


Rediscovering the art of medicine, rewards, and risks: Physicians' experience of providing medical assistance in dying in Canada

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Abstract

Background: Medical assistance in dying opens up uncharted professional territory for Canadian physicians extending their practices to include assisting and hastening death for eligible patients.

Objectives: To understand physicians' experience of participating in assisted dying and the emotional and professional impact.

Methods: An interpretive descriptive methodology and thematic analysis were used for this research. We interviewed eight physicians engaged in assessing and providing medical assistance in dying. Data were collected through audio taped, semi-structured interviews in person or by phone.

Results: Three overarching themes included (1) rediscovering the art of medicine, (2) unexpected rewards, and (3) negotiating risks and challenges. Each theme has accompanying sub-themes.

Conclusion: Medical assistance in dying is markedly different from other physicians' practices in that it has an enriched capacity for caring. The process brings deep satisfaction characterized by intimate, personalized contact with patients and families. The professional rewards of providing medical assistance in dying outweigh the challenges, offering an alternative narrative to more publicly accepted views of assisting someone to die.

Keywords

Death and dying, medical assistance in dying, physicians, art of medicine, end-of-life issues, stories, Canada, compassion satisfaction

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Introduction

(A Physician's Story) *I just want to emphasize, as cliché as it sounds, this work, being a provider, a prescriber for medical assistance in dying, has been truly extraordinary work. I have met extraordinary people—especially in the early days and continuing today. The courage it took those people to step forward, to ask for this care, these were independent, strong-willed, long-lived, hard-core, independent people. These were extraordinary people who led extraordinary lives. Their whole lives had been like that. They had stories about what they'd done in their lives that were mesmerising. To be able to do this with them and give them this gift, and the reward I got personally and professionally by doing that, was shockingly amazing. And it continues to be, to this day. I find it the most extraordinary work. I keep finding myself in the position of meeting people and finding myself in situations I never would have dreamed of—like holding someone's hand you just met a week ago, who now trusts you intimately and infinitely to do this most intimate act*

with them and they're thanking you as they're dying. Like crazy things that five years ago I never would have thought possible and they keep coming up, these crazy situations keep coming up. It's amazing. It blows my mind still. I don't think I take it for granted yet. I don't think I ever will. (Physician provider of medical assistance in dying—Participant 5)

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Canadian physicians have been directly affected by 2016 legislation¹ that set the stage for allowing assisted dying under specific legal and regulatory circumstances. Because of the sensitive nature and relative newness of assisted dying in Canada, understanding the experiences of physicians participating in medical assistance in dying (MAiD) is vital to ensuring a smooth transition of assisted dying into health care. This legislation is unique in that it includes voluntary euthanasia (in which a medical practitioner administers a lethal dose of medication to cause the death of a patient) and assisted suicide (in which the medication is administered by the patient). (Note: In the province of Quebec, only voluntary euthanasia is legal.) MAiD heralds an unprecedented change for physicians who have been educated and trained to support life. Physicians with expertise in providing end-of-life care are also entering uncharted territory, personally and professionally. All are being called to rethink their practice by reorienting toward directly assisting eligible patients who make this choice.

The College of Physicians and Surgeons of BC Standards² states that a physician must “provide patients with enough information and assistance to allow them to make informed choices for themselves” about medically assisted death. The scope of practice extends from performing patient assessments and/or to performing MAiD. Although physicians may conscientiously object to assessing a patient for or performing MAiD and may choose to not be involved, they are required “to provide an effective transfer of care for their patients by advising patients that other physicians may be available to see them” (p. 6). As with other health care professionals, physicians have a duty of care that must be continuous and nondiscriminatory. Although national data are slowly being compiled,³ and a body of literature is rapidly evolving, to date limited research is available on how physicians are engaging in assisted dying in the Canadian context.

Literature review

The number of jurisdictions across the world where some type of legislation related to assisted dying/suicide and voluntary euthanasia are in place continues to grow since it was first introduced in Switzerland in 1942. Currently, euthanasia is legal in the Netherlands, Belgium, Columbia, Luxembourg, and Canada. Assisted suicide is legal in Switzerland, Germany, the Netherlands, the state of Victoria in Australia, and in the US states of Washington, Oregon, Colorado, Hawaii, Vermont, Montana, Maine, New Jersey, California, and the District of Columbia.

Amendments made to the Canadian Criminal Code on 17 June 2016 mean that Canadians can now legally access MAiD. The spirit of the law is that this new service be provided compassionately and ethically, that all involved are supported, and that harm is not caused to patients or staff.

The path to physician involvement in MAiD has been fraught with tension.^{4,5} Initially, some physicians struggled to reconcile themselves to this major practice change, but general sentiment is slowly changing. From 2013 to 2015, the number of Canadian physicians supporting MAiD rose from 34% to 45%, with 83% of those surveyed in 2017 supporting the idea of advance requests.⁶ A recent survey of medical students showed that among Canada’s new generation of doctors, 71% would offer MAiD.⁷ Although provisions are in place to ensure physicians can decline to help on moral or religious grounds, researchers in Quebec found that the majority of physicians who refused to participate did not oppose MAiD. Rather, their expressed concern was “the emotional burden related to this act and the fear of psychological repercussions.”⁸

Notwithstanding that what is known about physicians’ experiences in the Canadian context remains scant, a growing body of research from other countries is available. In a recent scoping review, Fujioka et al.⁹ examined the roles of physicians and other health care professionals in decision-making related to MAiD and the professional challenges that arise when they are confronted with patient requests. Key challenges reported by physicians included tensions caused by colleagues conscientiously objecting to MAiD. In a qualitative study from the Netherlands, some palliative care physicians felt pressured to comply with patients’ requests for euthanasia, despite their own discomfort.¹⁰ Other challenges included the emotional tensions experienced by palliative care physicians in the Netherlands and United States, including feelings of strain, loneliness, and being conflicted.¹¹

Similarly, Brooks¹² conducted a scoping review of qualitative literature and called for further investigation into the experiences of diverse MAiD providers in the Canadian setting. Reported findings specific to Dutch physician providers include studies that underline stressful, negative experiences of providing assisted dying.^{10,13} According to another study, physicians in Oregon faced ethical complexities and a negative emotional impact,¹⁴ and yet they did not express major regrets over their decision to participate. The findings showed how requests for assisted dying prompted discussion of important issues and increased physicians’ confidence and assertiveness in discussing end-of-life issues with other patients. Mixed findings regarding physicians’ experience have been thrown up by, among others, a quantitative study whose authors reported that euthanasia was seen as burdensome and emotional for 42% of all cases of hastening death that they investigated, and 52% of the physicians reported feelings of satisfaction and relief.¹⁵ Although the body of research is growing regarding physicians’ roles, attitudes, and opinions on assisted dying in Europe and, to some extent, the United States, we aimed to understand better the direct physician-provider experience in the Canadian context.

Table 1. Overarching themes, sub themes.

Themes	Description	Sub-themes
Rediscovering the art of medicine	Providing assisted dying is a process that calls physicians into embodied awareness and relationships of intimacy and grace.	<ul style="list-style-type: none"> • Remembering whole-person care • Practicing differently • Intimate, emotional engagement • Embodied awareness
Gaining unexpected rewards	Personal and professional well-being is gained from satisfaction and appreciation of living core values.	<ul style="list-style-type: none"> • Compassion satisfaction • Aligning values and beliefs • Conviction of doing the right thing • Outpouring of gratitude
Negotiating risks and challenges	Legal, collegial, and institutional barriers must be navigated. Individuals have concerns over sustainability of workloads.	<ul style="list-style-type: none"> • Being vulnerable • Collegial discord • Risk of reprisals • Workload and financial impact

Study purpose and design

The purpose of this study was to enhance the general understanding of Canadian physicians' experience of directly providing MAiD (referred to as "providers").

Methodology

We used a qualitative design drawing on thematic inquiry¹⁶ to identify themes, as well as interpretive description¹⁷ to work interpretively with participants' narratives.

Participants

Eight physicians volunteered from urban and rural areas who were providers of MAiD. Participants were recruited from across the local health authority via a poster sent to medical divisions and physicians who had completed MAiD assessments. Participants included general practitioners (GPs) and nonspecialist physicians from urban and rural communities working in acute and palliative care. Ages ranged from 33 to 62 years (average age 49), with an equal number of men and women. The majority identified no active religious affiliation, and ethnicity was withheld to protect anonymity. Years of experience ranged from 6 to 38 years (average of 23), and experience with MAiD provision ranged from 12 to 113 assisted deaths. Only one physician was dedicated to full-time provision.

Data collection

Data were collected using semi-structured interviews lasting 40–70 min. Interviews were audio-recorded and conducted in person or by telephone by coinvestigators (Ab, MH). The majority of interviews were conducted via telephone to facilitate participation throughout the large geographic region. Interviews were guided by questions including: (1) Please tell me about your experience of being asked to participate in a medically assisted death and

how you came to your decision; (2) Tell me about your MAiD experience. What has been most challenging? (3) What concerns did you have, if any? and (4) How are you (or are you) reconciling your personal and professional beliefs? What challenges do you foresee in moving forward with MAiD?

Analysis

We followed a layered approach informed by Thorne's¹⁷ interpretive description and Braun and Clarke's¹⁶ thematic analysis. Analysis began with identifying individual and collective narratives via preliminary questioning of the data: What narratives surprised us, what was missing, and what patterns were we beginning to see? A second layer of analysis included identifying categories and preliminary coding. Transcripts were systematically coded and recoded using Atlas-ti™, collapsing codes into overarching themes and sub-themes.

As with any qualitative research, we focused on attaining not a high quantity but rather a high quality of participant experiences; interviews that had a depth and richness of detail and nuance. After analysis of eight interviews, we noted that the amount of variation had leveled off and thus felt confident with the data set.

Ethics and rigor

We received approval from the Human Research Ethics Board as per *Tri-Council Policy Statement*.¹⁸ This included approval from Island Health and the University of Victoria.

Findings

Physicians' experiences of providing MAiD were conceptualized into three overarching themes of rediscovering the art of medicine, gaining unexpected rewards, and negotiating risks and challenges. Each theme was accompanied by descriptive sub-themes (Table 1).

Rediscovering the art of medicine

Providers acknowledged how MAiD offered a personal engagement rarely experienced with patients in the hubbub of daily work. They described a sense of slowing down and practicing medicine differently, and they remembered similar experiences back in medical school. One physician described the need for “keeping the grace central” in order to intimately listen to their patients’ suffering (#3). Another described the process as “very meditative and contemplative in a different sense than I do in my other practice” (#8). One foregrounded the mutuality with patients:

There just seems to be more of an intimate contact . . . maybe because I spend a longer time with them? There’s often a home visit and there’s, I don’t know, a sort of mutuality about it. It’s different than general practice—I find that I invest more emotionally but that doesn’t mean I’m upset, it just means I’m using more of an emotional side of myself than I do in an ordinary general practice consult. (#4)

The science and art of medicine were central, with “the art piece really coming full strength now with MAiD.” Tremendous consideration went into ensuring practical (and vital) details such as the need for administering of medications not to take center stage. One participant experimented with multiple inches of IV tubing so she could stand *behind* the patient and family and “be one layer back, sort of in the second row seat. Which I really feel is good.” She explained,

I needed to figure out how to let the family be the main people that the [patient] is seeing . . . I needed to feel fluid enough with my drugs and syringes that I could just focus on the patient. [I use] eye contact and demonstrate where people should focus because sometimes they just look at me and the needle. (#8)

Another skillful aspect of the “art” involved an embodied self-awareness, “paying attention to my syringes,” while concurrently attuning to both people and the quality of space in the room:

[I try to] focus on what else is going on in that room. What else is going on with the patient? Am I picking up any undercurrents and am I tuning into any undercurrents of tension, hostility, sadness, that I should address? So it’s a very different type of attentiveness, I feel like all of my skin is on edge watching . . . the vibe in the room. It’s a different type of attentiveness, and in a different way tiring—It’s not so much the technical part, that part is easy. The difficult part is being on alert for what’s happening in the room. (#8)

Unexpected rewards

An overarching theme was how unexpected and “extraordinarily rewarding” the work had become. We have conceptualized this as “compassion satisfaction,” and as one participant shared, “it feels like the most important medicine I do.”

Compassion satisfaction. Participants also described MAiD as a process that included expressions of “deep empathy” and “love” and as “amazing.” Some used this type of animated language, while others grappled with how challenging the experience was to articulate. Nevertheless, other descriptors included “gratifying,” “it feels good,” and “I hadn’t expected this.” Some physicians compared the almost inexplicable experience of honoring and assisting death to the joy of attending a birth, and all prescribers valued the unique nature of the work:

It’s a very positive experience and difficult to put into words how it makes me feel. It makes me feel really kind . . . I feel like I’m doing a good thing . . . heart-warming. It’s quite loving. (#4)

Participants often expressed these views softly, as if hesitant to describe the experience in such an affirming way, which may run counter to what other physicians or the public might imagine the experience of assisting death to be like. The unanticipated and high levels of satisfaction were illustrated by one participant who stopped providing MAiD as a result of his workload, but who later returned (after a few months), stating how much he “missed it.” Several participants likened the experience to being joyous, an end-of-life experience that left them feeling high. Many spoke of their love of the work, even after providing many deaths: “It’s amazing. It blows my mind still.”

Aligning with deeply held values and interests. Reasons underpinning such satisfaction may include how closely MAiD aligned with deeply held values and interests, participants’ conviction of doing the right thing, and the outpouring of gratitude from patients and families. We will now discuss each in turn.

For many participants, the decision to become a MAiD prescriber was based on core values and beliefs such as “a fundamental value of patients’ autonomy” (#7). Other beliefs referenced undercurrents of social justice and a history of activist engagement on many fronts, be it with women’s reproductive rights, animal rights, HIV/AIDS work, debates on end-of-life care, and palliative care at a time when its merits were also being debated. Although only some participants were interested in assisted death as a social movement, they all expressed personal interests beyond professional obligation; as one participant stated, “I would personally ask a physician to do the same for me.” Several had a long-standing interest in medically assisted dying and were preparing in advance of the legislation so as to be ready as soon as it became legally available:

I’ve always been interested in the intersections of medicine, ethics, and law my entire career and . . . I always followed along the national discussion and debate about end-of-life care since the Sue Rodriguez case, which was going on actively when I was in medical school. So it’s always been at the back of my mind. . . I went to a conference in Amsterdam and it was

extraordinary, and basically the conference convinced me that I wanted to work in this area—it was something I really, really wanted to do. (#8)

Participants were unequivocal in believing they were doing the right thing. As one physician quipped, “You could perhaps describe me as a conscientious provider . . .” (#3). Like others, he contrasted against those who refuse to participate in MAiD on moral or religious grounds (conscientious objection) with his own strongly held belief that providing assisted dying is the right action. As another provider advised, “you have to be 100% sure that you believe in this and that you are happy with the law and the rules” (#2). Most participants expressed this certainty and were committed to providing assisted dying as soon as the legislation was passed:

Well the first year . . . there was a certain number of people who stepped forward—and I think we were taken advantage of, quite honestly. But we didn’t care, because we were going to show that it could be done [MAiD], and we were going to show that it could be done well, and we were going to spread the word, and recruit people, and change the world kind of thing. So we did that. (#5)

Although most participants wanted to provide MAiD once it was legal, this was not unanimous. One participant shared her initial indecision. Although she agreed with the legislation, she needed more time to do some “soul searching.” She questioned, “Will I be able to cope?,” “Will the deaths haunt me?,” and “Will it be too great a burden?”:

I thought about it for six months before I decided that I could do it. I discussed it with my partner, talked it over, and just dwelled on it a bit really. [I wondered] whether the ways I’ve dealt with death before, whether it would bring back any bad memories of my own parents’ death. I just mulled it over. I did quite a lot of soul searching to see would I be emotionally resilient [enough] to do it. (#4)

Finally, providing individuals with an assisted death also generated an intimate outpouring of gratitude by patients and families, and the extent of this landed on the prescribers in an overwhelming and significant way. Patients’ gratitude seemed to buoy, empower, and affirm participants’ convictions about patient choice and their role in reducing patient suffering.

Negotiating risks and challenges

Participants were also frank about fears and challenges associated with being a provider, especially in the early days after the legislation was passed. These included concerns about what their families might think and worries for their personal safety. They acknowledged feeling vulnerable by stepping up to offer this service when others would not and opting to make their names public as MAiD providers. As one

physician stated, “So emotionally, I was fearful but not so much of the work as I was of the backlash of the work” (#5):

I was worried that it would be like abortion, meaning providers would be at risk of shootings and stabbings and having their offices blown up and that has not happened with MAiD . . . it has not elicited the same level of anger. (#7)

Fear of reprisal from oversight bodies such as the coroner’s office was particularly present in the early days. A heightened sense of risk related to what seemed for some to be disproportionate surveillance: “We’re being scrutinized a lot more” and “I’ve never once been called by the coroner, but for a MAiD death I’ve been called two or three times.” Concerns over repercussions led to time-consuming and meticulous consultation notes for their personal records. Some worried whether their notes would be sufficiently thorough and defensible. The range of patient diagnoses necessitated significant background work if providers were not familiar with particular diseases. This added layers of apprehension when conducting an assessment:

Your heart sort of sinks when you get this letter from the coroner because I guess they have great powers to request anything so you kind of think, oh God, what’s going to happen? It is pretty intense making sure you get all the pieces in order because you can’t be wrong from a procedural aspect. There is this kind of fear in the background that there could be legal repercussions, so I suppose that’s part of the emotions. (#1)

In contrast, participants described strong prescriber support received via a web-based physician list-serve. Some spoke cautiously about their national organization that provided legal advice. The thornier ethical and legal issues were the most worrisome, and as one physician explained, support from legal advisors was often limited: “As lawyers [they] are very conservative and so with any sort of grey area—they’re going to say don’t do it.” This was perceived as frustrating:

I can understand why they’re super conservative about their advice but at the same time because they do that, it makes me less likely to actually seek their advice because I already know what they’re going to say. Whereas if they’re more, I guess, understanding of the situation and able or willing to put—I think it’s important for our peace of mind that they put it in writing because when they give us an opinion in writing that’s something I keep always in my documents—if they were willing to say in writing that they were able to sanction or recommend, or say that it seems reasonable, I’d be much more likely to seek their advice in the future. And I think I’m actually less and less inclined to seek their advice because of that, which is not good. I should be wanting to get an opinion from them. But then others argue that we should be consulting with other physicians, not with lawyers because the decision lies with us, not with lawyers. (#6)

Collegial challenges also included tensions with physicians related to poor communication when patients requested MAiD without informing their attending

physician or palliative care team. Participants described trying to protect professional courtesies:

It is sort of a passive relationship with the personal physician. I'm never too sure where I stand on that. I try and give them a bit of [a] heads up if they haven't already been aware that this is happening if the patient hasn't communicated. (#1)

Feeling unsupported, especially in smaller communities, was another issue identified by some providers. Early in 2016, participants spoke of resistance from individuals or faith-based institutions disagreeing with the legislation:

One thing I should add so you understand what's difficult—what has been the biggest thing in our town—because the hospital was Catholic, we had limited supports, so we could not get patients to get an IV. We had to do a lot of undercover, underground work. We had to visit patients afterhours, pretend to just be visiting them, close the door and do an assessment whispering behind the closed door, or ask other colleagues to just quickly come to a patient's room to quickly sign a request form and then all scatter so no one knows a request form was signed. These things were hard because we had to manage all of this on top of managing the family's grief, the patient's process, the legal process, and having to find a place to do this in a community that was otherwise not very supportive. The hardest thing was witnessing patients suffer because the hospital would not allow certain things to happen. (#2)

Another challenge considered part of the process was turning down a patient who was not eligible. A further challenge arose on hearing the patient say they would “end it themselves” if they were not deemed eligible. Other difficulties were having to cancel a planned MAiD because of a patient's loss of capacity and facing a devastated family. Although most families reportedly accepted these often unforeseeable situations, participants shared infrequent stories of facing loud or threatening families or when a patient wanted MAiD and his or her partner did not support the decision.

Finally, concerns about insufficient remuneration and a growing workload were widely shared. Most GPs had no administrative assistant who could complete the required paperwork; the volume and process of reporting were perceived as burdensome. As one participant shared, “There's no other aspect of medicine that I practice where I'm shuffling that much paperwork and I'm personally responsible for getting it done” (#6).

Fears of burnout and the unsustainability of workload were pervasive. One provider shared, “There were times when I was getting five or six referrals in a week and it was completely overwhelming.” With the exception of a few, most physicians conducted MAiD on top of their regular workload, with many doing so in the evenings or on weekends. One participant shared, “The future of providing access and quality end-of-life care for those who cho[ose] MAiD is not sustainable with the lack of physicians or nurse practitioners” and the current system. Others shared hard-won

lessons of putting boundaries on this work by designating particular days and times for providing MAiD. Some described limiting their role as consultant on MAiD to help with the workload, recognizing: “I'm not the expert in those other alternatives, especially complex palliative medicine or whatever else; I'll get those folks involved.”

Discussion

The themes of rediscovering the art of medicine, gaining unexpected rewards, and negotiating risks and challenges might be expected with a medical change of this magnitude. Personal passion and conviction, followed by intense satisfaction, provided a foundation for participants' willingness and commitment to provide assisted dying. We are seeing similar perspectives in editorials and personal narratives across Canada. To name a few, eminent palliative care physician and MAiD provider Sandy Buchman^{19,20} and three physicians featured by Evans²¹ share similar commitments. Family physician Tony Reid²² described his experience of providing MAiD as “an extension of palliative care”; “profound” and “astonishingly rewarding,” “it combines so many of the skills and art that make family medicine so fulfilling” (p. 640). Many participants also saw MAiD work as an extension of palliative care and, while facing resistance from some palliative care providers, they appreciated deeper connections and the recent goal of coexistence²³ with palliative care teams in their communities.

Rediscovering the art of medicine

A key finding of this study was how providing an assisted death felt like rediscovering what participants once knew and valued—practicing the art of medicine. This contrasts starkly with recent claims that intimate, personalized medical practice has become “an unfortunate causality in a health-care system that values volume, numbers and data over caring [for] the whole person.”²⁴ Study participants reported how providing MAiD is remarkably different from their other clinical work, in part because of the intimacy and care required in opening oneself up to and understanding the grievous and irremediable suffering of another. It is this capacity for caring that Gillespie et al.²⁵ defined as the art of medicine. Furthermore, this kind of medical attention and “relationship-centered care” are said to enhance personal growth and physicians' well-being.^{26,27} Participants seemed to support this assertion, describing MAiD as highly satisfying, and for some it has become the culmination of their career. Medicine as an art has long been recognized as “residing in the interpersonal aspects of [the] patient–physician relationship,”²⁸ and participants also go beyond the interpersonal to include larger goals of social change and service to society. This is reminiscent of Hippocrates, who reportedly said, “Wherever the art of medicine is lived, there is also a love of humanity.”²⁹

The findings from this study support Peabody's claim that "the art and science of medicine are not antagonistic but complementary."²⁵ Participants reported the beauty of being able to see *and* hold both the technical and the human, to be invisible *and* visible to families in the process, to be clinically concise *and* have grace, to feel meditative *and* fatigued from the high level of alertness. The ability to hold opposites at the same time, to be deeply passionate and yet cautiously reluctant, builds on current hallmarks in understanding the art and science of medicine.

Compassion satisfaction

Another key finding of compassion satisfaction offers an emerging narrative that counters more publicly accepted views (and cultural norms) that assisting someone to die will be emotionally distressing. Piemonte went so far as to claim, "a broader look at the research surrounding physicians' psychological responses to suffering and death suggests that physicians are more fearful of death than either patients or persons in good health" (in Frank, 2018, p. 43).³⁰ The finding that MAiD evoked a sense of deep satisfaction is critical when considering that an alarming number of Canadian doctors (one in four) report burnout.³¹ An irony is that in current general practice, many physicians refer their patients to palliative specialists and in essence "give away" what could be one of the most rewarding aspects of care. Further research is needed to understand why family physicians may not lean into end-of-life conversations and care; we wonder about potential discomfort or a perceived lack of skill.

Our study participants were drawn to MAiD: holding the conviction of doing the right thing and having values and beliefs that align. Although the emotional challenges of end-of-life care are reported,^{32,33} there is also a growing interest in the potential positive effects for clinicians working in difficult situations including end of life and trauma.³² The findings from our study add to this growing body of knowledge by illustrating participants' experiences of compassion satisfaction through providing assisted dying.

These findings support research describing compassion satisfaction as stemming from emotional rewards when providing meaningful care to another,^{34,35} resulting in feelings of positivity and pleasure.³⁶ Stamm³⁴ suggested that compassion satisfaction can be an antidote to clinician burnout. In a recent study, Khoshnood et al.³⁷ found that MAiD providers also experienced the work as highly rewarding and believed that other physicians and the public were not ready to hear it. The findings from this study support this attitude of reticence alongside the view that MAiD provision is satisfying and personally sustaining.

Negotiating risks and challenges

Findings regarding the risk of physician vulnerability, fear of reprisals, and workload concerns are similar in the literature.^{27,37}

Khoshnood et al.³⁷ reported physicians' commitment to provide assisted dying despite the collegial, financial, and scheduling limitations they were facing. A recent Canadian study by Shaw et al.²⁷ identified similar challenges and pointed to a growing need to support physicians working in small communities and facing disapproval of MAiD from colleagues and faith-based institutions. In addition, nuanced support for physicians facing ethical-legal dilemmas that goes beyond "standard" advice from formal sources, such as the National Protective Society for Physicians, is needed. Findings point to perceptions of legal advice as conservative, risk averse, and often unhelpful when navigating complex cases. Consequently, physicians created networks among themselves to support their decision-making and practice, with similar findings shared by Shaw et al.²⁷ The clinical judgment required in determining eligibility for MAiD can be nuanced and has led to wide variability in opinions about when a person becomes eligible.³⁸ More research is needed into what resources would be helpful when facing complex cases rooted in unclear legal, moral, and ethical considerations. For example, if suffering was believed to be what the patient says it is,³⁹ and assessing "reasonably foreseeable death" was ambiguous, physicians must work through the risks of legal challenges alongside what they can personally live with.⁴⁰ A greater understanding of effective supports for physicians interested in becoming MAiD providers is essential. Without resources and supports, the pool of physicians willing to provide assisted dying will not keep pace with patient demand, and the risk of provider burnout may be inevitable.

Limitations

Interviews occurred in the first 2 years of assisted dying legislation being enacted (March–June 2018) and provided an early account of physicians' experiences as MAiD providers. The study was limited in its diversity of perspectives; we sought to recruit physicians who held objections to or moral conflicts with assisted dying but were unsuccessful in our efforts. Participants came from a single health authority where GPs provide assisted dying as sole practitioners. Consequently, we excluded nurse practitioners who were not serving in a provider role at that time in the health authority. Finally, sampling was purposive, and participants self-selected, which should be considered when interpreting these findings.

Closing thoughts

In this study, we addressed existing gaps in knowledge of how providers are making sense of and being affected by MAiD. Such evidence is vital for ensuring responsive, sustainable, and effective implementation of assisted dying. Overwhelmingly, the physician participants shared stories that conveyed how the rewards of the practice outweighed the risks and burdens. Participants related to the experience

as rediscovering the art of medicine in a way that was unexpectedly satisfying and meaningful, both professionally and personally.

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Declaration of conflicting interests

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

Ethical approval

Ethical approval for this study was obtained from *Island Health*, Health Research Ethics Board (HREB) (Certificate of Ethical Approval for Harmonized Minimal Risk Health Study, #J2017-102. Physicians Experiences of Assisted Dying) and also reviewed and approved by University of Victoria, in accordance with the *Tri-Council Policy Statement*.

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Informed consent

Written informed consent was obtained from most subjects before the study. Written consent was not possible for participants interviewed by phone. In this instance, verbal consent was obtained. The researcher conducting the interview reviewed the consent form and asked for verbal consent verbally, and this was recorded.

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References

1. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) (S.C. 2016, c. 3), http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html
2. College of Physicians and Surgeons of British Columbia (CPSBC). Practice standard: medical assistance in dying, 2019, <https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf>
3. Government of Canada. Third interim report on medical assistance in dying in Canada, 2018, <https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-june-2018.html> (accessed 8 October 2018).
4. Chochinov H and Frazee C. Finding a balance: Canada's law on medical assistance in dying. *Lancet* 2016; 388(10044): 543–545.
5. Upshur R. Unresolved issues in Canada's law on physician-assisted dying. *Lancet* 2016; 388(10044): 545–547.
6. Picard A. CMA poll finds rising support for medically assisted death. *The Globe and Mail*, 23 August 2017, <https://www.theglobeandmail.com/>
7. Falconer J, Couture F, Demir K, et al. Perceptions and intentions toward medical assistance in dying among Canadian medical students. *BMC Med Ethics* 2019; 20(1): 22.
8. Bouthillier M and Opatry L. A qualitative study of physicians' conscientious objections to medical aid in dying. *Palliat Med* 2019; 33(9): 1212–1220.
9. Fujioka J, Mirza R, McDonald P, et al. Implementation of medical assistance in dying: a scoping review of health care providers' perspectives. *J Pain Symptom Manage* 2018; 55(6): 1564–1576.
10. van Marwijk H, Haverkate I, van Royen P, et al. Impact of euthanasia on primary care physicians in the Netherlands. *Palliat Med* 2007; 21(7): 609–614.
11. Voorhees J, Rietjens J, van der Heide A, et al. Discussing physician-assisted dying: physicians' experiences in the United States and the Netherlands. *Gerontologist* 2014; 54(5): 808–817.
12. Brooks L. Health care provider experiences of and perspectives on medical assistance in dying: a scoping review of qualitative studies. *Can J Aging* 2019; 38(3): 384–396.
13. Georges J, The A, Onwuteaka-Philipsen BD, et al. Dealing with requests for euthanasia: a qualitative study investigating the experience of general practitioners. *J Med Ethics* 2008; 34(3): 150–155.
14. Dobscha S, Heintz R, Press N, et al. Oregon physicians' responses to requests for assisted suicide: a qualitative study. *J Palliat Med* 2004; 7(3): 451–461.
15. Haverkate I, van der Heide A, Onwuteaka-Philipsen BD, et al. The emotional impact on physicians of hastening the death of a patient. *Med J Aust* 2001; 175(10): 519–522.
16. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
17. Thorne S. *Interpretive description: qualitative research for applied practice*. New York: Routledge, 2016.
18. Government of Canada. *Tri-council policy statement: ethical conduct for research involving humans*, 2018, <https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf>
19. Buchman S. The doctor who took on death, 2017, <http://www.macleans.ca/society/the-doctor-who-took-on-death/>
20. Buchman S. Why I decided to provide assisted dying: it is truly patient centred care. *BMJ* 2019; 364: l412.
21. Evans S. *Medical assistance in dying: meet the physicians involved in this work*. Island Health, 2017, pp. 20–23, <http://viha.uberflip.com/i/804582-island-health-magazine-spring-2017>
22. Reid T. Reflections from a provider of medical assistance in dying. *Can Fam Physician* 2018; 64(9): 639–640.
23. Canadian Hospice Palliative Care Association (CHPCA). Palliative care and MAiD: co-existing in the new environment (survey report), 2018, http://www.virtualhospice.ca/Assets/MAiD_Report_Final_October_15_2018_20181218165246.pdf
24. Rousseau P. Unspoken words. *J Palliat Care* 2015; 31(4): 268–269.
25. Gillespie H, Kelly M, Gormley G, et al. How can tomorrow's doctors be more caring? A phenomenological investigation. *Med Educ* 2018; 52(10): 1052–1063.

26. Beach MC and Inui T. Relationship-centered care research network and the relationship-centered care research network. Relationship-centered care: a constructive reframing. *J Gen Intern Med* 2006; 21(Suppl. 1): 3–8.
27. Shaw J, Wiebe E, Nuhn A, et al. Providing medical assistance in dying: practice perspectives. *Can Fam Physician* 2018; 64(9): e394–e399.
28. Fong HJ and Longnecker N. Doctor-patient communication: a review. *Ochsner J* 2010; 10(1): 38–43.
29. Pandya S. Why do we need the humanities in medicine? *Neurol India* 2018; 66(3): 889–891.
30. Frank A. A medical pedagogy of mutual suffering. *Hastings Cent Rep* 2018; 48(5): 42–43.
31. Canadian Medical Association. *CMA National Physician Health Survey: a national snapshot*, 2018, <https://www.cma.ca/sites/default/files/pdf/Media-Releases/nph-survey-e.pdf>
32. Bybee S. Vicarious posttraumatic growth in end-of-life care: how filling gaps in knowledge can foster clinicians' growth. *J Soc Work End Life Palliat Care* 2018; 14(4): 257–273.
33. O'Mahony S, Gerhart JI, Grosse J, et al. Posttraumatic stress symptoms in palliative care professionals seeking mindfulness training: prevalence and vulnerability. *Palliat Med* 2016; 30(2): 189–192.
34. Stamm BH. Measuring compassion satisfaction as well as fatigue: developmental history of the compassion satisfaction and fatigue test. In: Figley CR (ed.) *Treating compassion fatigue*. New York: Brunner-Routledge, 2002, pp. 107–119.
35. Alkema K, Linton JM and Davies R. A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *J Soc Work End Life Palliat Care* 2008; 4(2): 101–119.
36. Montross-Thomas LP, Scheiber C, Meier EA, et al. Personally meaningful rituals: a way to increase compassion and decrease burnout among hospice staff and volunteers. *J Palliat Med* 2016; 19(10): 1043–1050.
37. Khoshnood N, Hopwood M, Lokuge B, et al. Exploring Canadian physicians' experiences providing medical assistance in dying: a qualitative study. *J Pain Symptom Manage* 2018; 56(2): 222–229, [https://www.jpmsjournal.com/article/S0885-3924\(18\)30239-2/pdf](https://www.jpmsjournal.com/article/S0885-3924(18)30239-2/pdf)
38. Downie J and Scallion K. Foreseeably unclear. The meaning of the “reasonably foreseeable” criterion for access to medical assistance in dying in Canada. *Dalhous Law J*, 2018, <http://dx.doi.org/10.2139/ssrn.3126871>
39. Schiller C, Pesut B, Roussel J, et al. But it's legal, isn't it? Law and ethics in nursing practice related to medical assistance in dying. *Nurs Philos* 2019; 20(4): e12277.
40. Petropanagos A. Conscientious objection to medical assistance in dying [MAiD], 2019, <http://www.royalcollege.ca/rcsite/bioethics/cases/section-5/conscientious-objection-medical-assistance-e>