

Original Article

Exploring Canadian Physicians' Experiences Providing Medical Assistance in Dying: A Qualitative Study



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Abstract

Context. Medical assistance in dying (MAiD) allows a practitioner to administer or prescribe medication for the purpose of ending a patient's life. In 2016, Canada was the latest country, following several European countries and American states, to legalize physician-assisted death. Although some studies report on physicians' attitudes toward MAiD or describe patient characteristics, there are few studies that explore the professional challenges faced by physicians who provide MAiD.

Objectives. The objective of the study was to explore the professional challenges faced by Canadian physicians who provide MAiD.

Methods. Sixteen physicians from across Canada who provide MAiD completed in-depth, semistructured telephone interviews. An inductive thematic analysis approach guided data collection and the iterative, interpretive analysis of interview transcripts. Three members of the research team systematically co-coded interview transcripts, and the emerging themes were developed with the broader research team. NVivo was used to manage the coded data.

Results. Participants described three challenges associated with providing MAiD: 1) their relationships with other MAiD providers were enhanced and relationships with objecting colleagues were sometimes strained; 2) they received inadequate financial compensation for time, and 3) they experienced increased workload, resulting in sacrifices to personal time. Although these providers did not intend to stop providing MAiD at the time of the interview, they indicated their concerns about whether they would be able to sustain this service over time.

Conclusion. Physicians described relationship, financial, and workload challenges to providing MAiD. We provide several recommendations to address these challenges and help ensure the sustainability of MAiD in countries that provide this service. *J Pain Symptom Manage* 2018;56:222–229. © 2018 The Authors. Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Key Words

Suicide, assisted, euthanasia, physicians, Canada, workload, qualitative study

Introduction

In Canada, medical assistance in dying (MAiD) includes circumstances in which a physician or nurse practitioner (“practitioner”), at an individual’s

request, administers medication to cause death (also known as euthanasia) or when a person self-administers medication prescribed with the intent of causing their own death (also known as physician-

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assisted suicide).¹ Historically, it has been a crime in Canada to assist another person with ending their life. However, on February 6, 2015, the Supreme Court of Canada, in the case of *Carter v. Canada*,² determined that an absolute prohibition of MAiD was unconstitutional. MAiD was legalized throughout Canada on June 17 2016.³ Patients can request MAiD from their practitioner or directly from a provincial or territorial end-of-life care service.⁴ If a practitioner declines to provide MAiD, patients are required to make an effective referral to another practitioner or agency. Two practitioners must independently assess and confirm a patient's eligibility for MAiD. Patients are eligible if they are aged 18 years or older, are eligible for health services in Canada, are capable of making health care decisions and providing voluntarily consent, and have a grievous and irremediable medical condition with a reasonably foreseeable death. There is a 10-day grace period from when the patient makes the written request to when the procedure can be completed.¹ Although the legislation allows for physicians and nurse practitioners to provide MAiD, at the time this article was written, physicians had provided the service in 96% of all cases.⁵ As such, we focus on physicians' early experiences after the legalization of MAiD.

Despite having been practiced in a number of countries since 2002,⁶ a literature search of physicians' experiences and assisted death or euthanasia revealed a paucity of research examining physicians' experiences with providing MAiD or physician-assisted suicide. A majority of the studies identified focused on the complex ethical considerations and emotional impact associated with the provision of MAiD.⁶⁻¹¹ Although a few studies briefly reported the impacts of MAiD provision on clinical practice, we did not identify any studies that purposefully performed an in-depth investigation of the professional experiences of MAiD providers. In one study from Oregon, some physicians reported that at least one patient had left his/her practices based on his/her positions on assisted suicide.¹¹ Another study from Oregon reported that assisted suicide cases required a substantial time commitment.⁷ Before the legislation of MAiD in Canada, 82% of surveyed physicians and 72% of surveyed allied health providers who treated patients with amyotrophic lateral sclerosis felt unprepared for delivering MAiD and indicated a desire for training modules and guidelines.¹² Finally, a recent cost-analysis suggested that MAiD could result in substantial savings to the Canadian health care system¹³; however, the direct impacts on physician finances and practice workload have not been documented.

Since the implementation of the legislation is in its nascency, understanding how providing MAiD impacts practitioners is integral to the optimal delivery of

MAiD. This article is part of a broader study investigating the overall experiences of Canadian MAiD providers. The questions guiding this article are as follows: What are the professional challenges experienced by physicians who provide MAiD, and how do they influence the sustainability of this service? Given that there is limited literature about MAiD practice in Canada, we chose a qualitative approach because this method is well suited for the exploration of empirical phenomena that are underexplored, evolving, and context specific.

Methods

Design

This qualitative study used an inductive thematic analysis approach to generate a detailed description and interpretation of physicians' experiences when providing MAiD.¹⁴ We conducted semistructured interviews to allow for a more naturalistic exploration of experiences or concepts. At the time of data collection, both of the principal investigators (M.-C. H. and N. K.) practiced palliative medicine with a home-based palliative care center in Toronto, Ontario. Both principal investigators support and provide MAiD as a part of their practice. As such, they have a normative stance toward assisted dying, which guided their analysis and interpretation of the data and the recommendations that are made.

Sampling and Recruitment

To ensure a diverse and rich participant pool, we purposively selected participants who had experience with MAiD from across Canada. Owing to the sensitivity surrounding public opinions about MAiD, the initial identification of participants was a challenge as there was some reluctance about being identified as a MAiD provider. In addition, some provinces had one or no MAiD cases, which limited the number of providers eligible for recruitment. Our recruitment strategy included two modes of identification. First, the principal investigators (M.-C. H. and N. K.) invited colleagues through phone, through e-mail, or in person. These colleagues were aware that the investigators were palliative care physicians who provided MAiD. Second, Dying with Dignity Canada and regional health authorities from Saskatchewan and Manitoba each sent e-mail invitations to their member physicians who could self-identify to the study's investigators for participation. In one instance, a participant identified an eligible physician to participate in the study. All participants were aware that the investigators were researchers affiliated with a Toronto-based palliative care center.

Participants were included if they were licensed to practice medicine in Canada and were present for at

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