Exploring How Internal Medicine Residents Approach Requests for Medical Assistance in Dying: An Exploratory Qualitative Study at the University of Calgary

Krista M Reich MD, MSc¹, Amy Tan MD, MSc²,³, Jacqueline Hui MD, MHPE³

¹Division of Geriatric Medicine, Department of Medicine, University of Calgary, Calgary, Alberta, Canada; ²Division of Palliative Care, Department of Family Practice, University of British Columbia, Vancouver, British Columbia, Canada; ³Division of Palliative Care, Departments of Family Medicine and Oncology, University of Calgary, Calgary, Alberta, Canada

Corresponding Author: Dr. Krista Reich MD MSc FRCPC, Division of Geriatric Medicine, Department of Medicine, University of Calgary, Calgary, Alberta, Canada. Email: krista.reich@albertahealthservices.ca

Submitted: 27 September 2022; Accepted: 7 July 2023; Published: 28 August 2023

DOI: https://doi.org/10.22374/cjgim.v18i3.665

Abstract
To develop Medical Assistance in Dying (MAiD) competencies and curricula, we aimed to create a framework outlining how internal medicine (IM) residents approach MAiD requests and identify subsequent learning gaps. We used qualitative descriptive methodology to explore individual participant responses to three clinical vignettes centered on aspects of MAiD, followed by a group discussion. Responses were recorded and transcribed. Codes were reviewed and iteratively organized into themes, highlighting the steps taken for each MAiD scenario. Themes were compared and classified into broader categories within a framework to describe the participants’ overall approach to MAiD requests. Three overarching categories illustrated the approach taken by participants when faced with MAiD requests: 1) Action: the pragmatic steps participants took to respond to requests 2) Decision: the rationale behind how participants decided if MAiD was an option; and 3) Reaction: the emotional reactions that arise from requests; each highlighted significant learning gaps. Participants lacked understanding in concurrent medical and symptom management, MAiD eligibility and referral criteria, roles and responsibilities, and were uncomfortable discussing MAiD. IM residents not only require education on MAiD as a topic but on developing an approach to responding to requests and ways of addressing subsequent personal reactions.

Résumé
Afin de développer les compétences et les programmes d’études en l’aide médicale à mourir (AMM), nous avons cherché à créer un cadre décrivant la manière dont les résidents en médecine interne (MI) abordent les demandes d’AMM et à identifier les lacunes d’apprentissage qui en découlent. Nous avons utilisé une méthodologie descriptive qualitative pour explorer les réponses individuelles des participants à trois vignettes...
Cliniques centrées sur les aspects de l’AMM, suivies d’une discussion de groupe. Les réponses ont été enregistrées et transcrites. Les codes ont été examinés et organisés de manière itérative en thèmes, mettant en évidence les mesures prises pour chaque scénario l’AMM. Les thèmes ont été comparés et classés dans des catégories plus larges à l’intérieur d’un cadre destiné à décrire l’approche globale des participants à l’égard des demandes d’AMM. Trois grandes catégories illustrent l’approche adoptée par les participants lorsqu’ils sont confrontés à des demandes d’AMM: 1) Action : les mesures pragmatiques prises par les participants pour répondre aux demandes ; 2) Décision : les raisons pour lesquelles les participants ont décidé si l’AMM était une option ; et 3) Réaction : les réactions émotionnelles suscitées par les demandes ; chacune de ces catégories a mis en évidence d’importantes lacunes en matière d’apprentissage. Les participants ne comprenaient pas bien la gestion simultanée des soins médicaux et des symptômes, les critères d’éligibilité et d’orientation d’AMM, les rôles et les responsabilités, et n’étaient pas à l’aise pour discuter d’AMM. Les résidents en médecine interne ont besoin d’une formation non seulement sur l’AMM en tant que sujet, mais aussi sur l’élaboration d’une approche pour répondre aux demandes et sur les moyens de faire face aux réactions personnelles qui en découlent.

**Keywords:** medical assistance in dying, medical education, internal medicine

**Introduction**

Medical Assistance in Dying (MAiD) is a term that encompasses both voluntary euthanasia and physician-assisted suicide. The Supreme Court of Canada passed Bill C-14 in June 2016, legalizing MAiD for competent adults diagnosed with a grievous and irremediable medical condition. Since legislative enactment, the number of MAiD requests and subsequent deaths has been growing steadily each year. In 2021, around 80% of MAiD requests culminated in the provision of MAiD, and the total number of MAiD deaths was 10,064, accounting for approximately 3.3% of all deaths in Canada. This represents a growth rate of 32.4% from the previous year.

Under federal regulation, MAiD is considered a professional standard of practice. However, postgraduate medical education programs lack formally established MAiD education competencies to prepare postgraduate trainees for this new professional area of care. In a 2016 provincial survey of resident physicians of British Columbia, 75% (total n=299) reported having had no formal MAiD education, and 64% disagreed that their residency programs provided sufficient education to support patient-informed decision-making about MAiD, with no difference across training programs. Furthermore, only 30% were comfortable discussing MAiD with patients, with an even smaller proportion of residents within Internal Medicine (IM) (19%). Consequently, there exists a critical need for structured MAiD education among postgraduate residents in Canada.

Although there are resources available for clinicians to learn more about MAiD, little research exists on identifying resident-specific learning gaps that would help inform the development of a MAiD curriculum. More specifically, there is a lack of literature regarding MAiD-related learning needs of IM residents. While the frequency of MAiD requests among IM residents is unknown, a significant number of family medicine residents (87.5%) have reported receiving one or more requests for MAiD. With 25% of MAiD recipients having multiple underlying medical conditions, including common ones such as cancer, cardiovascular, and respiratory conditions, it can be anticipated that IM residents also frequently receive MAiD requests. We sought to explore the following research question: how do IM residents at the University of Calgary respond to MAiD requests? In doing so, the purpose of this study was to: (1) create a framework that describes how IM residents approach MAiD requests, and (2) identify learning gaps in responding to MAiD requests. The findings from this study aim to provide valuable insights to shape the future development of a MAiD residency training curriculum for IM residents.

**Methods**

**Study design, setting, and sample**

We used qualitative descriptive methodology to explore IM residents’ experiences of responding to MAiD requests and develop a framework describing how IM participants respond to these requests.

We employed purposive and criterion sampling techniques to identify and recruit participants who had first-hand experiences relating to our phenomenon of interest. The study sample included first to third year residents...
(i.e., PGY1-PGY3) completing their core IM training at the University of Calgary (UofC) during the 2018-2019 academic year. Trainees rotate through urban academic settings with dedicated weekly protected time for AHD.14

The researcher scheduled 1 hour of curricular time with the UofC Internal Medicine Residency program to conduct this study at the end of an AHD session in a classroom. Participants were recruited and consented through an email invitation sent 1 week prior to and again in person right before the session by KR, who was a co-resident at the time of the study. Written informed consent was obtained from each resident prior to participation. Participation was voluntary, with no bearing on evaluations or training. Participants could skip questions or withdraw from the study at any time. Nonparticipants were given the option to stay as observers but were requested not to actively participate in activities involving data collection. This study received ethics approval from the UofC Health Research Ethics Board (REB18-0308).

Data collection
Demographics and prior education, experience, and confidence in MAiD
Participants were asked at the beginning of the session to complete an online pre-session survey using Qualtrics about participant demographics (e.g., age, sex, PGY), prior training relating to MAiD, and confidence in responding to MAiD requests (Appendix A).

Clinical Vignettes
Participants were then asked to complete a separate online survey, unlinked to the first to promote anonymity, prompting for individual reflections and written responses to three hypothetical patient scenarios centered on patients with life-limiting medical conditions (Figure 1).

The patient scenarios were created by an expert clinician-educator (JH). The scenario questions were designed to explore the participants’ approach to MAiD requests. At the time of the study, MAiD legislation required death to be reasonably foreseeable; however, we would like to highlight that with new legislation in 2021, individuals whose natural death is not reasonably foreseeable (non-RFND) are now eligible to request MAiD (former Bill C-7).3,15 Despite this, non-RFND provisions are infrequent (2.2%),3 and thus the scenarios used in this study remain pertinent and applicable.

With each successive scenario, the patient portrayed met additional eligibility criteria for MAiD at the time. For example, in scenario 1, the patient was not eligible for MAiD and

![Figure 1. Residents responded to open ended questions on aspects of MAiD for three clinical vignettes of hypothetical patient scenarios with life limiting medical conditions.](image-url)
in scenario 3, the patient was eligible for MAiD. Scenario 2 intentionally incorporated ambiguity in eligibility criteria to introduce a nuanced scenario, given this study took place when eligibility for MAiD was presented as the most important component of the MAiD legislation for all clinicians to be aware of, irrespective of their involvement in MAiD provision. However, based on new legislation that death does not need to be reasonably foreseeable, the patient in scenario 2 would now be eligible for MAiD.

Once written responses to each vignette were submitted online; participants joined a large-group, in-person discussion focused on each scenario and led by an expert educator and clinician with experience in MAiD assessments (JH). JH is a palliative care physician with training in MAiD education and was not in an evaluative role. The facilitator asked the whole group to share their responses to each patient scenario voluntarily and posed informal questions to facilitate and encourage discussion. This facilitated case-based discussion was audio-recorded, transcribed, and de-identified. This was followed by a 20-minute lecture on MAiD by JH. Residents were asked to complete a post-session online survey to identify perceived learning needs (Appendix A).

Data analysis
Data from the online survey were analyzed in SPSS Version 25 (IBM Corp, USA) using aggregate descriptive statistics. For categorical variables, proportions were calculated as percentages. For continuous variables, medians and interquartile ranges (IQR) were calculated based on the distribution of the data. Using inductive thematic analysis, initial codes of the written responses, transcripts, and post-survey responses were reviewed and discussed over multiple meetings to identify patterns in the data and iteratively organized into broader themes for how participants approached MAiD. We characterized themes as units that reflect recurring patterns of shared-meaning relating to a central organizing concept (i.e., MAiD), and sub-themes as domains that capture an important facet of a central organizing concept within a theme. Through iteratively reviewing coded segments of data, we identified various themes, explored their relationships to one another, and classified themes to broader categories creating a framework to describe how participants approached MAiD requests.

We considered data saturation and information power to be achieved since no new themes were identified, nor did any codes fail to map to a theme. 

Researcher Positionality
Two investigators were present at the session (KR, JH) and the third investigator (AT) was absent, thereby providing an outside perspective on themes identified. All authors were involved in the coding of the data. At the time of the study, KR was a PGY2 IM resident and provided a unique lens on data interpretation. JH and AT are palliative care physicians (CCFP (PC), FCFP) who have received MAiD requests and are familiar with the MAiD process in Alberta; they are not MAiD assessors or providers. Both are educators who have held leadership roles in undergraduate and postgraduate medical education.

Results
Study participants
A total of 97 IM residents were in the 2018 – 2019 academic year at UofC, of which 20 participated in the pre-session survey, 28 in the clinical vignettes, and 12 in the post-session survey. We did not record the number of participants who actively participated and verbally shared their approach in the group discussion. Of those who participated in the pre-session survey, 50% were female, and 55% were in their first year (Table 1).

Prior education, experience, and confidence in approaching a MAiD request
During residency, only 35% (7/20) of participants received education in MAiD and 40% (8/20) received a prior MAiD request, of whom did not feel confident in responding to the request; this was defined by reporting “a little confident” or “not at all confident.” The type or format of teaching was not...
specified. Regardless of exposure to MAiD requests, 90% (18/20) of participants lacked confidence in responding to a potential MAiD request. All participants (20/20) identified they would like more education about MAiD incorporated into their residency training (Table 2).

Clinical Vignette Responses
From the 28 participants who submitted responses to the three clinical vignettes, 14 pages of qualitative data were collected. Our analysis of this data identified three categories that reflect how IM residents approach decision-making when presented with a MAiD request: 1) Action, 2) Decision, and 3) Reaction. Within each category, learning gaps were further identified (Figure 2). In analyzing the data, we noticed that the participants approached MAiD-request scenarios by what they perceived they did not know (i.e., learning gaps) rather than describing their actual approach to these clinical scenarios, such that our themes highlighted areas where they grappled with or responded to incorrectly in working through the scenarios. Themes, sub-themes, and key supporting quotes that led to the formulation of these three categories can be found in Table S1 (Appendix B).

CATEGORY 1: Action
Action describes the pragmatic steps participants took to respond to a MAiD request and involves Communication and Medical and Symptom Management.

Communication
Creating an environment for shared decision-making
Participants consistently provided empathy, formed trusting relationships, and established a common understanding. This was done by exploring the wishes and values of patients and their families to understand patient preferences around their medical care and clarifying previous goals of care, advanced care plans, and alternate decision-makers. They identified their obligation to the patient first and created an environment for shared decision-making.

“...I'm sorry to learn you feel so terrible. I would like to have a better and thorough understanding of what you're going through, what you cannot tolerate, your values, and preferences surrounding your medical care ...”

“Would address if any alternate decision maker is established or advanced directive. Understand the patient’s values ... and create a shared decision-making plan ...”

“Obligation is first to the patient...”

Exploring reasons for requesting MAiD
Participants tried to understand the underlying motivation behind the request by exploring the reasons for requesting MAiD. They assessed symptom control, quality of life, and mood.

“Try to understand further what ... has prompted (the patient's) request ...”

“Explore the wish for MAiD and specifically what is driving it ...”

“Assess ... quality of life, mood and physical symptom progression.”

Medical and Symptom Management
Lack of understanding that medical and symptom management can occur concurrently
When starting a management plan, participants prioritized medical management over symptom control in keeping with physician-driven attention to symptoms. This was evident from frequent quotes stating participants would treat acute and chronic medical problems first before considering symptom control in patients living with a serious illness and requesting MAiD. If medical management was
unsuccessful, participants would be more comfortable moving toward symptom management rather than managing them concurrently.

“Treat what is treatable first and then provide symptom control.”

“I would have a GOC (goals of care) discussion with the family with the goal of proceeding with medical therapy and ultimately comfort care if medical therapy was unsuccessful.”

“…transition to palliative care should all medical conditions be treated and refractory to improvement.”

“I would assess why (the patient) feels this way ... (determine) whether (the patient) has potentially treatable causes.”

Lack of comfort with symptom management
Participants who identified the need to manage symptoms, frequently mentioned they would consult palliative care for ongoing symptom management. This is in keeping with patient-centered symptom management but reflects lack of comfort in managing symptoms independently.

“Offer to consult palliative care for symptom management.”

“Offer further palliative care support ... to provide good symptom management.”
“Would like to involve palliative care to manage his symptoms better.”

CATEGOR Y 2: Decision
Decision describes the rationale behind how participants decided if MAiD was an option based on their knowledge about MAiD eligibility, processes, and patient experiences. It involves assessment of MAiD eligibility and consideration of Roles and Responsibilities.

MAiD Eligibility
Awareness of core eligibility criteria
Participants were aware of the eligibility criteria of having the capacity to consent to MAiD, a grievous and irremediable medical condition, and acknowledging the request must come from the patient, including assessing for external coercion. No other criteria were identified.

“MAiD would be an option if we felt that the patient was … capable of making decisions.”

“I do not think MAiD is an option as the patient is not compos mentis and family members cannot make the decision (regarding) MAiD…”

“Make sure there is no outside pressure or motivation.”

“If (the patient is) suffering from an illness/disease process which is irremediable that causes undue suffering or is expected to progress into undue suffering then potentially MAiD is an option.”

Lack of understanding that active medical and symptom management can co-exist with a MAiD referral
Participants perceived patients as eligible for MAiD only when medical therapy failed and symptoms were controlled. Their decision around referral to the MAiD team was driven by the degree of symptom control, the degree of reversibility of symptoms, and/or if all other treatment options had been tried and/or failed. This was demonstrated by quotes where participants felt they had to explore all options and patients had to be medically optimized before MAiD could be considered as an EOL care option.

“Before offering MAiD, obligated to confirm that there are no more treatment options that could potentially improve this patient’s QoL (quality of life).”

“I am not sure if MAiD is an option, given there may be some reversibility.”

“Ensure we have explored all options to ensure (the patient) is suffering as little as possible (before referring for MAiD).”

“It is not at that point – not all medical management has failed.”

“Theoretically, if symptoms are palliated to the best of our medical and pharmacological ability, then yes (MAiD is an option).”

Roles and Responsibilities
Lack of understanding of roles and responsibilities
Participants lacked understanding of their role in the referral process and their obligations as a physician who receives MAiD requests. Participants assessed patients’ eligibility for MAiD to determine if they should refer the patient or not as an informal assessment. This was demonstrated by quotes around assessing capacity, cognition, and mood before referring for MAiD.

“Obligation to legal/society to do a complete assessment and ensure competent (before referring for MAiD).”

“Screen for depression - if not depressed, then contact the MAiD team.”

“I think I would assess for a mood disorder, is this related to depression or consciously thinking about how this affected (patient’s) life at this point, do a cognitive assessment to make sure (patient) has capacity (before referring for MAiD).”

Lack of understanding of pragmatic steps in referring a patient for MAiD
Furthermore, participants lacked understanding of the direct referral process, how to make a referral, and how to support patients accessing resources.

“(lack of knowledge on) who to contact, what happens, etc.”

“(lack of knowledge on) how to specifically get a hold of the MAiD team.”

“No understanding of the process.”
CATEGORY 3: REACTION

Reaction represents the emotions in responding to a MAiD request, involving Discomfort with Discussing MAiD.

Discomfort with Discussing MAiD

Lack of an approach to responding to MAiD requests

Participants felt discomfort discussing MAiD with patients due to lack of an approach to these discussions and perceived legal landmines. This discomfort was a deterrent to even bringing up MAiD as an option for EOL care.

“Being human, (I am) worried about the implications of the law ... worry about the ramifications of bring it up to (a patient).”

“I do not feel fully informed about its practical and legal details.”

“(I have) discomfort in bringing up MAiD because (I) don’t have the facts or legal or practical details of how to go about it.”

“(I) struggle with understanding at what point are you screening somebody or are you proving MAiD as a care option and coercing them when they are vulnerable, with a lot of pain and suffering, and not really knowing how navigate those conversations.”

Lack of ability to balance the ethical complexities of MAiD

There was no discussion around the ethical principles, addressing emotions, or acknowledging unconscious bias. Participants assumed responsibility for addressing patient reasons for requesting MAiD to “remedy” patient concerns or symptoms.

“Try to determine whether anything can be done to remedy these concerns.”

“(determine) if there are specific symptoms or scenarios which they are trying to avoid by pursuing MAiD.”

“...definition of ‘suffering’ may not be at threshold yet/ could be addressed.”

“If there are ways to manage ongoing dyspnea (e.g. from a palliative approach) these should be brought up and the physician should see if the patient is willing to try these options before discussing MAiD.”

Lack of self-identified need for addressing emotional responses

When asked to self-identify their learning needs in MAiD, participants would prefer specific education on the practical considerations and realistic aspects of their legal requirements around MAiD referrals and processes. They were less interested in case-based discussions and in addressing their emotional responses. Participants prioritized a pragmatic approach to MAiD education.

“What would be most helpful would be very specific information of who to call once a patient has requested MAiD.”

“Logistics of who can become an assessor and the aspects of training.”

“The actual nitty gritty of forms, who to contact, what happens etc.”

“Reviewing some of the more practical points e.g., timing of the request, legalities, re: who is eligible or ineligible to make the request.”

Discussion

We completed a qualitative descriptive study using thematic analysis to explore IM residents’ responses to clinical vignettes centered on aspects of MAiD. We identified three categories that outline how IM residents approach MAiD requests: Action, Decision, and Reaction, identifying five themes that reflect key facets of the approach to MAiD requests and highlighting areas that can be addressed through further training.

Our findings illuminate key steps for how IM residents in Calgary, Alberta approach MAiD requests and are similar to the findings of Patel et al. who reviewed clinician experiences with hastened death requests. Comparable with our subtheme, where participants explored reasons for requesting MAiD, clinicians try to comprehend the underlying reasons for these requests and determine whether it stems from physical or psychological symptoms or existential suffering. However, in our study, participants prioritized medical issues and often relied on palliative care consultants for symptom management, representing a lack of comfort in managing patients’ symptoms. This aligns with the palliative care literature, where Canadian IM residents express uncertainty around
integrating medical management with comfort-focused modalities and feel uncomfortable with all areas of symptom management. Addressing this learning gap is crucial, as 58% of MAiD requests in 2021 were driven by inadequate pain control. The initial approach to MAiD shares similarities with palliative care. Future education should emphasize the generalist palliative care skills of symptom management, serious illness conversations, and advance-care planning, allowing patients to make informed choices around continuing with medical management or exploring other options, even when contemplating or awaiting MAiD assessments.

Major learning gaps were identified in the domains of MAiD eligibility and clinician roles and responsibilities. Participants essentially performed informal MAiD assessments for eligibility and inappropriately considered MAiD as an option only after exhausting all medical options and optimizing symptoms. This may lead to delayed referrals and ineligibility due to loss of capacity. To address this, IM residents would benefit from further education on understanding their role in responding to MAiD requests, eligibility criteria, referral processes, and policies. This includes learning about the provincial MAiD Care Coordination program and additional training required to become an assessor.

MAiD requests trigger discomfort and many clinicians feel overwhelmed when approaching requests for hastened death. This is in keeping with our findings, where residents felt discomfort with discussing MAiD. This discomfort may stem from concerns around patient coercion and legal vulnerability due to lacking an approach to navigating such conversations. As a result, participants were uncomfortable with even bringing up MAiD as an option of EOL care, echoing Patel et al’s findings that some clinicians actively avoided conversations about MAiD due to discomfort. Furthermore, insufficient training in communication and ethics related to EOL care can contribute to burnout and moral and psychological distress. Residents may benefit from developing communication skills related to EOL conversations and an ethical framework for addressing MAiD requests. Additionally, faculty development to develop preceptors’ skills in fostering a supportive environment where residents can express their discomfort will be essential to mitigate the emotional burden of these experiences.

Our study highlights the ethical complexities surrounding MAiD requests. Participants’ efforts to address patients concerns reveal the impact of professional identity and the ethical dilemmas arising from such requests. When physicians cannot effectively alleviate suffering, their professional identities may become compromised. Competing interests of patient autonomy further complicate this. Consequently, attempts to address patient concerns in our study may stem from moral distress related to perceptions that MAiD requests represent a failure of medical care, aligning with findings from Patel et al. Additionally, unconscious bias may lead to a lack of prioritization of patient autonomy, resulting in circumvented referrals. These observations underscore the influence of professional values on clinicians’ response to requests for hastened death and can contribute to postponed referrals. Despite this, there was limited discussion around personal reactions and emotions among participants, consistent with existing literature. We strongly recommend that educational sessions include ways of approaching personal reactions, including reflection on personal readiness for this professional role, identifying and navigating moral and ethical tensions and unconscious bias. Ultimately, this preparation would enable participants to better balance respecting patient autonomy and honouring their values.

Limitations

The nature of the sample, approach, and training context limits transferability of findings from this study. This study sample comprised IM residents within a university in Western Canada who attended an AHD session, which was not representative of all UofC IM residents or other institutions. Voluntary participation also introduced self-selection bias. Furthermore, we did not link resident characteristics to their responses, preventing differentiation based on training level, experience, and aspects of personal identity. The case vignettes used in the study were developed de novo, and responses to theoretical scenarios may differ from real-life situations. Having not used standardized questions during the open discussion, we may not have identified all learning gaps, and the social dynamics of a group discussion may have limited exploration of personal reactions. It is important to note that while healthcare delivery is a provincial/territorial responsibility in Canada, MAiD is governed by Canadian legislation; therefore, these results are generalizable to other medical programs nationwide.

Conclusions

This is the first study to identify learning gaps in MAiD of IM residents, highlighting the need for integrated MAiD
and EOL care education within IM training programs. We identify overlapping skills required for approaching both MAiD and EOL discussions and addressing symptoms. By presenting an integrative curriculum rather than treating MAiD and EOL care as separate entities, we can better reflect the comprehensive EOL options available for Canadian patients. Furthermore, we propose a longitudinal reflective component on identifying and addressing emotional aspects evoked from MAiD discussions to enhance patient care for those seeking MAiD and promote the well-being of trainees responding to these requests.

Author Contributions

All three authors contributed equally to the conception and design, procurement of data, and data analysis. Krista Reich completed the first draft of the manuscript, and all three authors contributed to the critical review and revision of the final manuscript.

Funding

There was no funding for this project.

Conflict of Interest

All three authors have no conflicts of interest to disclose.

References

7. Canadian Association of MAID Assessors and Providers CAMAP. Clinician Resources.[Internet]. Canada: [publisher unknown]; [updated 2022; cited 2023 June 12]. Available from: https://camapcanada.ca/clinicians/clinician-resources/
Exploring how internal medicine residents approach MAiD requests

Appendix A
Pre-Session and Post Session survey

Pre-Session Survey

Demographics:
1. Please specify your sex: male/female/other: (free text)
2. Please specify your age: (free text)
3. Please specify the residency program you are currently part of (if you are in a fellowship program or enhanced skills program, please specify that program and your previous general residency program): (free text)
4. Please specify the year you are in of your current residency program (if you are in a fellowship program or enhanced skills program, please specify what year you are in of your current program, and number of years completed in your previous general residency program): (free text)

Previous Teaching/Training in MAiD:
1. How many hours of MAiD education have you had before your residency training? (free text)
2. How many hours of MAiD education have you had since the beginning of your residency training? (free text)
3. If you are in a fellowship program, how many hours of MAiD education have you had while in this current program? (free text)
4. Do you think more education in MAiD should be a part of your residency program? (Yes/No)

5. Have you received a request for MAiD during your training? (Yes/No)
   a. If yes, please rate your confidence levels in responding to the MAiD Request.
      
      | Not very confident | A little confident | Don't know | Fairly confident | Very confident |
      |--------------------|--------------------|------------|-----------------|---------------|
   i. In what ways did you or did you not feel confident? (free text)
   b. If no, please rate your confidence in responding to a potential request at this time.
      
      | Not very confident | A little confident | Don't know | Fairly confident | Very confident |
      |--------------------|--------------------|------------|-----------------|---------------|
   i. In what ways do you or do not feel confident? (free text)

Post-Session Survey
1. We understand that the didactic lecture may not have addressed all your learning needs in MAiD. After going through the cases and having a brief teaching session on MAiD, what else would you like to learn about (free text)?
2. Would you recommend we do anything differently at any point during the session? (free text)
3. Was the format appropriate in exploring your learning needs in MAiD?
   a. If no, please explain what could be changed.
<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Sub-Theme</th>
<th>Participant Quotes</th>
</tr>
</thead>
</table>
| Action   | Communication | Creating an environment for shared decision-making | “I’m sorry to learn you feel so terrible. I would like to have a better and thorough understanding of what you’re going through, what you cannot tolerate, your values, and preferences surrounding your medical care ...”
|          |        |           | “Would address if any alternate decision maker is established or advanced directive. Understand the patient’s values ... and create a shared decision-making plan ...”
|          |        |           | “Obligation is first to the patient...”
|          |        |           | “Professional obligations to help patient whenever is possible”
|          |        |           | “Empathize with situation, try to clarify if patient had pre-existing goals of care documentation.”
|          |        | Exploring reasons for requesting MAiD | “Try to understand further what ... has prompted (the patient's) request ...”
|          |        |           | “Explore the wish for MAiD and specifically what is driving it ...”
|          |        |           | “Assess ... quality of life, mood and physical symptom progression”
|          |        |           | “To explore what the (patient) means by this request ...”
|          |        |           | “Explore ... symptoms that (I) could help alleviate”
|          |        |           | “what is (the patient's) understanding of (requesting MAiD)”
|          |        |           | “… evaluate if this is a long thought out process or a quick decision because of frustration ...”
| Medical and Symptom Management | Lack of understanding that medical and symptoms management can occur concurrently | “Treat what is treatable first and then provide symptom control”
|          |        |           | “I would have a GOC (goals of care) discussion with the family with the goal of proceeding with medical therapy and ultimately comfort care if medical therapy was unsuccessful”
|          |        |           | “…transition to palliative care should all medical conditions be treated and refractory to improvement”
|          |        |           | “I would assess why he feels this way ... (determine) whether (the patient) has potentially treatable causes”
|          |        |           | “Treat ... given there is a curative outcome”
|          |        |           | “Let's do more treatment ... Look for strategies to compensate for lost functions or find alternatives”
|          |        |           | “(Obligation to) ensure adequate medical therapy and investigations.”
|          |        |           | “(Obligation to) provide the best medical care available”
|          |        | Lack of comfort with symptom management | “Offer to consult palliative care for symptom management”
|          |        |           | “Offer further palliative care support .... to provide good symptom management”
|          |        |           | “Would like to involve palliative care to better manage his symptoms”
|          |        |           | “…transition to palliative care should all medical conditions be treated and refractory to improvement”
|          |        |           | “Assess if can obtain palliative care consult ...”
|          |        |           | “Offer palliative care if it is not already offered ...”
| Decision | MAiD Eligibility | Awareness of core eligibility criteria | “MAiD would be an option if we felt that the patient was ... capable of making decisions”
|          |        |           | “I do not think MAiD is an option as the patient is not compos mentis and family members cannot make the decision (regarding) MAiD...”
|          |        |           | “Make sure there is no outside pressure or motivation”
|          |        |           | “If (the patient is) suffering from an illness/disease process which is irremediable that causes undue suffering or is expected to progress into undue suffering then potentially MAiD is an option.”
|          |        |           | “As long as competent, not coerced - can go forward (with MAiD)”
|          |        |           | “Would explore any element of coercion from family”
|          |        |           | “Yes MAiD is an option....if patient clearly expresses wishes and deemed competent.”

(continues)
<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Sub-Theme</th>
<th>Participant Quotes</th>
</tr>
</thead>
</table>
|          |       |           | "It is an option given (the patient) has a terminal condition that is not going to improve."
|          |       |           | "MAiD is not an option if request is coming from wife."
|          |       |           | "Yes MAiD an option as (the patient) is competent, and request is coming from (the patient)"
|          |       |           | "MAiD may be an option, as (the patient) appears to have capacity"
|          | Lack of understanding that active medical and symptom management can co-exist with a MAiD referral |           | "Before offering MAiD, obligated to confirm that there are no more treatment options that could potentially improve this patient’s QoL (quality of life)"
|          |       |           | "I am not sure if MAiD is an option, given there may be some reversibility"
|          |       |           | "Ensure we have explored all options to ensure (the patient) is suffering as little as possible (before referring for MAiD)."
|          |       |           | "It is not at that point – not all medical management has failed"
|          |       |           | "Theoretically, if symptoms are palliated to the best of our medical and pharmacological ability, then yes (MAiD is an option)."
|          |       |           | "If we have maximized care, I would then speak with a MAiD specialist …"
|          |       |           | "If this is non-reversible, I would speak with a MAiD consultant."
|          |       |           | "If there are ways to manage ongoing dyspnea (e.g., from a palliative approach) these should be brought up and the physician should see if the patient is willing to try these options prior to discussing MAiD."
|          |       |           | "First, do no harm. There is an obligation to discuss current medical state and overall prognosis, treatment options, recommendations, and alternatives (before referring for MAiD)."
|          |       |           | "Would consider (MAiD) if getting optimal symptom control"
|          |       |           | "I would look for reversible aetiologies contributing to symptoms and poor quality of life. If … optimal medical therapy has not improved … I would speak with a specialist in MAiD …"
|          |       |           | "I would assess why (the patient) feels this way, whether he has depression or another potentially treatable cause etc. (before referring for MAiD)"
|          |       |           | "(I) need to fully understand the disease process in question, treatments that have been attempted, if there are any possible reversible causes which could be addressed … (before referring for MAiD)"
|          |       |           | "I do not think it is an option - we need to explore other treatments/alternatives"
|          |       |           | "We need to make sure his symptoms are adequately treated, so it is not an option right now"
|          |       |           | "Ensuring that (the patient) is otherwise optimized would be important before forsaking other palliative options and pursuing MAiD."
|          |       |           | "If no other management options left (would refer for MAiD)."
|          |       |           | "Optimize pharm and non-pharm management (before referring for MAiD)."
|          |       |           | "Symptoms are adequately addressed and that we are doing everything from a palliative perspective to ensure his dyspnea and mood are well managed before we look to MAiD"
|          |       |           | "MAiD could be an option … but consider if symptom control could be optimized"
|          |       |           | "(Consider MAiD) should all (patient’s) symptoms be treated and refractory to improvement."
<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Sub-Theme</th>
<th>Participant Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role and Responsibilities</td>
<td>Lack of understanding of roles and responsibilities</td>
<td>“Obligation to legal/society to do complete assessment and ensure competent (before referring for MAiD).”</td>
<td>“Screen for depression - if not depressed, then contact the MAiD team.” “I think I would assess for a mood disorder, is this related to depression or consciously thinking about how this affected (patient’s) life at this point, do a cognitive assessment to make sure (patient) has capacity (before referring for MAiD).” “If (patient) chooses MAiD, make sure that (patient) meets the criteria that defines eligibility (before referring for MAiD)” “Do a psych assessment- is (the patient) experiencing depression. Do a cognitive assessment- is (the patient) cognitively intact and capable of having discussions about MAiD.” “Psychiatric Hx, cognitive assessment. If cognitively intact, and choice is not affected by mood disorder then would (refer for MAiD)”</td>
</tr>
<tr>
<td></td>
<td>Lack of understanding of pragmatic steps in referring a patient for MAiD</td>
<td>“(lack of knowledge on) who to contact, what happens etc.” “(lack of knowledge on) how to specifically get a hold of the MAiD team.” “No understanding of the process” “No experience at all”</td>
<td></td>
</tr>
<tr>
<td>Reaction</td>
<td>Discomfort with Discussing MAiD</td>
<td>Lack of an approach to responding to MAiD requests</td>
<td>“Being human, (I am) worried about the implications of the law … worry about the ramifications of bring it up to (a patient).” “I do not feel fully informed about its practical and legal details” “(I have) discomfort in bringing up MAiD because (I) don’t have the facts or legal or practical details of how to go about it” “(I) struggle with understanding at what point are you screening somebody or are you proving MAiD as a care option and coercing them when they are vulnerable, with a lot of pain and suffering, and not really knowing how navigate those conversations” “You don’t want to not be offering something (MAiD), but you don’t want to rush towards a path …” “… there is gray zone of bringing up the idea of MAiD” “No understanding of the process” “No experience at all”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of ability to balance the ethical complexities of MAiD</td>
<td>“Try to determine whether anything can be done to remedy these concerns” “(determine) if there are specific symptoms or scenarios which they are trying to avoid by pursuing MAiD.” “… definition of ‘suffering’ may not be at threshold yet/could be addressed” “If there are ways to manage ongoing dyspnea (e.g., from a palliative approach) these should be brought up and the physician should see if the patient is willing to try these options prior to discussing MAiD.” “Ensure (the patient) understands the magnitude of request.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of self-identified need for addressing emotional responses</td>
<td>“What would be most helpful would be very specific information of who to call once a patient has requested MAiD.” “Logistics of who can become an assessor and the aspects of training.” “The actual nitty gritty of forms, who to contact, what happens etc.” “Reviewing some of the more practical points e.g., timing of the request, legalities, re: who is eligible or ineligible to make the request.” “How MAiD is enacted” “More details about the specific process” “How MAiD is actually carried out and what that involves – meds, location, who can administer”</td>
</tr>
</tbody>
</table>