

Providing medically assisted dying in Canada: a qualitative study of emotional and moral impact

Janine Penfield Winters ¹, Chrystal Jaye,² Neil John Pickering ¹, Simon Walker¹

¹Bioethics Centre, University of Otago, Dunedin, New Zealand
²General Practice and Rural Health, University of Otago Dunedin School of Medicine, Dunedin, New Zealand

Correspondence to

Dr Janine Penfield Winters;
 janine.winters@otago.ac.nz

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ABSTRACT

Purpose Medical assistance in dying (MAiD) in Canada places the medical provider at the centre of the process. The MAiD provider holds primary responsibility for determining eligibility and becomes acquainted with patients' inner desires and expressions of suffering. This is followed by the MAiD procedure of administering the lethal agent and being present at the death of eligible patients. We report participants' perceptions of the emotional and moral impacts of this role.

Methodology Two years after MAiD was legalised in Canada, 22 early-adopting physician providers were interviewed. Data were examined using both phenomenological analysis and a novel ChatGPT-enhanced analysis of an anonymised subset of interview excerpts.

Findings Participants described MAiD as emotionally provocative with both challenges and rewards. Providers expressed a positive moral impact when helping to optimise a patient's autonomy and moral comfort with their role in relieving suffering. Providers experienced tensions around professional duty and balancing self with service to others. Personal choice and patient gratitude enhanced the provider experience, while uncertainty and conflict added difficulty.

Conclusions Participants described MAiD provision as strongly aligned with a patient-centred ethos of practice. This study suggests that, despite challenges, providing MAiD can be a meaningful and satisfying practice for physicians. Understanding the emotional and moral impact and factors that enhance or detract from the providers' experience allows future stakeholders to design and regulate assisted dying in ways congruent with the interests of patients, providers, families and society.

INTRODUCTION

As Medical assistance in dying (MAiD) becomes legalised in varied jurisdictions worldwide, legislators determine the roles of medical providers. We began this project in 2018 when New Zealand was legislating MAiD and we noted little empirical evidence at that time for the normative arguments about the impact of MAiD on providers. We wanted to understand how elements specified in the statute influence providers' experience. We interviewed early-adopting providers in Canada about their experiences providing newly legalised MAiD. Our approach was an open-minded curiosity about participant experience and the thoughts and feelings they assigned to this. We wondered what factors make it more (or less) difficult to provide MAiD and how specific parameters of the statute regulating Canadian providers might impact their experience. Our intention was to provide

information useful for considering provider well-being when jurisdictions design and regulate legal medically assisted dying.

Canadian legislation defines the role of a single continuity provider as central to almost every step of the process, from first determination of eligibility to administration of the medications causing immediate death. We compare our results with a literature review of the emotional impacts and the moral tensions provoked by the 'killing-caring paradox'¹ when a caregiving health professional also proximally causes death.

To understand international perspectives on the MAiD physician-provider experience and identify knowledge gaps present in early 2019, we reviewed the academic literature and anecdotal reports from English-language newspapers, internet news and blogs.^{2–6} We also reviewed works speculating on anticipated or possible emotional/moral impact.^{7,8} Finally, we reviewed the literature about animal care workers who provide euthanasia. Our study explicitly seeks to understand the emotional and moral impact of providing MAiD in the North American setting when the provider is required by statute to be present from medication administration until death.

Terms

'MAiD' refers to a medically qualified provider ending a person's life at their request in the setting of a terminal illness with a short life expectancy. The distinction between provider-administered MAiD (often termed euthanasia) and self-administered MAiD (often termed physician-assisted suicide) is significant, but the terminology varies by stance and region. We decided to use the term MAiD throughout and describe the administration type where relevant.

'Canada' includes Quebec, although the timing of legalisation and specifications of the statute were slightly different in Quebec than in the rest of Canada. MAiD was initially legalised in Quebec in 2014,^{9,10} and then a 2015 court decision required the Canadian legislature to legalise assisted dying for the rest of Canada by mid-2016.¹¹ The statutes in Quebec and the rest of Canada were similar enough in the study period (2016–2019) to consider the two collectively.

'Emotional impact' can be positive or negative. While medical caregiving can be gratifying, many physicians undertake roles that include witnessing suffering and grief, coping with heartbreaking situations and making high-stakes decisions in conditions of uncertainty. Studies document that physicians frequently struggle emotionally when treating people with devastating illnesses and loss.¹²



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Emotional distress in physicians working with suffering people affects their inner lives. It can lead to burnout and other negative consequences that have downstream effects on their professional lives and the quality of their future patient care.^{13–16} Physicians witnessing dying and caring for the seriously ill elicit ‘intense emotions arising from the care of patients’^{16 17} Unacknowledged emotions can result in behavioural changes and detract from ‘the quality of their medical performance as well as their personal growth in their profession.’ (Vicini *et al*,¹² 1192) The personal toll on physicians includes professional loneliness, loss of professional sense of meaning, cynicism, frustration and anger.¹⁴ Resulting in physician behaviours including avoidance, incoherent care goals, patient mistrust and failures to identify patient and family values that influence decisions. (Meier *et al*,¹⁴ 3008) The inner lives of physicians at the front line of high-stakes clinical medicine and the related phenomenon of emotional regulation and burnout in these professionals have become an area of intense scrutiny.¹⁸

Animal care workers are described as challenged by the ‘killing-caring paradox’,¹ the emotional and moral stress caused by euthanasia provision within veterinary care, which is found to contribute to provider burnout.^{19–22} The robust literature about the impact of the caring-killing paradox on animal workers was helpful for considering the challenges of providing euthanasia.^{23 24}

‘Moral impact’ is intertwined with the emotional domain but can be defined and described separately, such as in the nursing literature about moral distress. Physician-centric literature describes that the stress (and distress) of caring for dying patients impacts physicians in both emotional and ‘spiritual’ domains.^{14 25} We use ‘moral domain’ rather than ethical or spiritual. Moral philosophy and moral psychology assist with understanding and describing the experience of MAiD providers. ‘Moral intuition’ and ‘moral justification’ are concepts described in moral psychology that other MAiD researchers have used to describe moral responses to MAiD.²⁶ Haidt writes that human brains first experience non-verbal moral intuitions and then justify intuition through moral reasoning.²⁷ ‘Moral responsibility’ describes a situation where a person has enough choice and control to have a ‘causal role’ and thus accountability for an outcome.^{28 29} MAiD providers have ‘agency’ in that they choose to provide MAiD for a specific patient in a specific circumstance. A person with moral responsibility may perceive a ‘moral burden’ if they later question the decision-making that led to their actions. We summarise the moral domain as including the intersection between a provider’s pre-existing ethical stance, the provider’s attempt to resolve presenting clinical ambiguities, their recognition of ethical tensions, and, finally, internally justifying one’s choices.

Canadian statute

Key requirements of Canadian law that may influence emotional or moral impact include the manifest causal link between the provider’s role and the patient’s death. Additionally, the stipulation that the provider be present with the patient from administration of the lethal medications until after death ensures that the provider witnesses the entire process, including family grief. It also accentuates the provider’s experience of the differences between the duration of completion between the oral and intravenous routes. With the intravenous route, death occurs within 3–15 min in most cases.³⁰ The oral route allows a possible prolonged period between administration and death. Since the law came into effect in Canada, the intravenous route has accounted for the vast majority of MAiD deaths in Canada.³¹

The shortened interval between administration and death makes the cause-and-effect relationship obvious, which may increase the provider’s sense of responsibility for the death process.

Canadian providers are also longitudinally responsible for the patient in the interval between qualification for MAiD and death. After assessment of eligibility, the provider has continuing obligations to ensure all procedural safeguards are met, to obtain, use, store and return the pharmacologic substance. The many roles of the MAiD provider are outlined in the statute^{32 33} and are described and analysed in detail elsewhere.³⁴ This is different from the ‘assisted suicide’ model, which minimises the provider’s responsibilities after the qualification assessment. The Canadian provider’s role after qualification includes negotiating a time and place, responsibility for picking up medications and transporting them, injecting the lethal medication, proximally causing and witnessing death. After death, the Canadian provider has continued responsibilities including paperwork, disposing of unused medications and comforting and taking leave of a grieving family.

Provider experience of MAiD

Newly implemented MAiD: An international review of health-care providers’ perspectives on implementing MAiD summarised 33 publications on the topic.³⁵ Known stressors from providing MAiD include provider mistakes and unexpected harm, family conflict and the perceived departure from cultural norms.^{35–37} Departure from the traditional moral stand is an important but time-specific challenge for physician providers of newly legalised MAiD. As societal norms changed and public demand for MAiD grew, some physician groups articulated opposition to it coming under the umbrella of medicine³⁸ because many thought that doctors hastening death could undermine the covenant of trust between the doctors and society.^{39 40} For many countries, including Canada, during the 2014–2016 legalisation process, the traditional ethical codes for physicians continued to predominate and medical professional organisations opposed MAiD. As these organisations set physician standards, acting in opposition to the traditional social contract posed tensions for physician providers. This was described in a recent Australian study as physicians having to ‘individually determine’ the way they participate in MAiD due to their ‘profession’s response and collective belief’ that MAiD ‘does not form part of medical practice (and) this tension underpins one of the most enduring professional challenges raised by participants’ (Rutherford *et al*,³⁷ 1064).

Canadian provider experience: The information available on provider experience in Canada has grown rapidly since we completed data collection in 2019. When our study was developed, very little had been published about the experiences and challenges of Canadian MAiD providers. In one study, conducted just a few months after legalisation of MAiD,⁴¹ found that providers reported being undercompensated financially for their time, sacrificing personal time due to increased workload and that MAiD provision affected some collegial relationships. There was concern that providers could not continue to provide the service over time without addressing these challenges to providers.⁴¹ Studies also indicate that initially there were few organised supports available for providers, including a paucity of precedents, guidance, mentorship or evidence-based educational support for their individual circumstances.⁴²

Oregon provider experience: Before Canadian legalisation, the North American experience with legalised MAiD was confined to ‘assisted suicide’, which was legalised in Oregon in 1997.⁴³ Almost 30 years of research document various aspects of the Oregon model, which was later emulated by other US

jurisdictions.⁴⁴ Beyond provider administration of the lethal medication, the Oregon model does not require continued involvement of the provider. The Oregon providers' obligations end when the prescription is given to the patient while the Canadian provider continues to have a role central to the entire process. The Oregon patient must pick up, store the medication and then choose when and how to ingest it, and many who complete the qualification procedure choose not to proceed to pick up or ingest the medications. Research from Oregon reveals that only about half of the people who asked for MAiD and completed the qualification process actually ingested the lethal substance.⁴⁴ In the Oregon model, the link between provider role and death is diffused by time, location, and the patient's initiative in taking the lethal substance.

Reports of provider experience in Oregon are mixed. Studies indicate that doctors sometimes describe participating in MAiD as difficult, troubling, extracting a significant emotional toll and 'an excruciating thing to do'.⁴³ On the other hand, a 1999 survey of Oregon doctors reported that only four of the 144 providers who returned the survey expressed 'ambivalence', and only one reported deciding not to provide it again.⁴⁵ Seminal research by Emanuel *et al* reported data about physicians who provided MAiD in the USA.^{36 46} These authors identified an inverse correlation between the doctors' perception of the severity of physical pain expressed by the patient and the oncologists' acceptance of the acceptability of MAiD.³⁶ A majority (54%) of interviewed provider oncologists expressed comfort in knowing they had helped a patient end their life the way they wished. One-quarter of the providers reported regret after providing MAiD for specific or non-specific reasons. Specific reasons for regret included reflecting on a patient who 'might have benefited from living to the end' and feeling empathy for family members who did not get to say goodbye. Non-specific regrets included worries about 'playing God' and feeling conflicted or 'at odds' with themselves or their role. One in six providers reported experiencing emotional distress severe enough to affect their medical practice.⁴⁶

Experiences in other jurisdictions: A multinational 2006 article reviewed publicly available provider statements (mainly from The Netherlands and Oregon) and reported 'emotional and psychological effects' of MAiD. This study concluded that

Physician participation in assisted suicide or euthanasia can have a profound harmful effect on the involved physicians. Doctors must take responsibility for causing the patient's death. There is a huge burden on conscience, tangled emotions and a large psychological toll on the participating physicians (Stevens,⁴⁷ 213).

The Dutch have longitudinal experience of doctors directly administering the lethal agent because doctor-administered MAiD has been legal since 1984. Research indicates that doctors sometimes find MAiD difficult or troubling.^{48–50} However, it has been argued that the experiences of Dutch providers cannot be directly compared with those of North American providers, given the vast differences in the cultural and medical milieu (Norwood,⁵¹ pages 94, 153).

In summary, cross-cultural literature reveals reports of retrospective regrets or burdens on some physician providers of MAiD, but these seem to occur in a minority of those interviewed in qualitative studies and have variable effects on the providers' well-being. Based on these studies, we wondered if a small but not inconsequential subgroup of doctors involved in the provision of MAiD in Canada would experience negative emotions or regret.³⁶

Study purpose

Our study presents participants' perceptions of the emotional rewards and challenges of providing MAiD and their moral reactions and reasoning. We wondered if self-reports of provider experience in Canada might vary from other jurisdictions because of the specific statutory conditions influencing the subjective experiences of those working within these conditions. Relevant elements for provider experience included (1) requiring the provider to be responsible for steps in between qualification and provision, (2) requiring the provider to be present from administration until death and (3) allowing the provider to deliver a rapid-acting lethal agent directly and intravenously (instead of self-administration). If these constitute a burden on the practitioners, then we would expect that to appear in accounts of their subjective experience. During the conceptualisation phase of our study, the impact of these factors had not yet been studied in Canada. This study explores the self-reported provider experience when the providers were required to be face to face with patients and causally responsible for administering a rapid-acting lethal substance.

METHODS

A mixed-model qualitative design within an interpretive phenomenological framework was employed.^{52–56} An interview guide was developed that included both factual (closed-ended) and emotive (open-ended) prompts to encourage dialogue and reflection.⁵⁷ Human ethics approval was obtained in both New Zealand and Canada prior to recruitment. Further description of design and methods is found in previously published articles based on this study.^{42 58}

The recruitment strategy used networking and snowballing methods. Networking emails were sent to seven professional contacts in Canada, including two rural family doctors, one academic family doctor, one rural palliative care doctor, one physician spokesperson for a general medical organisation and two medical ethicists. During snowballing, a contact posted our recruitment notice on the web bulletin board of the Canadian Association of MAiD Assessors and Providers (CAMAP). We sought to include doctors from rural settings and doctors who routinely see indigenous patients. Our goal for enrolment was 16–22 participants based on earlier reports that 1 in 6 providers experienced emotional distress.³⁶ Twenty-six potential participants were identified, and 21 English-speaking Canadian physicians completed consent and were enrolled in the study.

Interviews were conducted in late 2019 and lasted 65–90 min. Face-to-face interviews were conducted for all but four participants, who were interviewed via Zoom. Interviews were recorded, reviewed and transcribed. Primary analysis was via a phenomenological approach⁵⁹ using an immersion crystallisation technique.⁶⁰ ATLAS.TI software was used to assist with coding. Initial coding was completed by the first author, in consultation with the research team, who met to compare and review coding strategies and recoded random samples to establish concordance.

We employed a novel secondary analysis using ChatGPT. First, the authors scrutinised participant excerpts initially coded as 'provider meaning and emotions' and selected 136 long quotes (14 000 words) most representative of the range and variability within the data. These were edited for grammar and anonymity. ChatGPT was then asked to analyse each quote via the prompt, 'Can you provide themes for these quotes?'. We then prompted ChatGPT to provide an overview thematic analysis of all the quotes ('Do a thematic analysis of all the quotes I have provided in this conversation'). Finally, we asked ChatGPT for a

meta-analysis of the themes, 'Can you provide a thematic analysis of all the themes you have provided during this conversation'. All ChatGPT-generated thematic analyses were compared with earlier inductive analyses, and themes were condensed and curated.

RESULTS: PARTICIPANTS

More than half of the participants were recruited via email networking. The others were recruited from the post made by a potential participant on the CAMAP website. Participant demographics (self-reported gender, age, ethnicity and religion) and professional attributes (region, patient population, years in medical practice, medical specialty, practice setting and indigenous population served) are reported in [table 1](#). The number of provisions of MAiD per provider was not collected formally, but the reported numbers ranged from 2 to 150.

Results: principal findings

Inductive and ChatGPT-enhanced thematic analysis provided congruent themes on provider emotional and moral impact. Factors that enhanced or detracted from participant experience of MAiD provision were extracted. The excerpts from our participants include at least one excerpt from each study participant and no participant's voice is repeated within the same category.

Domain 1: emotional impact on provider

Participant statements about emotional impact varied greatly between providers. For organisational reasons, we categorised emotional impact into positive (rewarding) impacts and negative impacts involving challenges or personal costs. The excerpts paint a nuanced picture of bitter-sweet experiences with simultaneous joys and sorrow. As far as the magnitude of impact, a few participants reported little impact, many compared the emotional impact as similar to other weighty burdens of medicine, and some described it as life-changing.

Within the positive category ([box 1](#)), a prominent theme was the importance of patient gratitude. A large majority of the participants mentioned this as important and provided vivid descriptions of being acknowledged as compassionate or brave. One participant described these acknowledgements as biblical 'mana' for his soul, as they nourished his feeling of professional well-being. Expressions of gratitude from families and community members were greatly appreciated by participants.

Descriptions of positive emotional impact also included an appreciation of intimate and solemn moments during MAiD procedure, a sense of 'privilege' to share in the connection of the relationship, professional satisfaction for providing an important patient service and satisfaction in the immediacy of the positive impact of their work.

Descriptions of the negative emotions and challenges ([box 2](#)) included acknowledgements of the emotional investment and personal costs. Participants recognised the emotional weight of providing a life-ending procedure and the unique emotional challenges of the first MAiD provision. They described emotional tension prior to the procedure, followed by relief that it went smoothly. They expressed concerns about isolation and lack of support for MAiD providers. Emotional challenges were amplified by stressful situations such as family conflict, delays, limited clinical resources and lack of support. Providers recognised an emotional toll of witnessing and responding to family grief. Managing personal grief was considered especially challenging when providing MAiD for a younger person. Our participants reported that the emotional burdens of providing

Table 1 Participant self-reported demographics and professional attributes

Attribute	Participants (21 total)
Gender	9 male, 12 female
Age	1 under age 31 3 age 31–40 3 age 41–50 4 age 51–60 3 age 61–70 0 age 71–80 1 over age 80 6 no data
Ethnicity:	19 Caucasian with various subgroupings, including Canadian, French-Canadian, Caucasian/Indigenous 2 no data
Religion:	11 'none' or 'not religious' 2 Catholic 2 Buddhist 1 each Hindu, Anglican, United Church of Canada, Jewish, First Nations 2 no data
Number of years in practice	5 under 10 years 5 with 11–20 years 2 with 21–30 years 7 with over 31 years
Medical specialty or concentration(s)	Family medicine or general practice (GP), many with one or more named secondary specialty or focus 3 palliative medicine (including geriatrics/palliative medicine) Emergency medicine, oncology, radiation oncology, internal medicine, internal medicine intensive care, tropical medicine/infectious disease, GP surgery, GP oncology, GP palliative medicine, geriatrics, older person health, social health, rest home medicine, gender care, abortion care, care of frail elderly, acupuncture, academic/teaching.
Retirement status	1 Previously retired 1 Semiretired (confined practice to assisted dying)
Regional location of medical practice	1 Western Canada (British Columbia) Eastern Canada (11-Ontario, 3-Nova Scotia, 3-Newfoundland, 1-New Brunswick, 2-Quebec)
Practice setting and patient population:	Large urban centres (tertiary care) 14 Rural or small regional hospitals 2 Remote 8 Practice settings included >1% people from Indigenous cultural groups (Metis, Mi'kmaq, Cree, Beaver) 3 Practice settings with >5% patients from Indigenous cultural groups

MAiD affected the entire healthcare team, and they reported a need for emotional release, self-care and decompression.

Domain 2: moral impact on provider

Providers' expressions of moral impact were less variable than descriptions of emotional impact. Most providers expressed a positive moral impact and personal meaning when helping to optimise patient-centred care and patient autonomy. A second theme was moral comfort with the provider's role of relieving suffering. Finally, providers expressed moral tensions around their sense of professional duty and balancing the self with service to others.

Autonomy and control: Patient autonomy and choice were described as morally significant, and providers described that legal MAiD allowed them to act on their commitment to honouring these. Participants decided to provide MAiD either to advocate for the advancement of patient-centred care generally or to uphold autonomy for individual patients. Many participants considered loss of autonomy as worse than death, and

Box 1 Emotional Impact—Interview excerpts about positive emotions and rewards

- ▶ 'A lot of people think that it's supposed to be hard for a variety of reasons, but it's more gratifying than most other areas of medicine.'
- ▶ 'Sometimes it's been absolutely magical what I've gotten back or been able to witness.'
- ▶ 'That was such a positive and wonderful experience for me that I said, 'This is maybe part of my purpose.'
- ▶ 'It [MAiD] is it is one of the most rewarding things you can do as a doctor. And you think that would be just the opposite. I used to say I hated doing ear cleanings because I didn't go all those years to medical school for that. But you know what, I love them. Because it's the one thing I get instant results and I get something. When you do the procedure [MAiD], the patient and the family and everyone is so grateful. You see some beautiful, really beautiful deaths. We're all dying anyways. When people say, 'Thank you,' I don't know how to feel. What do you say to somebody who says thank you for killing off their relative, basically? Everyone is so grateful. And it's so peaceful. When you know how awful it could be otherwise. That it is, that you're really doing something for somebody. And it is one of the most important rewarding experiences.'
- ▶ 'In family medicine I think, more than some other specialties, it's relatively uncommon for me to be able to make a concrete difference for people in the short term. Right? It's not that what we do doesn't make a difference, but it's usually sort of a bigger picture, long-term thing. So to be able to do something where patients or families can sort of see an immediate good outcome is nice... maybe that's easier for me to say because I've never done a borderline case, I've never dealt with an angry family. But at least so far, it's been clear-cut that it's both the legal and the morally right thing to do. And so I don't find it particularly emotionally difficult.'
- ▶ 'After the case was done, it was just this big release, and I was so emotional. It was emotional because it was an emotional moment, but it was a really beautiful moment as well. It was a very peaceful death in the end, aside from that noise. The family took it well and they were very pleasant ... I came to learn, these events are often, the mood is quite light. People tend to crack jokes, gallows humour I guess, and jokes that you wouldn't expect. You have to do your best not to laugh because they're just so funny, so many jokes.'
- ▶ 'That's probably as emotional as I've got. I just thought there was something so special about that moment [of death], right? The oldest son said, 'Was it okay? Did we do okay?' I said, 'This was one of my most special experiences.' I said, 'It will be a long time before this family is outdone for making this a very special occasion.'
- ▶ 'I'm getting my stethoscope to put over my neck, the priest is taking his stole, putting it around his neck. And our eyes met across the patient as we're both in the exact same action, me with my stethoscope and him with his stole. And there was just this look of recognition, of we each had this role to play ... Then I was holding the patient's hand and doing the IV, the priest put his hand on top, and then his stole on top. I was feeling like I was also being blessed with the patient as I was doing this ... it was recognition of what he was doing and his role to be able to sort of protect me too.'

Continued

Box 1 Continued

- ▶ 'I had a medical student with me. The [patient's] daughter was on one side holding one hand after the mom had passed, and I was on the other hand, it was like my mother's own hand in a way because we had become so deeply connected and it was huge to see the peace at the end. But at one point when I was sort of trying to get her [the student] to smile here and there, I said to her, 'You know, you know why I do this?' And she said, 'No.' I said, 'It's because I'm hoping somebody will do this for me.' She looked at me with a big smile and she said, 'I'll come back and do this for you.'

they recognised a departure from cultural and professional traditions that death is always the worst outcome. Participants often described the need to counsel family members about patient autonomy in that MAiD provision is honouring their loved one's choice (box 3). Four of our participants stated that patient autonomy places them (the providers) as a conduit in getting patients to their goal, but not as moral agents empowered to judge or stop the process (unless limited by law).

Relief of suffering: Participants discussed relief or release of suffering as a moral imperative for providing MAiD (box 4). Participant statements often contrasted their personal and professional duty to relieve suffering with important competing obligations, such as an obligation to follow the law and the need to discover and respect their own moral standpoint. A few described balancing a duty to support people wanting MAiD with uneasy personal feelings associated with participating in a profound life-ending decision.

Professionalism and balancing self with service: All but one participant acknowledged individual burdens associated with the time-consuming and emotionally intimate process of MAiD. They described the difficulty of managing MAiD, their other professional duties, and their personal time and wellness. Some spoke of professionalism as an obligation to meet the needs of patients in their community, even when meeting those needs was difficult. Some described their transition from theoretical support of assisted dying to the practical reality of being directly responsible for executing the process. They reflected on the importance of their own autonomy in maintaining personal and professional integrity. It was important to providers to have control (provider autonomy) to choose the patients for whom they provided MAiD.

Many participants emphasised their need to attend to their own resilience and moral integrity. Much of this internal work was done before provision by self-examination and discussions with their most trusted allies. Most participants mentioned resiliency practices after MAiD provision, such as debriefing, team support or 'giving themselves time'. Providers described the importance of collegiality and mutual support within the health-care team, characterising teamwork as either important or critical to the long-term resiliency of the team members. Participant excerpts demonstrated consideration of the interests of medical coworkers and community perception (box 5).

Domain 3: emotional and moral factors that made the provider role easier or more difficult

Using the same group of quotation excerpts, we combined the emotional and moral domains to identify factors associated with how the provider experienced the MAiD clinical encounter (box 6).

Box 2 Emotional impact—excerpts describing challenges and personal cost

- ▶ 'It is very emotional. Every time I'm with people who are dying, it's when the family come around the bed and the family [grief], that's what gets me.'
- ▶ 'I'm dealing with the family, who're anxious. I'm worrying that the patient is going to die during these [ambulance] transports. It was extremely stressful. There was no support from the hospital, so I was basically on my own.'
- ▶ 'It seems with MAiD that the providers are very much more isolated and that when things happen, when you have those cases that are upsetting, that there's not much resource or support or help.'
- ▶ 'I said [to the patient], 'You know, I'm not really crazy about doing this with a family member [daughter] who's totally against this.' You know what her answer was? She said, 'Well, couldn't you just do it in the middle of the night and not tell her, and then in the morning just when she'd come in to visit me, just tell her that she died overnight?' I said, 'I can't do that. I can't do that. I mean she's going to have access to the chart. I have to chart all this stuff. There's all this legal paperwork that we have to do. I can't force that on the nurses and force them to.' That really was tough on me because I thought, what am I going to do?'
- ▶ 'If it's a young person undergoing MAiD, that stays with me. I find that there's a difference between, say, when a 90-year-old person who has great grandkids is ill and it's just very clear that this is their time. It's different to provide for a 50-year-old with teenage sons, who has ALS.'
- ▶ 'You're feeling those things with the family.'
- ▶ 'They started to give the first medication and the son said, 'No, no. Stop the thing. We got to stop this; you can't do it yet.' [She] took the son off to the side and calmed down and then kept going with it as per the patient's wishes ... People can do anything when they're in altered state of distress.'
- ▶ 'For the people who [require MAiD] more urgent[ly], like the people who have just been diagnosed with cancer a few months ago, they're harder in the sense that the family is definitely less prepared. I think family preparedness is a big thing. I mean, the patients are always prepared, you know, more or less by definition. But if it's a more recent diagnosis ... it seems a lot harder for the families. So by extension that makes it a bit harder for me.'
- ▶ 'I recall somebody dying in emergency, the whole family was around the bed, and they were singing her favourite songs, saying prayers, and telling stories and it was beautiful. It was beautiful and I had to leave the room because I was crying. I was like, they don't need to see me like this, this isn't my show, go have your moment elsewhere. The same thing [happened] in a couple of the MAiDs that I have attended, where it's very beautiful to see somebody who's so loved and supported, but it's very hard to watch people go through that, it just is.'

DISCUSSION

Our results document the experience of providers who chose to be early adopters of providing face-to-face euthanasia via lethal injection with first-person descriptions of the emotional and moral impact and the factors within both categories that made the role of provider more or less difficult. The most robust and ubiquitous statements of moral priorities were the centrality of

Box 3 Provider excerpts about patient autonomy and control

- ▶ 'We often talk about patient-centred care in our healthcare system, and we have trouble delivering it. We are often limited by the system, by capacity, by practices. We're not able to provide patients the care that they need, at the time that they need it, at the place that they need it at. MAiD is the opposite of that. We provide patients the care that they need, when they ask for it, when at all possible, in the place that they ask for it. A provision, it can be, within reason, wherever they want it to be, whenever they want it to be, with whoever they want there, with whatever music they want playing in the background ... It's allowing us to push that patient-centred model forward, which we spent so much time talking about and so little time being able to deliver on.'
- ▶ 'I will try and support you [family members] as best as I can or get one of the social workers to talk to you, but ultimately, it's all about him. It's not about me. It's not about anybody else. It's all about him.'
- ▶ 'You're very uncomfortable the first couple of cases. Just because you're, you. I've gotten more comfortable with it ... you have to do what's right for them. Right? And I'm getting more and more comfortable, this is about them and not about me at all.'
- ▶ 'I will only do them for people that I have an established relationship with, and I feel very comforted, privileged and satisfied after I do the procedure that I've done it on their request, this is what they wanted, and they trusted me to do it properly.'
- ▶ 'He presented me with a gift to me right at the very end because he wanted me to remember him when I used it. To me, what that showed was MAiD was a palliative act for this man, that he enjoyed the last few months of life because he knew he was in control and could end it when he wanted.'
- ▶ 'I was a first-time provider. I found that a bit daunting and intimidating. But I just tried to be professional and say, 'I'm here to do this. This is what she wants, and I'm trying to respect her wishes.''
- ▶ 'It's heavy, but so is a lot of the other work that I do ... I typically feel like I'm doing something really good for people. Even when they just want to feel like the option is there. They want to feel like they're getting all of their choices and making an autonomous decision, and I feel like that's what we're doing. We're giving people more autonomous control over their lives and giving some more control over their death is giving them more control over their life. I've never really felt uncomfortable about what I'm doing.'
- ▶ 'You want them to be able to focus on that main concept that this is what they wanted, and we're respecting what they want. I prepare my colleagues to focus that, as a provider, you're not making any judgments about why they're choosing that, but you are there to hear them out, to evaluate, to listen to their reasons for their suffering. Providers have to be prepared to do that, to sit there and really have a chitchat and understand what brought them to that point and brought them to this decision ... I write it down as they say, describe your suffering to me, and I paraphrase them. I try to keep it so it's about them.'
- ▶ 'The spirit of the legislation is all about a person who is cognitively intact who has capacity making a decision about

Continued

Box 3 Continued

what is acceptable suffering or acceptable loss of dignity to them ... I think that people's wishes need to be respected, yeah.'

- ▶ 'There's a lot of focus on the death, almost too much in terms of the whole MAiD process, because really it's about empowering the patient. Just the fact that a patient knows that they have that little piece of control. At the end of life, so much is out of their control. Their health is out of their control. Often where they live, and their circumstances are out of control. Who's wiping their butt is out of their control. Everything is all wonky. So to be able to provide a patient with the ability to say, okay, where, when, and how I exit this world, is under my control. I can control that piece of it. I see a lot of the time people get a significant therapeutic benefit from being able to have that decision under their control. They've taken back a little bit of control that they have lost, and that therapeutic benefit is there whether they avail of it or not. So in many ways, whether they actually go through with having MAiD or they don't, it doesn't matter. That's not the point. The point is the patient has the right, the patient can choose, the patient chose ... They chose, and it's empowering ... This is one thing that you can do.'
- ▶ 'It's probably for me the biggest change in medicine... All these new drugs, new this, new that, to me this is the biggest, most impactful thing that I've seen in my career in terms of this change in ability to provide MAiD and to err on the side of patient autonomy and choice. Not err, but have more input in that part of ... yeah. That's the biggest change I've seen.'

patient autonomy and control. The duty to end suffering was the second moral imperative for providers. Finally, participants made frequent statements about professionalism, managing and negotiating obligations to self and others, and maintaining resiliency.

Before our study, we identified two areas as possibly emotionally or morally demanding for MAiD providers: the emotional dichotomy of helping someone by ending their life, also known as the 'killing-caring' paradox,¹ and the specific Canadian statutory rules that amplify the provider role and require a single provider to shoulder the multi-faceted qualification to provision process. We expected that either the frequency or severity of distressing emotions or moral burdens would be exacerbated by the high degree of longitudinal agency and accountability placed on Canadian MAiD providers by the legislation under which they operated.

The interview data suggested that the high level of provider agency legislated in the Canadian context was not associated with distressing emotions and may have increased their perceptions of service to patients. Providers' primary concerns were serving patients by honouring their wishes, a type of appeal to patient autonomy. Providers embraced a patient-driven model, in which the patient's desire for MAiD was presumed to be ethically central. As a result, the providers were not particularly concerned about a deviation from the previous norms of medical practice that might be expected after hastening death via injecting a lethal substance. Through the relief of suffering, the injunction to 'do no harm', traditionally attached to the moral assessment of euthanasia, was largely superseded by a sense of acting in the service of a justified response to the desires of desperate patients.

Box 4 Provider excerpts on the desire to relieve suffering

- ▶ 'You know you're going to make them better. That person is suffering. And she's suffering so much that she cannot wait for a natural death. So you're giving them their last, their last, last wish.'
- ▶ 'I feel very good about the current law, specifically that they need to be at the end of life, and they need to be suffering so much that they cannot wait for the end of their life.'
- ▶ 'When I hear somebody say, 'Doctor, can I have MAiD?' I hear, 'Doctor, my life is intolerable. Can you help me?' I explore the suffering, what makes it intolerable and understand all the aspects. The physical domain, social, spiritual, emotional, all the domains of suffering and so ... [about] 70 or 80% of the time you can actually address their suffering in another way. I work to reduce [number of provisions of] MAiD by addressing suffering.'
- ▶ 'It went beautifully, and he died peacefully. And it was consistent with who I was as a palliative care physician to alleviate suffering in a way that I could never have done before.'
- ▶ 'I've had one bad experience. The man was 90-something, and he had cancer with a lot of metastases to bone. He was suffering, suffering, not able to walk anymore, not able to eat. He was at end of life. He asked for it [MAiD] and signed everything. At that time I asked him, 'Are you sure you don't want your family to be involved? I would be more at ease if they know and they participate.' He said, 'Okay, call my family, tell them it's going to take place at that time and all that.' So I called and, it was a mess, a huge mess. They were against it. They were trying to change his medication and all that, but that's not what he wanted. He wanted to leave. He was suffering despite medication and all of that. I tried to explain to the family that it's a choice, and we have to do it fast because he's suffering a lot. Maybe he's not going to be a lucid until the end [and then he won't qualify] ... They came to see him the day before [MAiD] and they made him change his mind. They told him that God didn't want that... The saddest part was that he died 48 hours later, and his family wasn't at his bedside. We called them to say, 'He's dying right now, naturally.' But they didn't want to come. So they left him alone after they made him suffer like 48 hours more and were not at his side. It made me very uncomfortable. That was one of the worst.'
- ▶ 'I feel that it doesn't matter where you are, if your suffering is largely existential in addition to shortness of breath, chest pain, whatever. Palliative care can't fix existential suffering.'
- ▶ 'When I said I would explore [qualifying for] assisted dying with him, the crack at the door opened, he became illuminated, he became so hopeful that he may not have to face intolerable, inevitable suffering, which he already was experiencing. His depression cleared. I had him reviewed a couple times and all agreed that he was a different man, just with the possibility of exploring the option that I would consider him for an eligibility assessment.'
- ▶ 'It is rooted in my values. Would I want to suffer, wasting away in a bed? No, not for a second. Would I want my parents to if they ... I mean, it's everyone's choice. If they wanted to do that, good. I'm happy for them to

Continued

Box 4 Continued

want that, to be on palliative ward and whatever, live their life there.'

- 'I was surprised by how tired everyone was. I had this idea that there was going to be a very reverential thing, and it was going to be sort of formal, but at least much more respectful and dignified than it ended up being. Now that I've done it a few times I realized, the people who are doing this, they're not just sick. They're not just suffering. They are at the end, and they don't really care about anything anymore.'
- 'Again, this is a tool for treating suffering.'

In our cohort of participants, the balance of the positive factors outweighed the reported negative ones. We note that the numerous reports of substantial gratitude expressed to providers could be temporarily high because of the novelty. Patients and families recognised that this new practice could be challenging for early-adopting providers. None of our providers reported an experience where family, press or community brought public accusations, litigation or other reprisals. Many providers mentioned fearing these so we imagine that these types of stressors would have a considerable impact on providers.

Our results differed from older published literature from North America about the frequency of regret and serious negative emotional impact. Our results most closely align with studies completed in Canada in the last 5 years, such as a 2021 study of clinicians' perspectives on MAiD that focused on provider experience and found a problematic workload, remuneration issues, education needs, emotional impact and lack of institutional support.⁶¹ A rapidly changing cultural milieu around MAiD^{51 62} has placed our results within a specific moment in history. Just after we completed data collection for this study, another court decision, *Truchon v. Canada*⁵⁴ initiated a period of negotiation for further legislative change that became a work in progress, extending over several years. Further study is recommended to explain whether differing results can be explained by factors such as regional culture or changing normative values over time. We could not identify any patterns in the responses of participants by demographic factors such as age or years in practice.

Implications for legislating assisted dying

Our research results provide valuable information that can be used for the normative arguments made when legislating and regulating MAiD. Doctors are rarely thought of as a vulnerable group despite the fact that they take on many moral burdens in their work and are known to have high rates of substance abuse and suicide.⁶³ Doctors' occupations are stressful in many ways, and difficult aspects include witnessing crises, suffering and death and making morally difficult high-stakes decisions in conditions of uncertainty.

Our results support the idea that both patient and provider autonomy enable providers to feel connected to patients and morally comfortable with their work. Providers determine whom they approve as qualifying for MAiD and for whom they would provide. Our participants spoke about the importance of moral judgements and the difficulties of medical uncertainties that affect their moral reasoning. A strong sense of connection to the patient, combined with provider reliance on the patient to know what was 'right for them', gave providers a sense of moral security and purpose to continue providing MAiD.

Box 5 Provider views on professionalism and balancing self with service

- 'The biggest issue for me is that it really impacts my work-life balance in a way that the other cases don't ... the people who are actively dying, that's the only time I will ever do work stuff on weekends or evenings. I'll do it because I think it's important.'
- 'We don't get paid for that [travel]. I've been all over this province providing [MAiD] on the weekend. I've travelled in a snowstorm, I travelled 200 kilometres one way, and I have yet to see a dime from the province in reimbursement for my gas...we don't get paid for the time it takes to travel ... It's volunteer work. Volunteer work. People don't understand that...that I'm essentially traveling around the province providing medically assisted deaths for no money.'
- 'I've always burnt my candle at both ends and I'm still doing that hoping for greater good.'
- 'The GP runs the emergency, the GP does minor surgical procedures, the GP delivers babies, and then the GP does MAiD, because the GP does everything because there's no one else to do it. Maybe he doesn't like the idea of MAiD and maybe he's worried about the risk, but he feels a deep sense of duty to the community to be the guy who provides things, and if somebody comes to ask him, he's going to help out.'
- 'Negative feedback could potentially come with me being 'that death provider' in a small community like this. Sometimes I worry about who looks at me and do they talk and say that? 'Are you the doctor who will kill people.' I try to remove those words in my brain because I really don't feel I'm killing them. I'm just helping them die, which is what they want. They want help to die.'
- 'For me, the moral burden of euthanizing is quite similar just to the burden of grief, and you just need to work through that. Grief can become complicated, it can become pathologic, and that's where you need your support system.'
- '[I've] only [had] two MAiD cases, but the second one felt routine to me. I hope that doesn't come across coldly, because it's not, but it felt routine to me the same way breaking bad news to a patient does. There's nothing routine about it, but when you've done it for 20 years, you know how to comport yourself, how to handle the emotions that flood your way from the patient, and how to respond yourself.'
- 'For me, I try and deal with that moral burden by doing a thorough assessment and getting to know the person before their illness, what the illness has taken away and I can convince myself that this is an appropriate thing to do. Afterwards, I make sure there's some quiet time for meditation and reflection. I think that's how I deal with my own emotional health and the morals around 'are you doing the right thing?' At the end of the day, you do have to be able to get into bed and pull your covers up and go to sleep.'
- 'Oh, I sometimes cry. Yeah, I give myself permission to cry. I think one thing is how do we process this? I can't go in thinking about what groceries I need. You have to just empty yourself of all of that, because for me, it's really important when you go in you understand what you're doing, the significance of it, the fact that this is going to be a memory everybody holds of this person's time.'

Continued

Box 5 Continued

- ▶ 'I have no moral opposition to MAiD. I was involved in advocacy in favour of MAiD, but I pray every day when I walk into work, 'Please, nobody ask for MAiD. Don't ask for MAiD, don't ask for MAiD.' Why? Because you just destroyed my day. Now I have to sit down and call a bunch of people. We've got to go do forms, we've got to get witnesses. All of a sudden I have to dictate extremely long notes. I have to fill out order forms. It is a crapload of work for me to respond to a MAiD request.'
- ▶ 'I got myself together, did the documentation and went back and spent some more time with the family. Then his wife told me, 'He really enjoyed discussions with you and his time with you and he felt he had a real connection with you.' Through that, I was able to get grounded in terms of, okay, I think I can do this work.'
- ▶ 'I didn't know how I would feel. I just booked the whole afternoon off. I thought maybe I'll go down by the lake and have a big cry or whatever. Weirdly, I went home and lay on the couch, and fell asleep. It was profoundly emotionally draining, and I carried it with me for a long time. And obviously I think I still do think about it because it's an enormous thing. And I think it's a beautiful thing. And I think it's the right thing, but it is not like anything else that we do.'
- ▶ 'From the physician point of view [about oral route], I don't have a major interest in spending half a day with a family. But it isn't about the money, I think it's about the intensity of the experience. I've got tolerance for a couple of hours kind of thing, after that I'm starting to have trouble sort of keeping it all together.'
- ▶ 'When I leave or after I do a procedure, I make sure I had at least a half an hour to an hour to be quiet and reflect on what I learned about that person.'
- ▶ 'I actually left there feeling okay. I kind of anticipated I'd be nervous, I'd feel guilty, I'd feel bad. But I didn't because I reflected so much about it.'
- ▶ 'We always have a debrief ... That's helpful, because I find that talking to people that don't really understand it is of limited value, so being able to talk to your colleagues who were in the room with you, or knew the patient like you did, that's helpful. Looking after your wellness is really important.'

We identified variability in the impact and moral reasoning from provider to provider. We propose that future legislators of MAiD should expect variability between providers in interpreting the law and justifying whom they approve. This variation must be anticipated within the tolerances of what society intends for the breadth of assisted dying. We recommend further study about our impression that factors that enhance provider sustainability for providing MAiD (such as their connection to the patient, patient gratitude and a sense of purpose) may also influence some providers to have difficulty saying 'no' to patients not fully meeting eligibility criteria and thus provide MAiD at the margin or even outside the intended legal scope.

Study limitations

A significant limitation of this study was methodological choices that narrowed and probably skewed the pool of participants. To honour principles of research participant safety, we chose a recruitment strategy that required the participants to reach out to us via email. We also required a time commitment from participants as

Box 6 Factors associated with difficulty to provider

Less difficult

- ▶ Patient or family gratitude.
- ▶ Older age patients with a sense of life completion.
- ▶ More certainty in prognosis.
- ▶ Family agreement and participation at end of life.
- ▶ Relieved current or future physical or existential suffering.
- ▶ Returning a sense of control to the patient resulted in patient not continuing with the MAiD process and dying a comfortable natural death.
- ▶ Medical team collegial support, debriefing.
- ▶ Mentorship, training and accumulated personal experience.

More difficult

- ▶ Conflict, including family disagreement with the patient's wishes.
- ▶ Witnessing pain and suffering, especially if cannot modify that suffering.
- ▶ Level of agency and responsibility, being 'on the other end of the syringe'.
- ▶ Patient of young age.
- ▶ Witnessing family emotional crisis.
- ▶ Saying no to a person not meeting eligibility criteria.
- ▶ Uncertainty in prognosis.
- ▶ First-time provider.
- ▶ Difficulty with logistics.
- ▶ Paperwork—quantity, ambiguity and importance.
- ▶ Fear of accusation postdeath of wrongdoing (or doing paperwork wrong).
- ▶ Medical establishments getting in the way (bureaucracy, conscientious objection).
- ▶ Specific criticism of provider.
- ▶ Conflict or criticism by professional colleagues.
- ▶ Worry about censure from community (managing perception).
- ▶ Emotional distress of team member or trainee.

we chose to do extended (120 min) face-to-face interviews. Thus, our participants were restricted to providers who would take initiative and commit significant time. It is possible that MAiD providers with more negative experiences or experienced regrets would be less likely to volunteer for a lengthy interview.

Another limitation is the timing of our use of AI-enhanced analysis. We added the ChatGPT analysis in 2023 when ChatGPT was in its first months of use (introduced 30 November 2022). There was no literature to guide us on the reliability of artificial intelligence in thematic analysis. We considered our use of AI-enhanced analysis to be low risk because we used it to complement the analysis that had been completed almost 3 years earlier. We decided to adopt the novel strategy on our previously analysed data to see if it could assist in identifying human bias unknowingly embedded in our previously completed analysis. We did not find any significant differences. In summary, Chat GPT was useful in providing an excellent thesaurus of synonyms for ideas we already identified. Since that time, there are helpful publications about the strength and weaknesses of AI-enhanced analysis⁶⁴ and further researchers using these will have published experience to guide use and interpretation.

CONCLUSION

Understanding providers' experience of MAiD is important for stakeholders, patients, colleagues, ethicists, legislators,

regulators and future providers. The sustainability of MAiD relies on the willingness of medical providers to engage in the practice. Our study fits into the body of literature demonstrating that emotional and moral stressors affect physician well-being, which influences their effectiveness in their professional and personal lives.

In Canada, a central provider is almost entirely responsible for both the measurable and unmeasurable aspects of assisted dying. These roles and concerns go well beyond the individual patient, including interfacing with the family, medical team and community. Within the circle of influence for providers are community perceptions of professionalism and the well-being of the involved medical team.

Physician providers in this study were mostly very confident about their actions. Participants described MAiD as emotionally provocative with both challenges and rewards. Participants expressed a firm reliance on patient autonomy as a reason for providing MAiD and a secondary reliance on the duty to relieve suffering. They valued their professional autonomy to choose when and how to participate in MAiD. This sense of autonomy seemed to help offset the agency of doing a procedure with moral hazards. Participants also appreciated a sense of connection to the patient, gratitude from the patient and family, and the perception of doing the ‘right thing’ for the patient and themselves. Together, these provided a sense of purpose and moral security to continue providing MAiD.

Contributors JPW is responsible for the overall content as guarantor. The guarantor accepts full responsibility for the finished work and/or the conduct of the study, had access to the data and controlled the decision to publish. JPW conceived the study in close consultation with CJ and NJP, who were involved in every step of conceptualisation and design. JPW, NJP and CJ developed the theoretical framework. JPW collected the data. CJ and NJP aided JPW in the primary analysis. CJ, NJP and SW collaborated in secondary analysis. CJ, NJP and SW supervised the project. All authors discussed the results and contributed to the final manuscript. JPW took the lead in writing the manuscript, and CJ, NJP and SW contributed to all major drafts as well as contributing to the final version of the manuscript and supervised the project. All authors provided critical feedback and helped shape the research, analysis and manuscript. We used ChatGPT to confirm our inductive thematic analysis. This is described in the methods section. In the methods section, we quote the three prompts that we entered for our question to ChatGPT and which anonymised data excerpts were given to the ChatGPT to thematically analyse.

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ORCID iDs

Janine Penfield Winters <http://orcid.org/0000-0002-4505-4032>

Neil John Pickering <http://orcid.org/0000-0001-8629-1627>

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