldn't compromise high-quality palliative care</li> <li>- Protection of conscientious objectors</li> <li>- Overall suggests the need to stop the 'yes or no' debate, and start talking about policies and guidelines because "we may need them very soon"</li> </ul>
<b>Downar, Bailey &amp; Kagan (2014)</b>	The authors respond (Reply to Simon)	Canada	Critical Care/Palliative Care	Letters	<ul style="list-style-type: none"> <li>- Respect conscientious objectors</li> <li>- No need for a new profession because physicians do not unanimously oppose</li> <li>- Would fail to support patients if the professional body declines physician assisted death</li> </ul>
<b>Downar, Bailey &amp; Kagan (2014)</b>	The authors respond (Reply to Newman and Bright)	Canada	Critical Care/Palliative Care	Letters	<ul style="list-style-type: none"> <li>- Reassured by Netherlands data that involuntary euthanasia was less common after legalization of PAD, and data from U.S./Switzerland showing vulnerable as less likely to receive PAD.</li> </ul>



<b>Elliott (2014)</b>	Physician-assisted suicide	U.S.	Psychiatry	Medical Ethics	<ul style="list-style-type: none"> <li>- States many physicians believe their duty is to relieve suffering</li> <li>- Arguments against PAS started with the Hippocratic oath (will not administer poison or counsel anyone to)</li> <li>- AMA code of ethics: PAS incompatible with the role of healers</li> <li>- Sanctity of life over respect for patient autonomy; not relieving suffering, but attempt to heal and preserve life</li> <li>- “When roughly half of physicians and almost half of the public believe a practice is not objectionable ethically, professional societies ought to take into account an ‘evolving standard of decency’ and permit the practice”</li> </ul>
<b>English &amp; Ribeiro (2018)</b>	Should doctor assisted dying be legal?	U.K.	Cardiac & general surgery (and both former Presidents of the Royal College of Surgeons)	Head to head	<p><b>Terence English</b> = Support</p> <ul style="list-style-type: none"> <li>- Control for patients</li> <li>- Respect views of physicians who are against it, but shouldn’t impose their beliefs on patients</li> <li>- “In my view the safeguards contained in the Falconer bill provided both safety for the majority and an option for that relatively small number of people who would wish for this degree of control over their final days”</li> </ul> <p><b>Bernard Ribeiro</b> = Against</p> <ul style="list-style-type: none"> <li>- Worried about doctor-patient relationship</li> <li>- Not a proper role for physicians</li> <li>- Suggests that patients who say they ‘want to end it all’ have no desire to end their lives, they just want reassurance from their doctor</li> </ul>
<b>Fletcher (2015)</b>	Right to die in Canada: respecting the wishes of physician conscientious objectors (Reply to Vogel, 2015)	Canada	Family Medicine	Editorial	<ul style="list-style-type: none"> <li>- Doctor has no right to deny patients their legal right</li> <li>- Suggests we shouldn’t force objectors to refer</li> <li>- Points to abortion services and lack of referral system</li> <li>- Suggests service where patients can get end-of-life information</li> <li>- Hippocratic oath (‘one will not administer poison to anyone’)</li> <li>- Trust/doctor-patient relationship</li> </ul>

<b>Francescutti (2014)</b>	CMA president response: Physician-assisted death (reply to Downar <i>et al.</i> , 2014)	Canada	President of the CMA (Emergency Medicine)	Letters	<ul style="list-style-type: none"> <li>- Downar put the ‘cart-before-the-horse’ by preparing for MAiD when Canada needs better palliative care</li> <li>- Great societal need for high-quality palliative care and a better understanding of advance directives</li> </ul>
<b>Galishoff (2016)</b>	Responding to a request for physician-assisted death (Reply to Quill <i>et al.</i> )	U.S.	Internal Medicine	Letters	<ul style="list-style-type: none"> <li>- Says the ethical principle was not from Judeo-Christian tradition, the Greek tradition and Hippocrates, or the principal of ‘do no harm’</li> <li>- MAiD is a modern concept backed by utilitarian beliefs and ‘not grounded in the basic ontology of human life and humanity’</li> <li>- “Ending suffering by taking life is dehumanizing and as such lacks any form of dignity”</li> </ul>
<b>George (2014)</b>	We must not deprive dying people of the most important protection	U.K.	Palliative Care	Observations	<ul style="list-style-type: none"> <li>- Values at the end of life are complex (psycho/social/spiritual), so why are physicians the ones to make this decision</li> <li>- Doesn’t see why physicians should be involved</li> <li>- Sees dying patients treated ‘as second-class citizens’, so they must be protected from lethal acts</li> <li>- Impossible to separate those who might want to die, from those who think they ought to die</li> </ul>
<b>Goligher, Del Sorbo, Cheung, et al. (2016)</b>	Why conscientious objection merits respect (Reply to Fletcher)	Canada	10 authors from various specialties	Letters	<ul style="list-style-type: none"> <li>- Lists 5 reasons to respect contentious objection</li> <li>- Other treatments can be objected by physicians</li> <li>- Just referring can undermine the physician’s moral integrity</li> <li>- Respecting conscientious objectors can uphold moral integrity of the profession</li> </ul>
<b>Harlow (2012)</b>	Not all ‘good’ doctors do it anyway (Reply to Brewer)	U.K.	Palliative Care	Letters	<ul style="list-style-type: none"> <li>- Wrong to assume that everyone who opposes PAS is influenced by religion, because the author himself is agnostic</li> <li>- More wrong than good would come out of legalizing it</li> </ul>
<b>Hébert (2017)</b>	In good hands	Canada	Family Medicine	Humanities/ Encounters	<ul style="list-style-type: none"> <li>- “I do it because it has to be done. There is a need for it, so I do it.”</li> <li>- Expresses nightmares about doing it</li> </ul>

					<ul style="list-style-type: none"> <li>- Intolerable suffering of patient</li> <li>- Allows a gentle, dignified death</li> <li>- “I also feel complicit in ending lives that may have closed too soon – before I would have wanted to die or to have a loved one die”</li> <li>- “Guilt sits in my stomach like a hard stone”</li> </ul>
<b>Hurley (2015)</b>	A doctor who chose an assisted death	U.K.	U.K. Dermatologist (talking about her Belgian generalist father’s assisted death)	Features	<ul style="list-style-type: none"> <li>- Authors father often felt powerless to help patients in pain, was happy about Belgium’s assisted dying law</li> <li>- His doctor helped “out of a sense of duty” but it upset her</li> <li>- “To see the relief on his face when he realized he could go was incredible.”</li> <li>- Patient suffering</li> <li>- Alternative would have been “more pain and no predictability” – potential to die alone in a hospital</li> </ul>
<b>Johnston (2014)</b>	Re: Doctors’ attitudes shifting on physician-assisted suicide	Canada	Family Medicine	Personal View	<ul style="list-style-type: none"> <li>- “heed the warning signs from place like Belgium where these practices have become entrenched”</li> <li>- “The real risks of wrongful death could be glossed over, or we could do our job as doctors and warn the public accordingly”</li> <li>- Points to the use of palliative sedation as the answer for the right-to-die-movement</li> <li>- Should be focusing more on great palliative care</li> </ul>
<b>Kelsall (2018)</b>	Physicians are not solely responsible for ensuring access to medical assistance in dying	Canada	Family Medicine	Editorial	<ul style="list-style-type: none"> <li>- “Surely there is a way forward that ensures access for patients requesting MAiD without trampling on physicians’ rights enshrined in law”</li> <li>- Says that providing a referral to MAiD would make the physician complicit in the procedure, which could go against their religious or moral stance</li> <li>- “To be blunt, the physician must ask another health care provider to consider killing their patient”</li> <li>- Up to society to ensure access, not individual physicians</li> <li>- Both patients and physicians rights need protection</li> </ul>
<b>Kussmaul, 2017</b>	The slippery slope of legalization of	U.S.	Internal medicine/ cardiology	Editorial	<ul style="list-style-type: none"> <li>- Says slippery slope still exists with Canadian safeguards</li> <li>- Weakest part of the American College of Physicians paper is that it says euthanasia is outside the scope of medical practice</li> </ul>

	physician-assisted suicide				because if it was right and good, physicians should be willing to do it - “where these practices are legal, I believe that physicians should firmly decline to participate” - “with time, we will see whether our collective cultural conscience, including respect for the intrinsic value of human life, can keep us from sliding down the slope. Otherwise, it will merely mitigate our speed as we descend”.
<b>Li &amp; Kain (2018)</b>	The other side of sorrow: physician reflections on assisted dying	Canada	Palliative Care & Cancer Psychiatry	Humanities/ Encounters	- With regards to the assisted dying case: “I was struck by how rare it is for health care providers to be so deeply moved together; we realized that a medically assisted death could be both poignant and peaceful. I believed that I had helped Michael with his suffering, in the only way acceptable to him”
<b>MacCormick (2014)</b>	Assisting suicide goes against why most of us became doctors (Reply to Delamothe)	U.K.	Palliative Medicine	Letters	- “when doctors assess capacity, it is to protect patients from harm, not facilitate their suicide” - Capacity can be impaired and change at the end of life - Have seen patients change their wishes - Patients worry about being burdens - “it goes against why most of us became doctors”
<b>MacLeod (2012)</b>	Euthanasia and physician-assisted death	New Zealand	Palliative & Psychiatry	Unclassified	- Medical practitioners don’t have the expertise or knowledge to decide who is fit for euthanasia - Speculates that patients would choose because they feel like burdens, and that ‘burnt-out’ physicians would more readily agree - Suggests it would lead to normalizing suicide by allowing terminally ill patients to access it (“likely to convey a rather conflicting public health message”)
<b>Nicholl, 2017</b>	Why I’ve changed my views on assisted dying	U.K.	Neurologist	Views and Reviews	- Did not agree with assisted dying until the death of his friend - Knew that his friend received good palliative care and that the care was not shaping his decision; believed it was about control; “having a sense of control over how they depart this life is crucial to a good death.”

<b>Noble (2013)</b>	Legalizing assisted dying puts vulnerable patients at risk and doctors must speak up	U.K.	Palliative Care	Personal View	<ul style="list-style-type: none"> <li>- “I have no religious objections, but I recoil from the vision of a society where death is a therapeutic option; the idea that there are two categories of suicidal people, those deserving and those undeserving of death; and the idea that doctors should do the sorting and the killing”</li> <li>- Doctors worry about ending life before you lose dignity becoming the new norm</li> <li>- Says that Oregon is the model for assisted dying, but suggests that we shouldn’t follow them morally because of their lack of gun control and access to healthcare</li> <li>- Points to vulnerable patients feeling pressured; like burdens</li> <li>- “I fear that our society’s neglect of older people, poverty, and the lack of home care service will drive up demand for assisted suicide”</li> </ul>
<b>Quill, Back &amp; Block (2016)</b>	Responding to patients requesting physician-assisted death: physician involvement at the very end of life	U.S.	Palliative Care, Oncology, Internal Medicine	Viewpoint	<ul style="list-style-type: none"> <li>- “Is physician assisted death ever justifiable – yes”</li> <li>- Control; Point to patients being prescribed PAS, but then not using it; say it’s important because it gives them a way out should they want it</li> </ul>
<b>Quill, Back &amp; Block (2016)</b>	In reply (Reply to Galishoff)	U.S.	Palliative Care, Oncology, Internal Medicine	Letters	<ul style="list-style-type: none"> <li>- Supporters of assisted death, point to reasons why it’s justifiable: Patient autonomy; assist a patient to find relief from suffering; and non-abandonment (the commitment to clinical care for patients at the end of life)</li> </ul>
<b>Quinn &amp; Detsky (2017)</b>	Medical assistance in dying: our lessons learned	Canada	Internal Medicine	Perspective	<ul style="list-style-type: none"> <li>- Both felt like it was the ‘right thing to do for the right kind of patient’, but reluctant to participate</li> <li>- [Going to watch MAiD, being an assessor] “Before the event we worried that after he died, we would feel awful. To our surprise, we didn’t. It was a very peaceful death.”</li> <li>- “Today we did a good thing”, but they weren’t sure if they’d ever do it again</li> </ul>

<b>Rowe (2015)</b>	Beliefs	U.S.	Neurology	A Piece of My Mind	<ul style="list-style-type: none"> <li>- Physician who sought &amp; received an assisted death</li> <li>- Concept of ‘first do no harm’ is wrong</li> <li>- First duty of physician is to relieve pain and suffering, second is to do no harm</li> <li>- Suicide only appropriate for untreatable, unbearable suffering</li> <li>- “I believe it to be morally, ethically, humanely and mercifully unconscionable that a dying person must accept prolonged suffering if that individual does not wish it”</li> <li>- “We are not ‘healers’. We almost never truly heal a patient of a serious disease, certainly not death. We are ‘treaters’ who should try to help each individual patient deal with his or her problem to the best of our ability.”</li> <li>- “Sometimes, for a dying patient, the option of an easy, assisted death is the most merciful, caring, and I believe, ethical way to do that.”</li> </ul>
<b>Simon (2014)</b>	Why <i>physician</i> -assisted death? (Reply to Downar <i>et al.</i> , 2014)	Canada	Palliative Care	Letters	<ul style="list-style-type: none"> <li>- Causing death is the antithesis of medicine</li> <li>- “Physicians have no greater training or particular skill set in this area”</li> <li>- Suggest creating a new profession</li> <li>- “Allowing natural death, caring always, these are part of the physician’s role. Add intentionally causing death to that and we risk altering the meaning of medicine and the fundamental trust and relationship between physicians and patients”</li> </ul>
<b>Sulmasy, Wesley &amp; Sprung (2016)</b>	To the Editor (Reply to Emanuel <i>et al.</i> )	U.S.	Internal Medicine, Surgery	Letters	<ul style="list-style-type: none"> <li>- Question if legalization of PAS in the US will eventually lead to euthanasia</li> <li>- No moral difference between PAS (prescribing) and euthanasia (injecting)</li> </ul>
<b>Young (2016)</b>	My mum’s decision changed my view of assisted dying	U.K.	Emergency Medicine	Views and Reviews	<ul style="list-style-type: none"> <li>- Thought that palliative care was the best approach for easing physical and emotional pain at the end of life</li> <li>- Believed that patients wish to die was caused by depression at the end of life, which could be treated</li> <li>- [From her mother requesting an assisted death] Realized it wasn’t depression, it was about what she wanted from life, and about what a meaningful life was to her</li> </ul>

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- “My view of assisted suicide had shifted, not only personally, but also professionally”; “I hated that we had to travel to Switzerland for her to have an assisted suicide”

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### Qualitative Studies.

<b>Bernheim, Distelmans, Mullie &amp; Ashby (2014)</b>	Questions and answers on the Belgian model of integral end-of-life care: Experiment? Prototype? "Euthanasia": the close historical, and evidently synergistic, relationship between palliative care and euthanasia in Belgium: An interview with a doctor involved in the early development of both and two of his successors	Belgium	3 physician-authors of a past paper (palliative care)	Interview	<ol style="list-style-type: none"> <li>1. Euthanasia as continuation of medical practice, similar to when a peaceful death is achieved with palliative care</li> <li>2. Patient choice, and for the physician no different than other 'life-abbreviating' decisions</li> <li>3. Deeply moving; drained, relieved and satisfied afterwards; “feels much like delivering a baby” (transcendental meaningfulness)</li> <li>4. Believe national cultural and legal context counts more than worldview/religion</li> <li>5. Condition of the patient, and patient wishes are most important</li> </ol>
<b>British Medical Association (2016)</b>	End-of-life care and physician assisted dying	U.K.	n = 237 physicians, and 269 members of the public	Eleven half-day dialogue events. Using inductive analytical approach.	<ol style="list-style-type: none"> <li>1. Doctor-patient relationships           <ul style="list-style-type: none"> <li>• Physicians acknowledged that there are high levels of trust &amp; expectations from their patients</li> </ul> </li> <li>2. Hopes, fears, and concerns about the end of life and dying</li> <li>3. Perceptions and experiences of end-of-life care</li> <li>4. Providing end-of-life care</li> <li>5. Potential impact of legalization of physician-assisted dying on doctor-patient relationships</li> </ol>

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<b>Jylhäkangas, Smets, Cohen <i>et al.</i> (2014)</b>	Descriptions of euthanasia as social representations: comparing the views of Finnish physicians and religious professionals	Finland	n = 12. 6 physicians (made up of 2 gerontologists, 2 anesthesiologists, 1 GP and 1 pediatrician) and, 6 religious professionals.	Semi-structured interviews; social representational approach	<ul style="list-style-type: none"> <li>• Believed it would have a negative effect on the doctor-patient relationship; fear of doctors and hospitals</li> <li>• Some physicians referenced a “good death”; choice to the patients</li> <li>• Not consistent with the role of a doctor; but others thought it was part of their role</li> </ul> <hr/> <ol style="list-style-type: none"> <li>1. Descriptions of euthanasia <ul style="list-style-type: none"> <li>• Ranges from ‘killing’ to ‘a pleasant death’</li> <li>• That death would be ‘comfortable and pleasant’</li> </ul> </li> <li>2. Euthanasia views and arguments <ul style="list-style-type: none"> <li>• Euthanasia is a ‘thought that can be entertained only in a very immature society’</li> <li>• “I don’t understand what kind of damage would happen if one had the opportunity to decide about his own death”</li> </ul> </li> <li>3. Natural death and sacredness of life</li> <li>4. The question of autonomy <ul style="list-style-type: none"> <li>• Almost all emphasized autonomy of the patient, but they didn’t always relate that to the issue of euthanasia</li> </ul> </li> <li>5. The role of a physician <ul style="list-style-type: none"> <li>• Wonder why it is always demanded that the physician do it; doctors’ role is to help people and optimize a good life</li> <li>• Feelings of guilt if did it; “physician executioners”</li> </ul> </li> </ol>
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					<p>6. Worrying about the weakest and the slippery slope</p> <ul style="list-style-type: none"> <li>• ‘Euthanasia is a very dangerous thing, no one is on the side of the weakest... it will easily go towards a slippery slope’; worried will be given to people with dementia</li> </ul> <p>7. Controlling a good death</p> <ul style="list-style-type: none"> <li>• “It is always possible to alleviate pain. Pain is not a proper reason for asking for euthanasia.”</li> </ul>
<b>ten Cate, van Tol &amp; van de Vathorst (2017)</b>	Consideration on requests for euthanasia or assisted suicide: a qualitative study with Dutch general practitioners	Netherlands	n = 33 Dutch GPs (18 from one study, 15 from another)	Secondary analysis of qualitative interviews from two previous studies	<p>1. Perceived legal criteria (incorrect knowledge of criteria)</p> <p>2. Individual interpretation of the legal criteria (e.g. incorrect interpretation of ‘unbearable suffering’)</p> <ul style="list-style-type: none"> <li>• Wouldn’t provide if walking, talking, eating; would be too hard on the physician</li> <li>• Wouldn’t provide for a patient with terminal cancer and no symptoms because life was still worth living</li> <li>• One said it’s only a solution in terminal stage, the very last weeks; another said wouldn’t grant if suffering was <i>less</i> than two weeks, where EAS for cases where suffering for a long time</li> <li>• ‘Voluntary and carefully considered’: some interpreted as many conversations over a long period of time, others thought one deep conversation about death</li> </ul> <p>3. Considerations unrelated to legal criteria</p>

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					<ul style="list-style-type: none"> <li>• Many thought important to have an existing relationship with the patient</li> <li>• Some believe there should be no unresolved family issues, and that the family agrees with the EAS decision</li> <li>• Patient acceptance and peace with their decision</li> </ul>
<b>Trankle (2014)</b>	Decision that hasten death: double effect and the experiences of physicians in Australia	Australia	n = 13 physicians (7 palliative care, 3 intensive care, 1 respiratory/thoracic, and 2 GPs)	Semi-structured interviews; thematic analysis	<p>1. Religion and sanctity of life</p> <ul style="list-style-type: none"> <li>• Provides support to physicians that believe death should not be deliberately hastened</li> <li>• Doctors shouldn't be executioners; need for another profession</li> <li>• "I don't see death as the ultimate relief of suffering. I see that as inducing death deliberately [...] I think that life is valuable and it's not for us to decide the time of our birth or death"</li> <li>• Risk to vulnerable people; "there's lots of vulnerable people in society where we're effectively saying 'OK your life is rubbish, let's end this'"</li> </ul> <p>2. Patient choice and autonomy</p> <ul style="list-style-type: none"> <li>• Control the time of death; "What would I want if this was me?"</li> <li>• "I think in principle I'd feel more comfortable that the person who's acting is clearly acting of their own volition. You're providing them with the drugs but they are taking the drugs, there's something nice about that"</li> </ul>

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<b>Voorhees, Rietjens, van der Heide &amp; Drickamer (2014)</b>	Discussing physician-assisted dying: physicians experiences in the United States and the Netherlands	U.S.	n = 36 physicians, different specialities (18 U.S., 18 Netherlands)	One-on-one semi-structured interviews	<ul style="list-style-type: none"> <li>• Patient autonomy, compassion and mercy as ethical principles</li> </ul> <ol style="list-style-type: none"> <li>3. Motivated by suffering           <ul style="list-style-type: none"> <li>• Want to relieve suffering; make comfortable</li> </ul> </li> <li>4. Active/passive distinction and double effect           <ul style="list-style-type: none"> <li>• Double effect more favorable than euthanasia because goal is not to kill</li> </ul> </li> <li>5. Feeling emotional pressure – the influence of others requesting death</li> <li>6. Dogs die a better death – requests as control over vicarious suffering</li> <li>7. A hastened death can be a good death           <ul style="list-style-type: none"> <li>• Unbearable suffering</li> </ul> </li> <li>8. Double effect is an ambiguous scaffold</li> </ol> <ol style="list-style-type: none"> <li>1. PAD discussions with patients</li> <li>2. Doctor-patient relationships           <ul style="list-style-type: none"> <li>• Strong doctor-patient relationship could facilitate occurrence of PAD discussions</li> </ul> </li> <li>3. Physician emotions           <ul style="list-style-type: none"> <li>• Described that when they considered actually performing PAD their emotions became more intense</li> </ul> </li> <li>4. Discussion with others</li> <li>5. Factors influencing PAD discussion           <ul style="list-style-type: none"> <li>• “Dutch doctors don’t want to do euthanasia... If possible, I would run away. But I see it as the last part of my care.” (Netherlands)</li> <li>• “I have to do no harm, and I just feel that if you’re assisting someone</li> </ul> </li> </ol>
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					<p>in dying... it's against what I've been trained... It's not up to me to decide when the patient dies" (US-Northeast)</p> <ul style="list-style-type: none"> <li>• Physicians want to honor autonomy, but not at the expense of their own morals (Netherlands)</li> <li>• Against Christian beliefs (Netherlands)</li> </ul>
<b>Wright, Fishman, Karsoho <i>et al.</i> (2015)</b>	Physicians and euthanasia: a Canadian print-media discourse analysis of physician perspective	Canada	n = 98 physician voices found in 285 print-media articles (between 2008 and 2012). Various specialties, with the majority not being reported; most common were palliative, family medicine and oncology	Discourse analysis of print media	<p>1. Contentions about integrating euthanasia within the basic mission of medicine</p> <ul style="list-style-type: none"> <li>• Medicine as healing; protecting life</li> <li>• "destabilize trust"</li> <li>• Vulnerable patients feeling pressured</li> </ul> <p>2. Distinguishing euthanasia from other end-of-life medical practices (e.g. euthanasia, withholding or withdrawing treatment, palliative sedation)</p> <ul style="list-style-type: none"> <li>• Euthanasia distinct from other end-of-life options because this one is deliberately ending someone's life</li> </ul> <p>3. Palliative care advocacy</p> <ul style="list-style-type: none"> <li>• Great palliative care would remove the need for euthanasia</li> <li>• Need better and more accessible palliative care in Canada</li> </ul>
<b>Quantitative Studies.</b>					
<b>Beaulieu-Volk (2014)</b>	Docs divided on today's most pressing ethical dilemmas	U.S.	n = 21,531 physicians – Members of MedScape, mix of specialties	Online survey	<p>- 31% against because violates Hippocratic oath</p> <p>- 54% in favor of allowing dignified, self-determined death</p>

<b>Broekman &amp; Verlooy (2013)</b>	Attitudes of young neurosurgeons and neurosurgical residents towards euthanasia and physician-assisted suicide	Netherlands	n = 295 neurosurgery residents (across Europe, split into North/East/South/West, and included Israel)	9-item survey	<ul style="list-style-type: none"> <li>- 195/274 (71.2%) in favour of legal regulation of euthanasia</li> <li>- 24/270 (8.9%) willing to inject drugs themselves</li> <li>- 55/277 (19.9%) willing to prescribe (significantly less in Northern Europe than East/West/ South)</li> </ul>
<b>Bulow, Sprung, Baras et al. (2012)</b>	Are religion and religiosity important to end-of-life decisions and patients' autonomy in the ICU? The Ethicatt study	Denmark	n = 304 ICU physicians	Survey of physicians, nurses, ICU survivors, and families of ICU patients	<ul style="list-style-type: none"> <li>- Active euthanasia in the case of terminal illness: 18% physicians who identified as 'religious' said yes, 38% physicians who identified themselves as having a 'religious affiliation' said yes</li> </ul>
<b>Cohen, Van Wesemael, Smets et al. (2012)</b>	Cultural differences affecting euthanasia practice in Belgium: One law but different attitudes and practices in Flanders and Wallonia	Belgium	n = 785 Belgian physicians (480 from Flanders (F) = Dutch; 305 from Wallonia (W) = French)	Secondary data analysis of two surveys	<ul style="list-style-type: none"> <li>- Not prepared to administer drugs: F/15%, W/25.9%</li> <li>- Sufficient palliative care prevents requests for PAS: F/49.6%, W/51.8%</li> <li>- Life ending can be part of good end of life care: F/81.8%, W/64.5%</li> <li>- More willing to perform sedation than end life: F/47.7%, W/59.4%</li> <li>- All circumstances should strive to preserve life: F/8.8%, W/11.9%</li> <li>- Everyone has the right to decide about their death: F/70.3%, W/74.3%</li> <li>- PAS acceptable with terminal disease and extreme pain/suffering: F/92.3%, W/86.9%</li> </ul>
<b>Dany, Baumstarck, Dudoit et al. (2015)</b>	Determinant of favorable opinions about euthanasia in a sample of French physicians	France	n = 170 physicians specialized in palliative care	Cross-sectional survey of physicians and medical interns	<ul style="list-style-type: none"> <li>- Opinion about euthanasia in general: 96.5% unfavorable, 3.5% favorable</li> <li>- Individuals' belief in God was significant independent factor linked to having a favorable opinion of euthanasia in general: Physicians who believe in God 46.2% euthanasia</li> </ul>

					favorable, those who do not believe in God 41.4% euthanasia favorable - When compared to medical interns (72% favorable), palliative physicians were more opposed (96.5% unfavorable)
<b>Doron, Wexler, Shabtai &amp; Corn (2014)</b>	Israeli dying patient act: physician knowledge and attitudes	Israel	n = 100 Israeli physicians (hospital based, different specialties, actively involved in the care of terminal patients)	25-item survey	- 32% law should support PAS of terminal patients - 44.4% law is consistent with personal/ professional ethical principles - Found that support for active euthanasia/PAS was only related to the importance of religion – inversely related. - No relationship between importance of religion and whether they would participate
<b>Giezendanner, Jung, Bandert et al. (2017)</b>	General practitioners' attitudes towards essential competencies in end-of-life-care: a cross sectional survey	Switzerland	n = 579 Swiss GPs	Large 3 section survey assessing attitude toward different end of life care options	- 72% stated that handling patients seeking PAS and 84% handling patient's wishes to die were important for end of life care quality - Only 35% felt confident handling patients seeking PAS, and 54% felt confident with patients who wish to die.
<b>Havill (2015)</b>	Physician-assisted dying – a survey of Waikato general practitioners	New Zealand	n = 78 GPs	3 question online survey	- When asked: “given adequate safeguards against abuse, do you support the passing of a law to allow a medical practitioner to give assistance to die, on request from a competent patient, 18 years and older, where the patient has end-stage terminal disease (e.g.) cancer), or is suffering from irreversible unbearable suffering (e.g.

					motor neuron disease, end-stage respiratory failure)?” 47.3% of respondents answered fully/probably support, 5% unsure, 47.3% totally/probably oppose
<b>Hetzler &amp; Dugdale (2016)</b>	Academic physician perspectives on the legalization and practice of physician-assisted suicide	U.S.	n = 488 academic physicians that work at Yale School of Medicine	3 question survey	<p>- Should PAS be legal? 63% yes, 18% no, 19% unsure</p> <p>- Would you participate? 22% yes, 48% no, 30% unsure</p> <p>- Sometimes necessary to hasten a patient’s death through PAS? 73% agree, 25% disagree.</p> <ul style="list-style-type: none"> <li>• Of those in agreement, 29% said they would perform PAS, 35% would not.</li> <li>• Of those who disagree, 2% would perform PAS, 86% would not.</li> </ul>
<b>Iivemark, Dahle &amp; Matzen (2016)</b>	Questionnaire-based survey suggests that the majority of Danish geriatricians are against euthanasia	Denmark	n = 120 geriatricians	12-item questionnaire	<p>- 32.8% agreed that everyone has the right to decide when to die</p> <p>- 13.3% agreed euthanasia should be offered as alternative to palliative treatment (73.4% disagree), 15% PAS as alternative (76.6% disagree)</p> <p>- 55.8% euthanasia, 64.2% PAS not ethically justifiable</p> <p>- More positive attitude in younger physicians with 29.6% under 50 agree/strongly agree ethically justifiable, compared to 12.2% in those over 50</p> <p>- 62.2% euthanasia would have neg. effect on the doctor-patient relationship; 65.3% PAS would have a neg. effect</p>

<b>Kouwenhoven, van Thiel, Raijmakers <i>et al.</i> (2014)</b>	Euthanasia or physician-assisted suicide? A survey from the Netherlands	Netherlands	n = 793 physicians (224 GPs, 131 elderly care physicians, and 389 medical specialists)	Questionnaire	<p>- 36% preferred euthanasia over PAS, 25% no preference</p> <p>- Attitude toward euthanasia and PAS:</p> <ul style="list-style-type: none"> <li>• GPs – 49% liberal, 44% reserved, 7% against</li> <li>• Elderly care physicians – 30% liberal, 62% reserved, 8% against</li> <li>• Medical specialists – 44% liberal, 50% reserved, 6% against</li> </ul> <p>- Performance of euthanasia or PAS:</p> <ul style="list-style-type: none"> <li>• GPs – 81% ever performed, 11% thinkable, 8% unthinkable</li> <li>• Elderly Care Physicians – 41% performed, 45% thinkable, 14% unthinkable</li> <li>• Medical specialists – 44% performed, 45% thinkable, 11% unthinkable</li> </ul> <p>- Patient with cancer and uncontrollable pain: 84% of respondents who agreed with PAS would also agree with euthanasia in that case. 15% would assess differently.</p>
<b>Kranidiotis, Ropa, Mprianas <i>et al.</i> (2015)</b>	Attitudes towards euthanasia among Greek intensive care unit physicians and nurses	Greece	n = 39 Greek ICU physicians	Questionnaire	<p>- Agreement with active euthanasia: 28.2% agree, 59% do not agree, 12.8% undecided</p> <p>- Person has right to decide: 59% strongly agree, 15.4% agree, 7.7% undecided, 2.6% disagree, 15.4% strongly disagree</p>



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<b>Louhiala, Enkovaara, Halila <i>et al.</i> (2015)</b>	Finnish physicians' attitudes towards active euthanasia have become more positive over the last 10 years	Finland	n = 1003 Finnish physicians	Questionnaire (comparing 2003 and 2013 answers)	<p>- Greek legislation should permit euthanasia: 41% strongly agree, 17.9% agree, 5.1% undecided, 7.7% disagree, 28.2% strongly disagree</p> <p>- Patients will lose confidence in the medical profession: 20.8% strongly agree, 20.5% agree, 15.4% undecided, 7.7% undecided, 7.7% disagree, 48.7% strongly disagree</p> <p>- Practice if legal: 20% would, 49% would not</p> <hr/> <p>- Euthanasia should be legalized:</p> <ul style="list-style-type: none"> <li>• 2003 – 29.4% agree, 60.7% disagree</li> <li>• 2013 – 45.7% agree, 45.4% disagree</li> </ul> <p>- I could sometimes practice it:</p> <ul style="list-style-type: none"> <li>• 2003 – 20.9% agree, 60.3% disagree</li> <li>• 2013 – 22.7% agree, 55.1% disagree</li> </ul> <p>- No need for active euthanasia:</p> <ul style="list-style-type: none"> <li>• 2003 – 62.2% agree, 31.3% disagree</li> <li>• 2013 – 55.5% agree, 38.1% disagree</li> </ul> <p>- Harm doctor-patient relationship:</p> <ul style="list-style-type: none"> <li>• 2003 – 43.6% agree, 39.9% disagree</li> <li>• 2013 – 33.3% agree, 47% disagree</li> </ul> <p>- In general, attitudes have gotten more positive</p>
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					- Willingness to provide has not increased significantly
<b>Montague, Nemis-White, Ayleen <i>et al.</i> (2017)</b>	Public and professional insights on end-of-life care: results of the 2016 health care in Canada survey	Canada	n = 100 doctors	Online poll (looking at public, nurses, pharmacists, administrators, allied professionals and doctors)	- Level of support for assisted death not as strong as the general public - Support particularly low among doctors – 58% strongly/somewhat support
<b>Rathor, Rani, Shahar <i>et al.</i> (2014)</b>	Attitudes toward euthanasia and related issues among physicians and patients in a multi-cultural society of Malaysia	Malaysia	n = 195 physicians	Questionnaire	- Support euthanasia: 28.8% yes, 69.7% no, 1.5% not sure - According to religion, euthanasia: approved (5.1%), approved conditionally (30.3%), prohibited (59.5%), not sure (5.1%) - Patient with terminal illness right to die: 21.5% yes, 77.9% no, 0.5% not sure - Should doctors be legally allowed to prescribe: 15.9% yes, 83.6% no, 0.5% not sure - Vote to legalize euthanasia: 26.2% yes, 72.8% no, 1% not sure
<b>Rousseau, Turner, Chochinov <i>et al.</i> (2017)</b>	A national survey of Canadian psychiatrists' attitudes toward medical assistance in death	Canada	n = 528 Canadian psychiatrists	Online survey	- Support for MAiD under certain conditions: 71.8% support, 24.8% do not support, and 3.4% don't know
<b>Sheahan (2016)</b>	Exploring the interface between 'physician-assisted death' and palliative care: cross-sectional data from	Australia (Australasia)	n = 156 palliative care specialists/registrar	Cross-sectional online survey, 18-item	- Should PAS be legalized: 8.9% yes, 75.2% no, 15.9% undecided - Provide PAS: 4.5% yes, 84.6% no, 10.9% undecided - When asked to select their most important factor in determining their

	Australasian palliative care specialists				<p>opinion (selecting only one option) and select other highly important factors (select multiple), both answers had the same top two responses: 1. traditional professional obligation to do no harm, and the doctor patient relationship; and 2. Community interest in protecting life and not intentionally taking a life</p> <p>- Do they see a potential impact on palliative services? No sig. impact (22.7%), reduction in availability/quality (29.9%), improvement in availability/quality (12.3%), removal of need (0%), other (35.1%).</p> <ul style="list-style-type: none"> <li>• Concern about impact negatively on their personal palliative practice; difficulties establishing trust when transitioning into palliative; need to focus on good end of life care and to improve funding for palliative</li> </ul>
<b>Thomas, O’Leary &amp; Fried (2014)</b>	A comparison of the willingness of resident and attending physicians to comply with the requests of patients at the end of life	U.S.	n = 431 (191 attending physicians, 240 resident physicians)	Survey with 5 vignettes	<p>- 80 y.o. man with metastatic lung cancer who is not depressed and demonstrates capacity. Would you comply with the patients’ request if lethal injections were legal?</p> <ul style="list-style-type: none"> <li>• 19% attendings and 32% residents would</li> <li>• Characteristics associated with willingness to provide were ‘religion not important’</li> </ul>

					and being a resident rather than attending
<b>Mixed Method Studies.</b>					
<b>Abela (2015)</b>	GPs and end of life decisions: views and experiences	Malta	n = 160 Malta GPs	Cross-sectional survey with qualitative comments section (open-ended)	<ul style="list-style-type: none"> <li>- Person should have right to decide if they want to hasten death: 43.4% agree, 31.4% neutral</li> <li>- High quality palliative care would remove request for euthanasia: 40% agree</li> <li>- Physicians should always aim to preserve life: 44% agree and 25% strongly agree</li> <li>- Use of lethal drugs at request of patient, will lead to use without a request: 28% agree, 20% strongly agree, and 26.9% disagree</li> <li>- Will harm the doctor-patient relationship: 32.5% agree, 25.6% disagree, 15.6% strongly agree</li> <li>- Would you consider euthanasia: 89.1% no, 6.3% administer and prescribe, 3.8% prescribe only, 0.6% administer only.</li> <li>- Qualitative Themes: ethical and religious issues (only god can decide); importance of the subject; feeling uncomfortable; ripple effect; legal aspects; symptom control and service provision</li> </ul>
<b>Abela &amp; Mallia (2016)</b>	Maltese doctors: views and experiences on end of life decisions and care	Malta	n = 356 Malta physicians (mix of specialties)	Survey with qualitative comments section	<ul style="list-style-type: none"> <li>- Patient has right to decide whether to hasten death: 42.9% agree, 31.5% neutral</li> <li>- Palliative care would remove requests for euthanasia: 48.6% agree, 23.9% disagree</li> <li>- Physician should always aim to preserve life: 60.4% agree, 23.9% disagree</li> <li>- Would you consider euthanasia: 90.2% would not, 5.9% would prescribe and administer, 3.4% administer only, 0.5% prescribe only</li> <li>- Very significant relationship between importance given to religion and considering euthanasia</li> <li>- Specialties that <i>would</i> consider: surgery (20%), "other" (19.05%), and psychiatry (14.29%) among highest</li> </ul>

					<ul style="list-style-type: none"> <li>- Specialties that <i>would not</i> consider: medicine (100%, geriatrics (100%), anesthesia and gynecology (both with 95.24%)</li> <li>- Qualitative Themes: importance of the subject; ethical and religious issues; feeling uncomfortable; system control; legal issues; service provision; need of training; ripple effect</li> </ul>
<b>Booij, Tibben, Engberts &amp; Roos (2014)</b>	Perhaps the subject of the questionnaire was too sensitive: Do we expect too much too soon? Wishes for the end of life in Huntington's Disease – the perspective of European physicians	Netherlands	n = 53 European physicians (within the European Huntington's Disease Network); various specialties	Survey with qualitative comment section	<ul style="list-style-type: none"> <li>- ½ respondents say patients express their wishes at the end of life, including assisted dying</li> <li>- Some respondents said quality of life could also mean quality of dying</li> <li>- Against assisted dying because it's 'giving up'</li> </ul>
<b>Brauer, Bolliger &amp; Strub (2015)</b>	Swiss physicians' attitudes to assisted suicide	Switzerland	n = 12 interviewed, n = 1318 surveyed. Physicians of various specialties.	Interviews and a cross-sectional survey; two-part inductive analysis	<ul style="list-style-type: none"> <li>- 73% believed physicians should be allowed to assist suicide if legal criteria are met</li> <li>- 43% believe acceptable and could imagine where would perform it; 28% tolerate and won't perform it</li> <li>- Justifiable if person is seriously ill, suffering severe pain, and approaching end-of-life: 58% yes, 20% probably</li> <li>- Qualitative Themes: alleviation of suffering as goal of medicine; patient autonomy; quality of physician-patient relationship (should know the person for a long time); central importance of voluntariness; physician autonomy</li> </ul>
<b>Kouwenhoven, Raijmakers, van Delden et al. (2013)</b>	Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed methods approach	Netherlands	n = 793 physicians (questionnaire), and n = 49 for saturation of interviews;	Questionnaire, and semi-structured interviews	<ul style="list-style-type: none"> <li>- "Everyone should have the right" to access euthanasia or PAS: 56% disagree, 28% agree</li> <li>- Opinion that only allowed to receive if life expectancy of a few weeks: 16% agree, 71% disagree</li> <li>- Should only performed at patients' explicit request: 88% agree, 7% disagree</li> </ul>

			various specialties		<p>- Vignette, cancer patient with loss of control and severe pain: 77% agree, 17% disagree</p> <p>- “Attitude towards euthanasia and PAS”: 45% liberal, 18% reserved, 7% against</p> <p>- Qualitative Themes: arguments for the possibility of euthanasia (patient autonomy, unbearable suffering); defense against misinformed critics; euthanasia act as a safeguard for careful and transparent practice; legal rules as a ‘helping hand’ and as a ‘shield’</p>
<b>Oliver, Wilson &amp; Malpas (2017)</b>	New Zealand doctors’ and nurses views on legalizing assisted dying in New Zealand	New Zealand	n = 298 physicians (and 478 nurses); various specialties	Online survey with open-ended qualitative questions (analyzed using thematic analysis)	<p>- PAD should be legal in NZ: 37% agree, 58% disagree</p> <p>- Agree with the availability of AD for certain circumstances:</p> <ul style="list-style-type: none"> <li>• Motor neuron disease: 81% agree</li> <li>• Terminal illness with a prognosis of six months or less: 75% agree</li> <li>- Willing to participate in AD:</li> <li>• Respond to initial request with information: 97% agree</li> <li>• Refer patients to another practitioner: 96%</li> <li>• Discuss AD with a patient: 86%</li> <li>• Do eligibility assessment: 70%</li> <li>• Write prescription: 66%</li> <li>• Administer the drugs via injection: 55%</li> </ul> <p>- Factors that may deter health practitioner participation “a lot” or “a bit”: lack of guidelines (89%), lack of professional support (86%), lack of training and skills (74%), fear of litigation or legal reprimand (66%), professional stigma/conflict (50%), personal philosophical obligation (35%)</p> <p>- “I’m hugely anxious about the potential for abuse, but I’m also hugely anxious about inflicting suffering on those for whom existence is miserable”; dignity &amp; comfort</p>

			<p>- “I have spent the whole of my professional career to date trying to save lives and alleviate suffering; helping someone to end their life is a complete reversal of this mindset”</p> <p>- Prescription is preferable to injection</p>
<b>Scholarly News Articles</b>			
<b>Eggertson (2014)</b>	Conscience should guide doctors at the end of life	Canada	<p>- Reporting on the CMA Annual Meeting</p> <p>- 91% voted “in favour of allowing individual physicians to follow their conscience in deciding whether to provide assistance”</p> <p>- Dr. Harvey: Physicians agreed the need for better palliative care, but still have a need for assisted death</p> <p>- Dr. Genge: ALS patients fear loss of control, suffering and being a burden. “The minute I do not allow my patient to discuss their desire to be in control of their death, I actually break the patient-physician relationship”</p>
<b>Eggertson (2015)</b>	Most palliative physicians want to role in assisted death	Canada	<p>- Canadian Society of Palliative Care Physicians (CSPCP) meeting</p> <p>- Dr. MacDonald (president of the CSPCP at the time): don’t see assisted suicide within the scope of palliative care and should happen away from palliative care. Misconception that palliative care includes ending life, which can deter people from seeking it.</p> <p>- Jan 2015 poll to society members (350 members, 26% non-response rate): 75% said euthanasia/PAS should not be provided by palliative care physicians</p> <p>- Dr. Barwich (past president): “it’s not part of our practice and we don’t anticipate it will become part of our practice”</p> <p>- Emphasis on better palliative care</p>
<b>Kermode-Scott (2016)</b>	Canada’s draft law on doctor assisted death is welcomed and criticized	Canada	<p>- CMA: happy that personal convictions of physicians will be respected</p> <p>- Dr. Lemire (College of Family Physicians of Canada executive director/CEO): looking for assurances that there will be a balance between the rights of the provider (conscientious objection) and the rights of the patients (not being abandoned when most vulnerable).</p>
<b>Vogel (2015)</b>	Many doctors won’t provide assisted dying	Canada	<p>- CMA member survey:</p> <ul style="list-style-type: none"> <li>• 29% would consider providing MAiD, 63% refuse outright, 8% undecided</li> </ul>

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<b>Wise (2014)</b>	Royal College of Physicians still oppose change in law on assisted dying	U.K.	<ul style="list-style-type: none"> <li>• 29% said they shouldn't be required to do anything, 19% supported referring patients to a colleague, 17% to an independent third party, and 8% to a 'medical administrator</li> <li>- Dr. Blackmer (VP of medical professionalism at CMA): no one should be forced to act against their conscience, but there is disagreement about what it means.</li> <li>- Some argue that there should be an information service for patients to access without a referral. Others argue that doctors should put their patient's rights first.</li> <li>- Dr. Bill Cavers: "A physician who refuses to provide service is serving his own needs, not his patients'. To not inform is 'abandoning the patient, pure and simple"</li> <li>- Dr. Whatley: fears assisted suicide will be seen as an alternative to better coverage and access to medically necessary care</li> </ul> <hr/> <ul style="list-style-type: none"> <li>- Comparing a survey from 2006 and now of the Royal College of Physicians</li> <li>- Members who opposed assisted dying decreased by 10.7% (from 73.2% to 62.5%)</li> <li>- 1 in 5 said that if the law changes, they would personally be prepared to participate (58% opposed, 20% neutral)</li> <li>- 44% said Royal College should oppose assisted dying, 25% should be in favour, 31% should be neutral</li> </ul>
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## Sample Interview Guide

### Appendix D

\*SUBJECT TO CHANGE AS PER STRAUSSIAN GROUNDED THEORY\*

“Thank you for agreeing to participate in this interview. I have a number of questions that I’d like to discuss with you about your opinion regarding medical assistance in dying. Please let me know if you don’t understand a question or you want me to repeat something I have said. As outlined in the letter of information, this interview will be audio-recorded and I will be taking some notes while we talk. If you want to skip any questions or stop the interview at any time, please let me know.

Do you have any questions before we begin?”

*If yes, answer questions and make notes.*

*If no, “Okay, let’s begin.”*

1. We will start off by getting some quick demographic information from you: how old are you? What specialty do you work in? And in what setting is that? Finally, how many years have you been practicing medicine?
2. What are your personal views towards medical assistance in dying?
3. *[In response to what the participant says]* Is there any reason you feel this way?
4. Is there anything in particular that you think shapes your opinion on the subject?
5. Do you have any experience with a MAiD case? And how did that make you feel?
6. Have your views towards MAiD changed over time, and if so was there anything that made you change your mind?
7. Are there any other comments you would like to make? Is there anything we should have asked but didn’t that we should know about?

Those are all of the questions that I had so unless there is anything else, that is the end of our interview. Thank you so much for your time.

## E-Mail for Physician Recruitment

### Appendix E

Dear Dr \_\_ ,

My name is Caitlin Robertson, and I am a Master's student at UNB. I am writing to you because you are a physician in New Brunswick. I am conducting a study looking at the perspective of New Brunswick physicians towards medical assistance in dying (MAiD).

I would like to invite you to participate in an interview for our research study called **Physicians Perspectives towards Medical Assistance in Dying in New Brunswick**. This project has been reviewed by the University of New Brunswick Research Ethics Board and is on file as REB#\_\_ (TBA). The interview will be approximately one hour in length and will take place in a mutually agreed-upon location. The interviews will be conducted exclusively by myself, and all of your data will be de-identified to protect your identity.

Attached to this email is a letter of information with more details about the study. If you are interested in participating in this study, please email me at Caitlin.Robertson@unb.ca or call me at (506) 645 – 7355 and leave a message. After we discuss the study in more detail and if you agree to be interviewed, we will set up an interview at a time and place that are convenient for you. At the interview, you will be given a consent form to read and sign.

Please note that you are under no obligation to participate in this study and you can leave the study at any time.

If you do not want to participate, please send me a reply e-mail saying 'No thanks.'

If you have questions or concerns about this research study, you can contact the following people:

- Caitlin Robertson (Principal Investigator) at (506) 645 – 7355 or Caitlin.robertson@unb.ca
- Dr. Emily Read (Supervisor) at (506) 541-6846 or erread@unb.ca.

Thank you for your time.

Sincerely,  
Caitlin Robertson, BSc, BA  
Master's in Applied Health Services Research Student  
University of New Brunswick

## Letter of Information and Consent

### Appendix F

**Study Name:** Physicians perspectives towards medical assistance in dying in New Brunswick

**Principal Investigator:**

Caitlin Robertson, BSc, BA  
Masters of Applied Health Services Research Student  
University of New Brunswick  
(506) 645-7355, Caitlin.Robertson@unb.ca

**Supervisor:**

Dr. Emily Read, RN, CPT, PhD  
Assistant Professor, Faculty of Nursing, University of New Brunswick, (506) 541-6846,  
eread@unb.ca

This project has been reviewed by the University of New Brunswick Research Ethics Board, and is on file as \_\_\_\_ (to be determined)

**Invitation to Participate**

This letter is an invitation to take part in a study about the opinions of New Brunswick physicians towards medical assistance in dying (MAiD). We are interested in understanding these views, and what shapes them. As a physician licensed in the province of New Brunswick, you are invited to participate in the study and contribute your opinions toward this new service in Canada.

**Purpose of the Letter**

This letter will give you the information you need to decide whether you want to be in the study and whether you are eligible to be in the study.

**Purpose of the Study**

The purpose of this study is to understand the varying opinions of New Brunswick physicians toward MAiD. Our hope is to better understand these views, and what shapes them.

This project is being conducted as part of the requirement for the Master's of Applied Health Services Research thesis project. As such, the results of this study will be published as a written thesis, and presented in a thesis defense. Additionally, we hope to publish the results of the study in an academic journal, as well as presentations at appropriate conferences. As such, there will be no identifying information published or presented.

**What You Need to Know**

In this study, you will be interviewed by the principal investigator (Caitlin Robertson). She will ask you about your opinion on MAiD and why you feel the way you do. You will be asked to share your views on this topic. Since this is such a controversial and difficult topic to talk about, we will ensure your confidentiality throughout the study. If you agree to participate in the study, you will be interviewed once in person by one interviewer (Caitlin Robertson). You will be asked questions about your views on MAiD, and what shapes those views.

**Inclusion Criteria**

To be involved in this study, you must be a licensed physician working in New Brunswick, Canada. In addition, you must be practicing as a physician (i.e. actively seeing patients, not solely teaching or working in research)

**How Many People Will Take Part in This Study?**

We do not have a set number of participants for this study and will continue to recruit and interview participants until no additional kinds of information or new perspectives are being discussed.

**Study Procedures**

You will be asked to participate in one in-depth, in-person interview, which will take approximately 60 minutes and will be audio-recorded. The interview will focus on your opinions towards MAiD and what you believe shapes those views. The interviews will take place at a convenient and agreed-upon time and at a location where you feel most comfortable (e.g. your office, or your home).

The data collected in this study will not be used for anything else outside the scope of the study explained above.

**Possible Risks and Harms**

There are no known or expected risks if you chose to participate in this study.

**Possible Benefits**

The potential benefits of this study include adding to the literature regarding this topic in a Canadian-context (specifically, New Brunswick). It has the potential to help better understand why New Brunswick physicians choose to, or not to provide MAiD to their patients. This can help the medical community better understand each other's differing opinions on this topic. Additionally, it has the potential to inform MAiD policies in the future.

**Costs to Participate**

There are no costs to participate in the study.

**Voluntary Participation**

You can choose to be part of the study. You can also withdraw from the study at any time, even if you consented to take part. You do not waive any legal rights by signing the consent form.

**Conflict of Interest**

There are no conflicts of interest associated with this study.

**Confidentiality**

Immediately after your interview, the audio-recorded file will be downloaded onto a secure folder only accessible to the principal investigator (Caitlin Robertson). Once transcribed, the audio file will be deleted. Identifying information (your name, your address, etc.) will not be included in the data that is transcribed from the interview. Data and consent forms will only be seen by members of the research team (Caitlin Robertson and Dr. Emily Read).

Under no circumstances will data that could identify you personally be published, shared, or otherwise made public, and if the results of the study are published, no personal information will be included. The study findings will be shared in health research journals, conferences, and presented as a final thesis defense at the University of New Brunswick.

**Publication**

To receive a copy of the study results or if you require further information, please contact the principal investigator, Caitlin Robertson: [Caitlin.Robertson@unb.ca](mailto:Caitlin.Robertson@unb.ca) or (506) 645 – 7355.

**Questions or Concerns:**

You may contact Caitlin Robertson with any questions or concerns about the study at (506) 645 – 7355 or at [Caitlin.Robertson@unb.ca](mailto:Caitlin.Robertson@unb.ca). If you prefer to communicate with a UNB representative who is not directly affiliated with this study, please contact the UNB Fredericton Research Ethics Board office at (506) 453 5189 or at [ethics@unb.ca](mailto:ethics@unb.ca).



## **Recruitment Advertisement, New Brunswick Medical Society eBulletin**

### **Appendix G**

#### **Seeking physician participants – MAiD Research Project**

Caitlin Robertson, a student at the University of New Brunswick, is seeking participants for a research study focusing on physicians' perspectives on medical assistance in dying (MAiD) in New Brunswick (UNB REB #2018-118). She is looking for physicians willing to be interviewed about their feelings on MAiD and what they think is shaping their viewpoint. These interviews can take up to an hour and will take place one-on-one with the student (she will travel to you). You are eligible to participate if you are a physician in New Brunswick; any specialty is welcome, and any viewpoint on MAiD is encouraged. To participate, please contact Caitlin at [caitlin.robertson@unb.ca](mailto:caitlin.robertson@unb.ca) or (506) 645-7355.

## Debriefing Protocol

### Appendix H

It is important to know that thinking and talking about such a controversial and sometimes upsetting topic, can produce emotional distress. It can also cause people to have emotional reactions in the days after you complete the interview. This is a stress reaction that is *completely normal*.

#### Some common signs of a stress reaction include:

PHYSICAL	EMOTIONAL	COGNITIVE	BEHAVIOURAL
Nausea	Fear	Confusion	Withdrawal
Vomiting	Stress	Nightmares	Restlessness
Dizziness	Anxiety	Hypervigilance	Changes in sleep
Weakness	Guilt	Disorientation	Changes in appetite
Sweating	Panic	Difficulty concentrating	Irritability
Difficulty breathing	Sadness	Forgetfulness	Activity level changes
Heart palpitations	Anger	Intrusive images	Substance use (i.e. alcohol, drugs)
Chest pain	Loss of control	Suspiciousness	

#### Managing a Stress Reaction:

If you notice yourself experiencing any of these signs, there are some things that you can do that might help. Do things that make you feel good, such as:

- Regular exercise alternated with rest
- Relaxation exercises
- Listening to music
- Writing, keeping a journal
- Eating nourishing meals
- Keeping a daily routine: structure your time (meals, shower, sleep)
- Allowing yourself to feel rotten, and sharing your feelings with others
- Reaching out to others and spending time with people you feel comfortable with and who give you energy. Decrease your contact with people who drain your energy.
- Be aware that numbing the pain with alcohol/drugs will complicate things



## Curriculum Vitae

**Candidate's full name:** Caitlin Michelle Robertson

### Universities Attended:

University of New Brunswick Saint John (Sept 2009 – April 2014), Bachelor of Science  
University of New Brunswick Saint John (Sept 2014 – April 2015), Bachelor of Arts  
University of New Brunswick Fredericton (Sept 2015 – April 2016), Non-degree courses  
University of New Brunswick Fredericton (Sept 2016 – March 2024), Master of Applied Health Services Research

### Other Education:

Canadian Frailty Network (Sept 2018 – August 2019), Interdisciplinary Fellowship Program

### Journal Publication:

Zhou, F., Chandra, K., Sohi, D., **Robertson, C.**, Fraser, J., Scoville, J., DeSousa, N., Vaillancourt, C. Atkinson, P.R. Do guidelines influence emergency department staff behaviours and improve patient outcomes? Evaluation of a multifaceted intervention for the implementation of local acute exacerbations of chronic obstructive pulmonary disease guidelines. *Cureus* 2018; 10(11): e3588.

### Abstract Publications:

**Robertson, C.**, Read, E.A. Physician perspectives of medical assistance in dying (MAiD): A scoping review. *Canadian Geriatrics Journal*, 22(2), pg. 88.

Chandra, K., Vaillancourt, C., De Sousa, N., Fraser, J., Sohi, D., **Robertson, C.** Scoville, J., Atkinson, P. Does implementation of local AECOPD treatment guidelines improve antibiotic stewardship in the emergency department? *Canadian Journal of Emergency Medicine*, 2015; 17 (Suppl 2), S26.

Chandra, K., Vaillancourt, C., De Sousa, N., Fraser, J., Sohi, D., **Robertson, C.** Scoville, J., Atkinson, P. Does implementation of local AECOPD treatment guideline improve patient outcomes? *Canadian Journal of Emergency Medicine*, 2015; 17 (Suppl 2), S57.

## **Invited Presentation:**

### *NURS6018 – Leadership, Policy, and Ethics*

Taught introductory information on medical assistance in dying (MAiD). We covered the history of the law, eligibility criteria, safeguards in place, some Canadian statistics, and any current issues surrounding the topic (October 21, 2019).

## **Conference Presentations:**

### *Oral Presentation*

Peterson, J., Yetman, L., Faig, K., **Robertson, C.**, Flannagan, K., Clancy, O., Feltmate, P. The impact of one more thing: A grounded theory study on nursing staff's experience of care delivery for older adults in acute care setting. *Health Research Week (HRW)*, Saint John, New Brunswick (2023).

Peterson, J., Fowler, S., Faig, K., Yetman, L., Prosser, J., **Robertson, C.**, Bamgboye, A., Clancy, O., Flanagan, K., Feltmate, P. Frailty-Focused Enhancements to Seniors' Hospital Care (FrESH): Does Specialized Education Work? *Health Research Week (HRW)*, Saint John, New Brunswick (2023)

**Robertson, C.** & Read, E.A. Physicians' perspectives of medical assistance in dying (MAiD): A scoping review. *Interprofessional Health Research (iHR)*, Saint John 2019.  
**Award:** iHR Student Oral Presentation 2019.

Chandra, K., Vaillancourt, C., DeSousa, N., Fraser, J., Sohi, D., **Robertson, C.**, Scoville, J., Atkinson, P. Does implementation of local AECOPD treatment guideline increase management adherence and improve antibiotic stewardship in the emergency department? *Canadian Association of Emergency Physicians (CAEP) Conference*, Edmonton 2015.

### *Poster Presentations*

Peterson, J., Fowler, S., Faig, K., Flanagan, K., Clancy, O., **Robertson, C.**, Yetman, C., Feltmate, P. Frailty-Focused Enhancements to Seniors' Hospital Care (FrESH): Does Specialized Education Work? *Gerontological Society of America (GSA) Annual Scientific Meeting*, Tampa, Florida (2023)

Peterson, J., Fowler, S., Prosser, J., Faig, K., Bamgboye, A., Clancy, O., Flanagan, K., **Robertson, C.**, Yetman, L., Feltmate, P. Frailty-Focused Enhancements to Seniors' Hospital Care (FrESH): Does Specialized Education Work? *Canadian Association on Gerontology (CAG)*, Toronto, Ontario (2023)

Bamgboye, A., Beckett, A., Doucet, R., **Robertson, C.**, Prosser, J., Clancy, O., Flanagan, K., Fowler, S., Nordstrom, C., Oakes, S., Peterson, J., Faig, K., Jardine, D., Yetman, L., Feltmate, P. Frailty-Focused Enhancements to Seniors' Hospital Care. *New*

*Brunswick Health Research Foundation (NBHRF) Conference, Fredericton, New Brunswick (2022)*

**Robertson, C.,** Read, E.A. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD). *Atlantic Health Exploration and Discovery (AHEAD) Conference, Online due to COVID-19 2020.*

**Robertson, C.,** Read, E.A. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD). *Graduate Research Conference (GRC), Fredericton 2020. [Cancelled due to COVID-19]*

**Robertson, C.,** Read, E.A. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD). *New Brunswick Health Research Foundation (NBHRF) Conference, Saint John, 2019.*

**Robertson, C.,** Read, E.A. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD). *Canadian Association on Gerontology (CAG), Moncton 2019.*

**Robertson, C.,** Read, E.A. Physicians' perspectives of medical assistance in dying (MAiD): A scoping review. *Canadian Association on Gerontology (CAG), Moncton 2019.*

**Robertson, C.,** Read, E.A. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD). *Canadian Frailty Network (CFN) National Conference, Toronto 2019.*

**Robertson, C.,** Read, E.A. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD). *Primary Health Care Research Day, Halifax 2019.*

**Robertson, C.,** Read, E.A. Physicians' perspectives of medical assistance in dying (MAiD): A scoping review. *Primary Health Care Research Day, Halifax 2019.*

**Robertson, C.,** Read, E.A. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD). *Canadian Association for Health Services and Policy Research (CAHSPR), Halifax 2019.*

**Robertson, C.,** Read, E.A. Physician perspectives of medical assistance in dying (MAiD): A scoping review. *New Brunswick Health Research Foundation (NBHRF) Conference, Fredericton 2018.*

**Robertson, C.,** Read, E.A. Physician perspectives of medical assistance in dying (MAiD): A scoping review. *Canadian Frailty Network (CFN) National Conference, Toronto 2018.*

**Robertson, C.,** Read, E.A. Physician perspectives of medical assistance in dying (MAiD): A scoping review. *Canadian Association for Health Services and Policy Research (CAHSPR), Montreal 2018.*

**Robertson, C.,** Read, E.A. Physician perspectives of medical assistance in dying (MAiD): A scoping review. *Graduate Research Conference (GRC)*, Fredericton 2018

Chandra, K., Vaillancourt, C. De Sousa, N., Fraser, J., Sohi, D., **Robertson, C.,** Scoville, J., Atkinson, P. Does implementation of a local AECOPD treatment guideline improve patient oriented outcomes? *Interprofessional Health Research (iHR) Day*, Saint John 2015

Chandra, K., Vaillancourt, C. De Sousa, N., Fraser, J., Sohi, D., **Robertson, C.,** Scoville, J., Atkinson, P. Does implementation of a local AECOPD treatment guideline improve patient oriented outcomes? *Canadian Association of Emergency Physicians (CAEP) Conference*, Edmonton 2015