Medical Assistance in Dying: Alberta Approach and Policy Analysis

James L. Silvius,[1] Ameera Memon,[2] and Mubashir Arain[2]

RÉSUMÉ

La légalisation de l'aide médicale à mourir (AMM) au Canada a permis aux médecins, aux décideurs politiques et aux patients de réexaminer les soins de fin de vie. Cet article présente les principales caractéristiques du programme albertain d'AMM, dans le contexte des programmes d'AMM mis en place dans les autres provinces. Nous avons également comparé les politiques et les pratiques en matière d'AMM dans différentes provinces et territoires du Canada. De plus, nous avons utilisé la base de données de l'AMM de l'Alberta pour dresser un portrait des données démographiques sur les patients et l'accès aux services d'AMM en Alberta en 2017-2018. Des différences significatives ont été relevées dans les processus et les pratiques des divers programmes provinciaux et territoriaux d'AMM. Les programmes de l'Alberta, de l'Ontario et du Québec sont plus complets. L'Alberta a mis en place des ressources dédiées pour l'AMM. L'âge médian des personnes qui ont reçu des services d'AMM en Alberta de juillet 2017 à avril 2018 était de 70 ans. Les bénéficiaires étaient majoritairement des hommes (55 %) et des patients ayant un cancer (70 %). Environ 39 % des prestations d'AMM ont été réalisées en milieu hospitalier et 38 % au domicile des patients.

Nous concluons avec quelques recommandations sur le développement, la mise en œuvre et l'évaluation du programme d'AMM, en nous fondant sur l'expérience de l'Alberta dans ce domaine au cours des deux dernières années.

ABSTRACT

The legalization of medical assistance in dying (MAID) in Canada has presented an opportunity for physicians, policy makers, and patients to rethink end-of-life care. This article reviews the key features of the Alberta MAID framework and puts it in the context of other provinces and their MAID programs. We also compared policies and MAID practices in different provinces/territories of Canada. In addition, we used the Alberta MAID database to provide the current state of patient demographics and access to MAID services in Alberta in 2017–2018. Significant differences were identified between provincial/territorial MAID program processes and practices. Alberta, Ontario, and Quebec have more comprehensive frameworks. Alberta has dedicated resources to the support of MAID. The median age of those who received MAID service in Alberta from July 2017 to April 2018 was 70 years; a higher proportion were males (55%) and the majority included patients with a cancer diagnosis (70%). Approximately 39 per cent of MAID events happened in a hospital setting, and 38 per cent occurred in patients' homes. We have presented some recommendations on MAID program development, implementation, and review based on Alberta's experience with MAID over the past two years.

[1] Alberta Health Services, Seniors Health Strategic Clinical Networks, Calgary, Alberta, Canada.

[2] Alberta Health Services, Health Systems Evaluation and Evidence, Calgary, Alberta, Canada.

* The authors of this study thank Melonie Keehn for help with data management.

Manuscript received: / manuscrit reçu : 30/11/18

Manuscript accepted: / manuscrit accepté : 12/02/19

Mots-clés : vieillissement, aide médicale à mourir, euthanasie, suicide assisté, soins de fin de vie, choix de fin de vie

Keywords: aging, medical assistance in dying, euthanasia, assisted suicide, end-of-life care, end-of- life choice

La correspondance et les demandes de tirés-à-part doivent être adressées à : / Correspondence and requests for offprints should be sent to:

Mubashir Arain, PhD.
Health Systems Evaluation and Evidence
Innovation and Research Management
Systems Innovations and Programs
Alberta Health Services
10301 Southport Lane SW
Calgary, AB T2W 1S7
Canada
(mubashiraslam.arain@ahs.ca)

doi:10.1017/S0714980819000175

Introduction

Canada's population is aging, bringing many challenges and repositioning many practitioners from across the health care spectrum to focus on supporting older persons (Statistics Canada, 2016). For those who are experiencing chronic conditions or end-of-life issues, the focus shifts to palliative and other end-of-life care services including medical assistance in dying (MAID) practices (Truog et al., 2001). MAID may include either self-administration or practitioner-administration of drugs deliberately intended to end life. MAID practices are consistent with a patient-centred approach and allow patients to exercise autonomy in end-of-life decision making.

Literature shows that the offering of MAID practices allows some patients to feel a greater sense of control and autonomy over their personal outcomes (Dying with Dignity Canada, 2016; Karsoho Fishman, Wright, & Macdonald, 2016; Wilson et al., 2007). Moreover, allowing MAID to be provided at home can further help these individuals to feel comfortable and in control (Wilson et al., 2007). Although provision of service within a health care environment allows for stricter institutional control, the sense of personal control and comfort in a home environment may reinforce patient dignity (Li et al., 2017).

Assisted death has been a long-standing issue of debate among policy makers, practitioners and Canadians. An overall shift in health care to patient-centred care and the recognition of patient autonomy as a pre-eminent value has fueled the conversation and created the impetus for legalization of MAID practices. This led the Supreme Court of Canada (SCC), on February 6, 2015, to unanimously rule in favour of legalization of MAID practices (Supreme Court of Canada, 2015). The court left it to the federal government as to whether or not formal changes to the Criminal Code of Canada would be legislated, but gave the government a year to do so.

Canada is one of more than 20 governments that have legalized MAID practices (Tretyakov & Cohen, 2016). Canada joins other European countries including The Netherlands, Switzerland, Belgium, Luxembourg, and Germany as well as a number of American states and the District of Columbia in this decision (Li et al., 2017). The Netherlands, Belgium, and Oregon have been active leaders in this area internationally.

The legalization of MAID in Canada came with significant ambiguity for health care administrators, clinicians, and regulatory bodies. While requests for MAID were being received, there was limited guidance to implement, fund, and monitor those requests and services. Health care authorities were attempting to respect patient autonomy and dignity while at the same time ensuring the right to conscientious objection for health care providers (Canadian Medical Association, 2017). Conscientious objection to MAID is the option for a practitioner to refuse to become involved in delivering MAID services to patients (Landry, Foreman, & Kekewich, 2015). Although surveys suggest that a majority of medical practitioners and hospitals do not object to MAID, some are in disagreement or discomfited with the MAID practice (Braverman, Marcus, Wakim, Mercurio, & Kopf, 2017). Alberta Health found similar sentiments in their extensive consultations with physicians and the public (Alberta Health, 2016).

This article presents the key highlights and features of the Alberta MAID framework. Alberta was one of the first few provinces to develop a comprehensive MAID framework following the 2015 Supreme Court ruling and the author (J.L.S.) received Canadian Medical Association Dr. William Marsden Award in Medical Ethics for establishing MAID in Alberta (Global News, 2017). Our focus is to highlight what Alberta has done differently to achieve one of the most successful MAID programs in Canada.

Approach

Alberta Health Services (AHS) delivers health services to more than 4,000,000 people living in Alberta and to some areas in British Columbia, the Northwest Territories, and Saskatchewan (Silvius, 2017). The development and implementation of the MAID framework was an extensive undertaking including key stakeholder consultations, review of the literature, development of resources, and the implementation of the process. Over a very short period, a core group of practitioners created a single province-wide framework and process for patient assessment and provision of the service to ensure equitable access and consistent care across the province, both within AHS and in the community. The core group consulted with Alberta Health, the College of Physicians and Surgeons of Alberta, individual physicians, the Alberta College of Pharmacists, the College and Association of Registered Nurses of Alberta, and other health professional colleges for implementation.

The Alberta MAID framework developed includes a comprehensive policy, a comprehensive clinical guide with five distinct phases, and the Care Coordination Service (CCS). The guide identifies that individuals will pass in a non-linear fashion through these phases as they contemplate, determine actions, and make decisions to access these services. The MAID framework also includes a structured care pathway; a visual guide (placemat); and educational resources for professional

https://doi.org/10.1017/S0714980819000175 Published online by Cambridge University Press

staff, patients, and families to guide communication and process for practitioners and patients involved in MAID. In addition, AHS developed specific education for practitioners involved in MAID services including the MAID online modules, and dedicated significant resources to the development of a MAID Web site.

Literature Search Strategy

Our search strategy was adapted from a comparative policy analysis protocol as suggested by Mallinson, Misfeldt, Boakye, Suter, & Wong (2017). Our goal was to identify pertinent literature and reports that describe the development of MAID across Alberta and MAID services as implemented across Canada.

Health care across Canada is the responsibility of the provincial and territorial governments and varies significantly across the country. With these significant differences in structure and resources, we expected to find a variety of materials as potentially relevant documents including articles, presentations, and sections from relevant policy documents, opinion papers, and official guidelines or standards of practice. PubMed and Cumulative Index of Nursing and Allied Health Literature (CINAHL) databases were searched for articles from January 2007 to January 2018. We supplemented the electronic search with extensive grey literature searches, conference abstracts from ethics and health system conferences, technical reports of MAID protocols, and institutional policies for MAID.

For grey literature, we used snowball sampling (such as pursuing references of references) to locate potentially relevant materials on MAID services in Canada. We reviewed key articles and dispersed the searches across Web sites, including the Health Council of Canada, Canadian Mental Health Association, the Government of Canada, and the Canadian Medical Association. We searched earlier reports and grey literature for information about MAID frameworks or standards of practice offered in each province and territory. We included literature, articles, and reports that describe the provision of MAID by either assisted suicide or voluntary euthanasia for adults over 18 years of age. We included technical reports, institutional policies, clinical practice guidelines, and clinical studies (case reports, observational studies or quantitative/qualitative studies). We excluded reports describing other end-of-life practices, including withholding or withdrawing of life-sustaining treatment, palliative sedation, or unintentional hastening of death via medications for symptom management. We did not include opinion papers, newspaper articles, or blog posts. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram shows the results of our literature search (Figure 1).

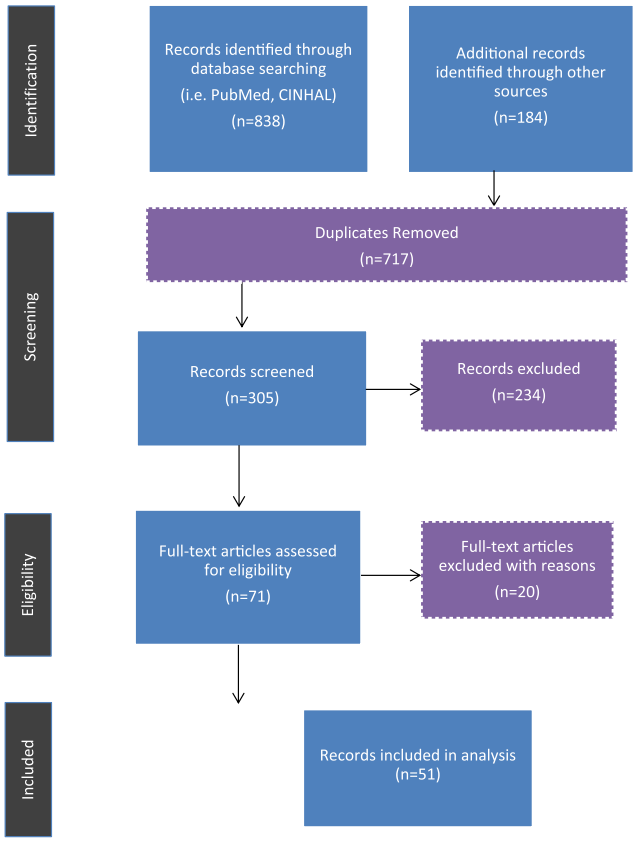

Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram showing literature search for medical assistance in dying

Alberta MAID database

Alberta receives a number of patient inquiries for MAID, which are recorded in a database. The purpose of the database is to record all inquiries and requests related to MAID along with demographic information of patients.

Data Analysis

The quantitative data collected from MAID database were analysed using descriptive and inferential statistics. All analyses excluded missing data. We used the t-test and χ^2 test analysis to determine if there were significant differences; Mann–Whitney U test was used for skewed data. SPSS version 19 was used for statistical analysis; p value < .05 was considered as significant.

The literature synthesis was mainly focused on extracting information related to existing MAID policies, including any commonalities and differences, and any general conclusions regarding the development and implementation of MAID frameworks. A variety of resources was considered in the review and documented using data extraction matrices. These extractions

https://doi.org/10.1017/S0714980819000175 Published online by Cambridge University Press

included information about the source (e.g., author's name, article title, publication year, main purpose, target audience, type of source, variables or key indicators, results/main themes, and any conclusions or recommendations). We did not intend to cover the entire record of MAID literature and practices in detail.

Results

Key Features of the AHS MAID Program

A key feature of Alberta's response to the new legislation was creating a single point of contact for patients, families, and health care providers through the MAID CCS (Table 1). Alberta was the first jurisdiction to create this service; others have, or are looking at, a similar model. This unique coordinating body is available to support patients, families, and care teams through the process of MAID, and serves as the central resource for consultants, transfers, forms, information, colleagues, and pharmacists. The CCS is accessible to all Albertans without referral. This approach supports patient-centred thinking, which increases access for the patient and ensures that the patient is well cared for while balancing the rights and values of a practitioner who may not be willing to participate.

A comprehensive education program and resources about end-of life care and communication are also available through the MAID program for professional development. Medical practitioners play a key role in alleviating the anxiety patients and family members may have about the MAID process. Recognition of communication and teamwork skills in this area can better prepare medical practitioners when delivering MAID; including knowing how to support and counsel patients and families, sensitivity in communication, and ensuring respect for a variety of religious and cultural beliefs. Research from the United States suggests that a "structured bereavement program" for clinicians may be an additional resource for clinicians and families to reflect on their experiences about the quality of care, successes, and challenges (Truog et al., 2001).

MAID Service Delivery

In compliance with federal legislation, Alberta requires that at least two physicians or nurse practitioners skilled in assessing patients' prognosis, suffering, and capacity complete independent assessments. By design, these assessments are kept entirely separate. Specific forms are available to help guide the components of the assessments. Both assessors must agree on the conclusions of their assessments to either provide or decline MAID. Disagreements between the two assessors are resolved through subsequent discussion, and experience has shown that decisions may go either way. Capacity to provide informed consent is assessed at defined points in time to ensure that the patient is willingly agreeing to seek MAID, including at the time of signing the request form, the assessments, and immediately prior to MAID delivery.

As part of a patient-centred care approach, the implementation of MAID services in Alberta is culturally sensitive. Patients are given every opportunity to experience spiritual meaning and fulfillment including the involvement of clergy and end-of-life rites at the bedside. Additionally, Alberta offers the opportunity to complete MAID in the patient's home. Research shows that environment can play an important role in promoting the patient's comfort at end-of-life (Georges et al., 2007), suggesting that returning to a more familiar (and possibly more private) setting is ideal. This transfer may also support less technology use and cost.

It is interesting to consider other safeguards not included in the Alberta MAID framework. For example, in British Columbia, one out of two MAID assessments may be completed by telehealth technology; however, another "regulated health professional" must be in attendance with the patient to bear witness

Table 1: Key features of the Alberta MAID policy/program

Resource/Tools	Purpose	Target Audience
Clinical guide	Identifies five distinct phases of contemplation, determination of action,. and decision making for individuals	Patients, providers
Care coordination services	Single point of contact to support patients, families, and care teams through the process of MAID Central resource for consultants, transfers, forms, information, colleagues, and pharmacists.	Patients, providers, family/ caregivers
MAID database	Data monitoring and quality assurance; reports generated from the database are provided for quality assurance and monitoring purposes	Providers, researchers, policy makers
MAID online modules	Guide education and professional development about end–of-life care and communication for MAID services	Providers, patients and families

Note. **MAID = medical assistance in dying.**

https://doi.org/10.1017/S0714980819000175 Published online by Cambridge University Press

to the assessment (College of Physicians and Surgeons of British Columbia, 2016).

Data Reporting and Monitoring

Data monitoring and reporting is of critical importance in documenting the successes and challenges of the MAID program in Alberta. The CCS maintains a MAID database as part of data monitoring and quality assurance. Reports generated from the database are provided for quality assurance and monitoring purposes. Ontario, Quebec, and Manitoba have developed their own distinct data management programs for this purpose.

Findings from Alberta MAID database

Table 2 provides a description of MAID requests and inquiries from July 2017 to April 2018. Of the 555 inquiries, 306 inquiries were requests for MAID and 231 were inquiries for information only. Eighteen inquiries had missing data; the nature of their request was unclear. The median age for those who made MAID requests was 70 with 55.3 per cent of persons being male. A large proportion of patients had a diagnosis of cancer. The primary diagnosis types included cancer (70%), neurodegenerative disease (10.4%), cardiovascular disease (4.3%), respiratory disease (6.0%), and other disorders (9.7%). Other diagnoses included paranoid schizophrenic disorder, and severe pain.

Table 2: Alberta MAID metrics for MAID inquiries (July 1, 2017–April 4, 2018)

Clinical Characteristics	MAID Requests	Inquiry Only
Number of requests	306	231
Median age (range), years	70.00 (63–79)	70.00 (58–82)
Gender, no. (%)		
Male	167 (55.3%)	118 (52.4%)
Female	135 (44.7%)	107 (47.6%)
Cancer diagnosis	202 (70.0%)	80 (52.3%)
Urban vs. rural [a] (*n*=184)		NA
Urban	117 (64%)	
Rural	67 (36%)	
Location of services (*n*=184)		NA
In hospital	49 (38.9%)	
Patient's home	48 (38.1%)	
LTC/ nursing home/ hospice	19 (15.1%)	
Other	10 (7.9%)	

Note. **[a] The rural–urban classifications used in this article are based on the Alberta Health Services (AHS) /Alberta Health (AH) Official Standard Geographies as produced by Geographic Area Working Group (GWG). The GWG was a pan-provincial group that included representation from multiple AHS portfolios as well as AH. These individuals established principles, guidelines, and standards as well as adopting standard methodologies and evidence-based approaches to construct all geographic areas in 2010. These rural–urban continuum areas are up to date as of January 2018. MAID = medical assistance in dying.**

Out of these requests, 174 were approved and a scheduled procedure date was provided. Seventeen of these requests were not completed for reasons including withdrawal of request, death prior to procedure date, loss of capacity, or other reasons. Overall, 28.2 per cent (157 of 555) of the individuals who inquired about MAID received the service. All MAID deaths were clinician- administered deaths. The median age was significantly higher for those whose request for MAID was approved compared with those that were unapproved (Table 3). MAID requests by females were 1.5 times more likely to be approved than requests by males. No significant differences were seen in approval rates between urban and rural areas. Although we cannot determine causal relationships with this small data set, this suggests an interesting trend in how MAID services have been accessed and utilized.

Cross-jurisdictional comparisons

Tables 4 and 5 show our findings from the comparative policy analysis of MAID practices in Canada. From this search, we developed a policy matrix with the key features and gaps in policies across Canada. Each province has developed a distinct resource model for service delivery for MAID, with a few provinces dedicating specific resources for the service as a central point of contact whereas others incorporate these practices as part of existing practitioner workloads. The tables also reflect potential gaps where specific provinces may need to develop their own resources and policies for improved implementation. Another clear distinction is the availability of the patient care pathway. Alberta, Ontario, New Brunswick, Newfoundland, and Prince Edward Island have some form of patient care pathway widely accessible; however, none is as directive and specific as that of Alberta. This resource may help mitigate any anxieties in the process for patients and families as they consider MAID as part of end-of-life services.

Our analysis suggests that differences lie in the development, key features, and monitoring of outcomes of the individual MAID policies or programs. These differences, we believe, are based on factors of environment and context, identified performance indicators, population values, interests, and resources available in each region.

Discussion

Over the past two years, MAID programs across Canada have been developed and implemented in

https://doi.org/10.1017/S0714980819000175 Published online by Cambridge University Press

Table 3: Comparing the characteristics of patients who requested MAID (July 1, 2017 – April 4, 2018)

Clinical Characteristics	Approved	Did not Meet Criteria	χ^2 Statistics	*p* Value	Odds Ratio (CI)
Median age (interquartile range), years	72.00 (Range 63–81) *n* = 151	68.00 (Range 62–77) *n* = 125	2.31*	.02	—
Gender, no. (%)			3.70	.05	1.59 (.99–2.55)
Male	79 (49.7%)	80 (50.3%)			
Female	77 (61.1%)	49 (38.9%)			
Cancer diagnosis			.14	.70	1.11 (.66–1.85)
	(*n* = 155)	(*n* = 117)			
	108 (69.7%)	79 (67.5%)			
Urban vs. rural			1.00	.32	.55 (.30–1.02)
Urban	58 (65.2%)	41 (50.6%)			
Rural	31 (34.8%)	40 (49.4%)			
Location of services			4.78	.19	—
In hospital	21 (31.8%)	24 (45.3%)			
Patient's home	25 (37.9%)	21 (39.6%)			
LTC/ nursing home/ hospice	12 (18.2%)	6 (11.3%)			
Other	8 (12.1%)	2 (3.8%)			

***Note.** Z score, based on Mann–Whitney *U* test. *p* values were calculated using 95% confidence level. MAID = medical assistance in dying, CI = confidence interval, LTC = long-term care.**

varying fashion. The Canadian legislation to legalize MAID services and expert advisory communities of practice have generally informed the processes for each province. However, in spite of the work by the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (2015), there are no common definitive strategies related to the implementation of MAID. The consistent themes that we found across MAID programs in different regions include: (1) protection of rights of vulnerable patients, (2) recommendation for family involvement, (3) right to confidentiality, (4) privacy of information, (5) recognition of conscientious objection, (6) right to practice rituals and cultural beliefs, and (7) need for sensitive and compassionate communication among medical practitioners, patients, and families. However, there are a number of key differences in implementation of MAID programs across Canada.

Our findings emphasize the importance of stakeholder engagement and consultation for a clearly defined policy and implementation for MAID. In Alberta, the intent was to develop one system for all of Alberta, whether within AHS or outside of AHS facilities and programs. The collaborative development with external partners of a written MAID policy framework, detailed guideline, and care pathway was key to supporting the consistent implementation across a large population base; these documents provide directive and detailed guidance to medical practitioners involved in MAID. Overall, Alberta, Ontario, and Quebec have provided comprehensive process pathways and monitoring measures to implement MAID services. Other provinces such as Saskatchewan, Nova Scotia, and British Columbia have indicated that their comprehensive policies are in the works and refer to standards developed either by their colleges of physicians and surgeons or by AHS. A policy framework acts as a check and balance to provide a consistent and appropriate delivery of MAID. Education about the framework and its dissemination also support the consistent and accurate delivery of services.

The primary stakeholders and players involved in developing the MAID frameworks differed according to the region. For example, in Alberta, AHS, the central health authority, was a key player in the development of the MAID policy, whereas in Saskatchewan, the College of Physicians and Surgeons was the primary player. Ontario commissioned a consulting group to develop an aggregated policy and framework that can be applied across all public health regions in Ontario. Although these differences are contextual, we found (according to the Alberta experience) that where provincial institutions or health authorities play a central role in all stages of the development process, they can support strong mechanisms, including financing, that strengthen consistency and coordination.

Limitations

A few limitations need to be considered when interpreting findings from this article. First, we reported those individuals who received MAID services and received a procedure date; however, some individuals dropped out of the program because of early death or for other reasons. Second, although we used a systematic approach to consider the various features of MAID policies in Canada, comparisons are difficult because of the differences among provincial

https://doi.org/10.1017/S0714980819000175 Published online by Cambridge University Press

Table 4: Characteristics of MAID services across Canada

Characteristics of Policy	BC	AB	SK	MB	QC	ON	NS	NB	NL	PE	YT	NT/NU
Health authority	6 health authorities	Alberta Health Services	Saskatchewan Health Authority, formerly 12 regional health authorities	6 regional health regions	18 health regions	14 health integration networks	Nova Scotia Health Authority	2 health networks	4 health authorities	Health PEI	Yukon Territory Health Region	8 NWT health authorities, Nunavut Health Region
Lead organization	College of Physician and Surgeons of BC and College of Registered Nurses of BC	Alberta Health Services	Saskatchewan Ministry of Health; College of Physicians Saskatchewan Medical Association; Registered Nurses Association Saskatchewan; College of Pharmacy Professionals	Winnipeg Regional Health Authority	College des Medecins du Quebec; Federation medicale etudiante du Quebec	Centre for Effective Practice	College of Physicians and Surgeons of NS; College of Registered Nurses Nova Scotia	Horizon Health Network; Vitalite Health Network	College of Physicians and Surgeons of Newfoundland and Labrador	College of Physicians and Surgeons	Yukon Medical Council	Government of Northwest Territories
Provincial document	Professional standards of practice from regulatory bodies	Provincial regulatory framework, policy, clinical guidelines	Guidelines	Schedule M guidelines	Act, practice guidelines	Act, regulatory body requirement, central MAID resource	Professional Standards	Recommendations	Standard of practice	Legislation, standard of practice	Policy, transdisciplinary manual	Policy, guidelines
Date when the policy first introduced	June 23, 2016; revised April 28, 2017	February 6, 2016; revised June 27, 2016; revised on August 29, 2018	September 17, 2016; revised March 24, 2017; revision scheduled for September 17, 2019	July 14, 2016; revised July 20, 2017	June 10, 2014; revised October 1, 2017	May 10, 2017; revised November 2016	June 2016; revised July 6, 2016	June 17, 2016; revision date: NA	March 29, 2016 Revision date: NA	September 27, 2016; revision date: NA	July 16, 2016; revised January 11, 2017	June 17, 2016; revision date: NA

Note. **MAID = medical assistance in dying, BC = British Columbia, AB = Alberta, SK = Saskatchewan, MB = Manitoba, QC = Quebec, ON = Ontario, NS = Nova Scotia, NB = New Brunswick, NL = Newfoundland and Labrador, PE = Prince Edward Island, YT = Yukon, NT = Northwest Territories, NU = Nunavut.**

Table 5: Policy comparison of medical assistance in dying (MAID) services across Canada

Implementation of Policy	BC	AB	SK	MB	QC	ON	NS	NB	NL	PE	YT	NT/NU
Definition of MAID team (e.g. first point of contact; pharmacists, nurses, and nurse practitioners [NPs])	–	Care coordination services	–	Clinical team	–	Care team	–	–	–	–	Care coordinator and physician	Central coordinating service
Process pathway	–	✓	✓	✓	✓	✓	✓	–	✓	–	✓	✓
Pharmaceutical instructions	Pre-printed prescription order form as part of guidelines with the College of Pharmacists of BC	Not available publicly; (standardized prescription form)	–	Not available publicly; (standardized prescription form)	✓	–	–	–	–	Not available publicly; (standardized prescription form)	–	MAID interim pharmacy protocols
Oversight mechanism (e.g. monitoring accountability structures)	–	✓	–	✓	✓	✓	✓	–	✓	Refer to SCC oversight	Refer to SCC oversight	✓
Supports for professionals (financial, infrastructure, resources)	✓	✓	–	✓	✓	✓	✓	–	✓	✓	–	✓
Assessment	MP and NP	1st: MP and NP 2nd: MP and NP	MP and NP	MP, nurse, and SW	PO	MP and NP	MP and NP	MP and NP	PO	MP and NP	MP and NP	MP and NP
Patient pathway	Interior Health adapted AHS pathway	✓	–	–	–	Patient fact sheet but no step by step pathway	–	✓	✓	✓	Refer to legislative body	✓

Note. **MP = medical practitioner, SW = social worker, PO = physician only, BC = British Columbia, AB = Alberta, SK = Saskatchewan, MB = Manitoba, QC = Quebec, ON = Ontario, NS = Nova Scotia, NB = New Brunswick, NL = Newfoundland and Labrador, PE = Prince Edward Island, YT = Yukon, NT = Northwest Territories, NU = Nunavut, SCC = Supreme Court of Canada.**

health care structures and the populations served by each health authority.

Conclusions and Recommendations

A range of policies and frameworks are currently in use to support and guide the implementation of the MAID legislation across Canada. It is clear that although legislation serves as the supporting backdrop for most policies, the implementation of these policies and strategies differs significantly across Canada.

The AHS MAID framework was established as a province-wide policy, as well as guidelines and processes to deliver MAID services equitably and effectively across the province of Alberta. The development of the Alberta MAID program was resource intensive; its sustainability and maintenance largely involves utilizing resources of the existing health care system in Alberta.

The following recommendations are based on the comparison of approaches and policies of MAID:

Development of a MAID Framework

- Engage stakeholders (e.g., health care providers, policy makers, patients, and family members) and appropriate regulatory bodies in the development of a consistent MAID framework.
- Assign a dedicated team of professionals to act as the first point of contact for those considering MAID as part of their end-of-life care.
- Consider cultural aspects in the development and implementation of MAID services.

Implementation and Uptake

- Provide clinical teams with effective dissemination and feedback loops to encourage knowledge transfer and uptake.
- Provide learning resources and capacity-building opportunities for health care provider such as webinars or online modules.
- Incorporate standards and expectations that support patient-centred care and practitioner support.

Reporting and Outcomes Review

- Establish safeguards related to MAID independent assessments.
- Identify key indicators for reporting and data collection requirements.
- Provide clear opportunities for bereavement and loss support for clinicians as well as opportunities for reflection on practice.

References

Alberta Health. (2016). What we heard: Medical assistance in dying PDF file. Retrieved 28 March 2019 from https://open.alberta.ca/publications/what-we-heard-medical-assistance-in-dying

Braverman, D. W., Marcus, B. S., Wakim, P. G., Mercurio, M. R., & Kopf, G. S. (2017). Health care professionals' attitudes about physician-assisted death: An analysis of their justifications and the roles of terminology and patient competency. *Journal of Pain and Symptom Management*, *54*(4), 538–545. doi: 10.1016/j.jpainsymman.2017.07.024

Canadian Medical Association. (2017). A Canadian approach to assisted dying. A CMA member dialogue summary report. Retrieved 28 March 2019 from https://legacy.cma.ca//Assets/assets-library/document/en/advocacy/Canadian-Approach-Assisted-Dying-e.pdf

College of Physicians and Surgeons of British Columbia. (2016). Professional standards and guidelines—Medical assistance in dying April 2017. Retrieved 28 March 2019 from https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf

Dying with Dignity Canada. (2016). A proposed framework for physician assisted dying. Retrieved 10 April 2019 from https://www.dyingwithdignity.ca/principles_for_legislation

Geographic Area Working Group (GWG). (2010). Official standard geographic areas. Alberta Health Services/Alberta Health. Retrieved 28 March 2019 from https://open.alberta.ca/dataset/a14b50c9-94b2-4024-8ee5-c13fb70abb4a/resource/70fd0f2c-5a7c-45a3-bdaa-e1b4f4c5d9a4/download/Official-Standard-Geographic-Area-Document.pdf

Georges, J. J., Onwuteaka-Philipsen, B. D., Muller, M. T., Van der Wal, G., Van der Heide, A., & Van der Maas, P. J. (2007). Relatives' perspective on the terminally ill patients who died after euthanasia or physician-assisted suicide: A retrospective cross-sectional interview study in the Netherlands. *Death Studies*, *31*(1), 1–5. doi: 10.1080/07481180600985041

Global News. (2017). Alberta doctor receives award for role in developing medically assisted dying framework. Retrieved 28 March 2019 from https://globalnews.ca/news/3493359/alberta-doctor-receives-award-for-role-in-developing-medically-assisted-dying-framework/

Karsoho, H., Fishman, J. R., Wright, D. K., & Macdonald, M. E. (2016). Suffering and medicalization at the end of life: The case of physician-assisted dying. *Social Science & Medicine*, *170*, 188–96. https://doi.org/10.1016/j.socscimed.2016.10.010

Li, M., Watt, S., Escaf, M., Gardam, M., Heesters, A., O'Leary, G., et al. (2017). Medical assistance in dying—Implementing a hospital-based program in Canada. *New England Journal of Medicine*, *376*(21), 2082–2088. doi: 10.1056/NEJMms1700606

Landry, J. T., Foreman, T., & Kekewich, M. (2015). Ethical considerations in the regulation of euthanasia and physician-assisted death in Canada. *Health Policy*, *119*(11), 1490–1498. doi: 10.1016/j.healthpol.2015.10.002

Mallinson, S., Misfeldt, R., Boakye, O., Suter, E., & Wong, S. (2017). Comparative policy analysis: Identifying policy

options for team-based primary care in Western Canada. Retrieved 28 March 2019 from http://methods.sagepub.com/case/identifying-policy-options-for-team-based-primary-care-in-western-canada

Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying. (2015). Final report. Retrieved 28 March 2019 from http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf

Silvius, J. (2017). Medical assistance in dying: AHS approach and implementation. Retrieved 28 March 2019 from www.accaiq.com/s/2-James-Silvius.pdf

Supreme Court of Canada. (2015). Bill C-14. An act to amend the Criminal Code and to make related amendments to other acts (medical assistance in dying). Retrieved 28 March 2019 from https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/LegislativeSummaries/PDF/42-1/c14-e.pdf

Statistics Canada. (2016). An aging population. Retrieved 28 March 2019 from https://www150.statcan.gc.ca/n1/en/pub/11-402-x/2010000/pdf/population-eng.pdf?st=82lsEyV5

Truog, R. D., Cist, A. F., Brackett, S. E., Burns, J. P., Curley, M. A., Danis, M, et al. (2001). Recommendations for end-of-life care in the intensive care unit: The ethics committee of the society of critical care medicine. *Critical Care Medicine*, *29*(12), 2332–2348.

Tretyakov, K., & Cohen, I. G. (2016). Medical assistance in dying and suicide tourism to Canada: Bill C-14 from a comparative perspective. *Journal of Ethics in Mental Health*, *9*, 1–6.

Wilson, K. G., Chochinov, H. M., McPherson, C. J., Skirko, M. G., Allard, P., Chary, S., et al. (2007). Desire for euthanasia or physician-assisted suicide in palliative cancer care. *Health Psychology*, *26*(3), 314–323. doi: 10.1037/0278-6133.26.3.314