



Medical assistance in dying in rural communities: A review of Canadian policies and guidelines

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ABSTRACT

In June 2016, the Canadian Parliament passed Bill C-14, legalizing medical assistance in dying (MAiD), elsewhere known as voluntary euthanasia or physician-assisted suicide. Related legislation and policies continue to evolve. However, there is a paucity of scholarship regarding their distinct implications for rural communities. This is significant given that rurality is an underrecognized but important determinant of health. In order to address this gap, we conducted a rural-focused scan of policies, guidelines, and legislation that govern the practice of MAiD in Alberta, Canada (N = 16). Drawing from rural health scholarship, we reviewed these documents with a focus on three key rural considerations (place, community, and relationships) and identified potential implications. Through an analysis of these findings, we identified four opportunities where policy can better serve rural communities. These included addressing geographic location, continuity of care, dual relationships, and systemic barriers. In light of this, we offer several recommendations for how future policy and guidelines can better support rural residents.

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1. Introduction

Until 2016, it was a criminal offence for a Canadian healthcare professional to assist a patient in ending their life. Following the passage of Bill C-14, this service, known as medical assistance in dying (MAiD) became legal nation-wide. This was the first step in an ongoing series of related policy and legislative changes. These changes have not been without controversy. MAiD has received much debate in medical circles and amongst the general public, particularly with the introduction of Bill C-7 (Bill C-7, 2021) that expanded eligibility to those whose natural deaths were not reasonably foreseeable. Within these discussions, rural parts of the country have received little attention. This is noteworthy, given that rurality is an underrecognized but significant determinant of

health (Smith et al., 2008) and geographic isolation has considerable implications for health service access and utilization. In order to better understand MAiD in rural settings, we conducted a review of MAiD-related policies for the province of Alberta and examined the ways in which rural considerations are included or omitted. In this paper, we outline the findings of this review. We establish the legal and policy landscape in the province, situate our findings in the rural health context, discuss the implications of these findings, and generate recommendations so that MAiD-related policies can be more context-specific.

2. Background

2.1. Legislative context and current controversies

MAiD is not unique to Canada. Other jurisdictions have also legalized assisted dying. This includes several states in the U.S., the state of Victoria in Australia, and the countries of Colombia, Belgium, the Netherlands, and Luxembourg (Government of Canada, 2017; Selby et al., 2020). The legislative requirements for MAiD differ between jurisdictions (e.g., in Oregon a physician can provide a patient with a lethal substance so that they can end their life, but the physician cannot

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actively administer the substance and bring about the death themselves) and result from distinct events in their legal histories.

In the landmark 1993 case of *Rodriguez v. British Columbia* (1993), the Supreme Court of Canada upheld a blanket prohibition on assisted death. It ruled that section 241(b) of the Criminal Code, which prohibited assisted death, was constitutionally valid and did not violate the Canadian Charter of Rights and Freedoms. However, dissenting judges and advocacy groups presented a number of counterarguments. For instance, they claimed it was arbitrary and discriminatory to prevent assisted death since able-bodied individuals are physically capable of ending their lives, should they so choose. Advocates argued that the prohibition disproportionately affected marginalized populations, particularly those with disabilities (*Rodriguez v. British Columbia*; *Factum of the Intervenor, The Coalition of Provincial Organizations of the Handicapped* (“COPOH”). Court File No. 23476).

Despite strong opposition, the blanket prohibition remained until 2015, when in *Carter v. Canada*, 2015, the Supreme Court unanimously voted that the prohibition was unconstitutional. The court claimed that the prohibition of assisted death did indeed violate the Charter. It suspended the declaration of invalidity for 16 months, allowing federal and provincial governments an opportunity to respond legislatively. This suspension left many organizations and jurisdictions to quickly implement guidelines and regulatory frameworks. In June 2016, the Canadian Parliament passed Bill C-14 to amend the Criminal Code and to make related amendments to other Acts in order to allow legal exemptions for MAiD. The Bill addressed who would be exempt and under what conditions a person could qualify for MAiD.

Following those legislative developments, MAiD continued to be a controversial healthcare service. Two of the more contentious eligibility criteria were 1) the requirement that a patient have a grievous and irremediable medical condition that includes having a serious and incurable illness, disease, or disability for which a natural death has become reasonably foreseeable and 2) the requirement that a patient have the cognitive capacity to provide final consent at the time of the procedure (*Bill C-14, 2016*). Several MAiD advocates claimed that this law was still too stringent and likely violated the Charter. For instance, some claimed that the requirement that final consent be obtained at the time of the procedure inadvertently results in patients obtaining MAiD earlier than they would have preferred, out of fear that they may lose their capacity to consent later in their disease progression (*Clark, 2019; Karstens-Smith, 2019*). Others argued that the condition that death be reasonably foreseeable is too restrictive and unjustly prevents those with slow degenerative diseases or mental health issues from participating in MAiD (*Shaw et al., 2018*). Since the passage of Bill C-14, concerns also grew among opposing medical providers who felt that offering MAiD would run contrary to their beliefs and values (*Jeffrey, 2018*). Physicians who conscientiously object to MAiD are still required to provide patients with an effective referral, which some view as a threat to the freedom of conscience and religion for healthcare providers. In November 2019, a member of the Legislative Assembly of Alberta tabled a private members bill to reopen the debate on physician conscience rights, citing MAiD referrals as a practice contributing to moral distress (*Bennett, 2019*). While this bill did not become law, its tabling reveals physicians' diverse perspectives and concerns about MAiD in Alberta. Recent analyses indicate that physicians who provide MAiD also experience challenges, such as strained professional relationships, inadequate financial compensation, and increased workload (*Khoshnood et al., 2018*).

In September 2019, in the *Truchon v Canada* (AG) decision, the Superior Court of Québec, declared the “reasonable foreseeability of natural death” eligibility criterion in Bill C-14, unconstitutional (*Truchon v Canada, 2019*). As a response to this ruling, the federal government introduced Bill C-7, which would amend the Criminal Code to permit MAiD for individuals whose natural death is not reasonably foreseeable. On March 17, 2021, the Bill received Royal Assent and included new provisions and safeguards. There were changes to the

witness requirements. Now, only one person is required to witness the MAiD request instead of the previous two (ss 1 (4)). The ten-day reflection period for those whose death is reasonably foreseeable is now eliminated. For those whose death is not reasonably foreseeable, a ninety-day reflection period now applies (ss. 1 (7)). The Bill also includes a waiver for final consent in particular circumstances (ss. 1 (7)). The federal government also stipulated a two-year end date on the prohibition of MAiD for those whose sole underlying medical condition is a mental illness (s. 6). Whether that prohibition will continue thereafter will be determined by Parliamentary Review. Bill C-7's expanded access has been very controversial, with strong opposition from disability rights advocates (*Council of Canadians with Disabilities, 2021a; 2021b; Nova Scotia Advocate, 2021; Inclusion Canada, 2020*). The precise criteria and processes for providing MAiD will likely continue to change through future legal challenges.

2.2. MAiD in rural settings

Despite its growing legalization in a number of jurisdictions, there is limited scholarship on MAiD in rural settings. In Canada, there are significant differences in MAiD processes and practices between provinces and territories (*Silvius et al., 2019*). Similarly, data from Alberta Health Services (AHS) South Zone (personal communication, April 2019) suggest intraprovincial differences between urban and rural communities, particularly related to knowledge and attitudes about MAiD. Although AHS has identified these differences, they have yet to be explored. It is important to examine the distinct conditions for MAiD in rural communities. For instance, Canadian health researchers have expressed concern that due to the reduced access to health services in rural areas, residents might feel compelled to choose MAiD as a default option (*Collins and Leier, 2017*). Some scholars have suggested that MAiD may be seen as the “perfect solution for rural and remote patients who want a home death, but are unable to find sufficient palliative care in their context” (*Pesut and Thorne, 2019, para. 18*). This is a critical consideration, given how important dying at home is for rural Albertans' perception of a good death (*Wilson et al., 2009*). Others have signalled for caution in order to ensure that geographically isolated individuals are not placed in a position where MAiD will be seen as their only “source of respite from end-stage disease” (*Collins and Leier, 2017, p.190*).

Providing MAiD to a widely dispersed population comes with additional challenges. Travel can be costly for healthcare professionals and can take emotional or financial tolls on patients and families. Although telemedicine could be used to reduce the amount of related travel, there is no language in Bill C-14 or Bill C-7 regarding its use and the provinces each have different approaches to using telemedicine or virtual options (*Schiller, 2017; Silvius et al., 2019*). This is noteworthy given that the shortage of physicians in rural Canada may impact access to MAiD services. For instance, in a small community with a limited number of physicians and nurse practitioners, it may be difficult to acquire the two independent assessments required for MAiD eligibility (*Schiller, 2017*). Even where mobile or virtual assessments may be helpful, they are of little use if there are no physicians or nurse practitioners physically present to administer the service (*Collins and Leier, 2017*). Similarly, if several rural healthcare providers in the same community conscientiously object to involvement in MAiD assessments or provisions, then it may leave their patients without any access to this service (*Schiller, 2017; Pesut et al., 2020*).

MAiD may also present distinct ethical challenges in small communities where there is less privacy or anonymity, and where people may be concerned about stigma or broken trust associated with requesting, providing, or receiving MAiD (*Mah, 2016; Pesut et al., 2020*). This is further complicated by the fact that many rural healthcare professionals are highly visible in their communities and often know their patients outside of the professional context (*Simpson and McDonald, 2017*). These longstanding relationships with patients may compound care

providers’ feelings of duty and/or grief. At the same time, rural settings may also provide particular benefits. The tight-knit nature of many rural communities and their active volunteer organizations may serve as tremendous assets during end-of-life care for patients and their families. These rural strengths have yet to be explored in MAiD-related research. In order to better understand how rural considerations are included or omitted from the regulatory environment in Alberta, we designed the policy scan described below and posed the following research questions:

- 1) What are the laws, policies, and guidelines that govern MAiD in Alberta, Canada?
- 2) How are rural considerations included/omitted in this legislative and policy environment?
- 3) What are the implications of these laws and policies for rural communities?

3. Methods

3.1. Document selection

We identified and retrieved documents that govern the practice of MAiD in Alberta. This included guidelines, formal policies, and Canadian law (N = 16). The documents were found using online searches including Google, health care organizations’ public-facing webpages, and targeted professional and regulatory organizations. These documents were sourced from regulatory colleges such as the College of Physicians and Surgeons of Alberta (CPSA) and the College and Association of Registered Nurses of Alberta (CARNA), the provincial health

authority (Alberta Health Services), a faith-based healthcare provider (Covenant Health), and organizations that provide guidance or advice to physicians or nurses on MAiD-related matters such as the Canadian Medical Protective Association (CMPA). Our inclusion criteria required that documents be formal policies or guidelines from organizations that either have authority over action or provide guidance on MAiD to appropriate medical personnel. We have only included publicly available, English language policies and guidelines that were enacted after the *Carter v. Canada* ruling (between 2015 and 2021). Additionally, we included Bills C-14, C-7, and also reviewed two legal cases related to MAiD in Alberta ([HS \(Re\), 2016 ABQB 121](#); & [Canada \(Attorney General\) v E.F., 2016 ABCA 155](#)). [Table 1](#) below provides an overview of all documents that were included in the review.

3.2. Analysis: key concepts

We analyzed these documents in relation to three specific rural considerations that we synthesized from two rural health frameworks: [Bourke et al.’s \(2012\)](#) framework for understanding rural health and [Simpson and McDonald’s \(2017\)](#) rural health ethics framework. These frameworks each provide thoughtful, detailed, and critical assessments of contemporary rural health issues. They come from different jurisdictions (Canada and Australia) but are conceptually consistent with one another, reinforcing the resonance and wide reach of these rural health concepts. The authors of both frameworks apply a critical perspective, prompting an important rethinking of rural health research and deeper consideration of contextual factors. We closely read both frameworks and identified their central features. Given the similarity in their foci

Table 1

Policies and guidelines reviewed.

The following table outlines the laws, policies, and guidelines that govern MAiD in Alberta and answers our first research question.

Organization	Type of Organization	Title of Document	Date Issued/ Published	Recent Revision Date	Type of Document
College of Physicians and Surgeons of Alberta (CPSA)	Professional regulatory body	Medical Assistance in Dying	June 2016	None	Policy/standard of practice
College of Physicians and Surgeons of Alberta (CPSA)	Professional regulatory body	Advice to the Profession: Medical Assistance in Dying	Feb. 2016	March 2021	Advice
Alberta Health Services (AHS)	Provincial Health Authority	Medical Assistance in Dying: Policy HCS-165-01	Feb. 2016	March 2021	Policy
Alberta Health Services (AHS)	Provincial Health Authority	Placemat for Responding to a Patient Request to Medical Assistance in Dying	April 2017	Removed/No longer accessible	Educational resource
Alberta Health Services (AHS)	Provincial Health Authority	Patient and Families Medical Assistance in Dying Process Map	Aug. 2016	Removed/No longer accessible	Educational resource
College and Association of Registered Nurses of Alberta (CARNA)	Professional regulatory body	Medical Assistance in Dying Guidelines for Nurses in Alberta	March 2017	Currently under review	Policy
College and Association of Registered Nurses of Alberta (CARNA)	Professional regulatory body	Medical Assistance in Dying Guidelines for Nurse Practitioners	Dec. 2018	Currently under review	Policy
College of Licensed Practical Nurses of Alberta (CLPNA)	Professional regulatory body	Medical Assistance in Dying: Guidelines for Nurses in Alberta	March 2017	Currently under review	Policy
Canadian Nurses Association (CNA)	National Professional Association	National Nursing Framework on Medical Assistance in Dying in Canada	2017	None	Education/ guidance
Covenant Health	Catholic healthcare organization	Responding to Requests for Medical Assistance in Dying Policy No. VII-B-440	Mah, 2016	Dec. 2018	Policy
Canadian Medical Association (CMA)	National professional association	Medical Assistance in Dying	2017	None	Policy
The College of Family Physicians of Canada (CFPC)	National professional association	A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia	Sept. 2015	None	Education/ guidance
Canadian Medical Protective Association (CMPA)	Association for Licensed Physicians in Canada	Medical Assistance in Dying: Where Do We Stand Now?	Oct. 2019	Removed/No longer accessible	Education
Canadian Medical Protective Association (CMPA)	Association for Licensed Physicians in Canada	The Continuing Evolution of Medical Assistance in Dying	May 2021	June 2021	Education
Parliament of Canada	Federal Government	Bill C-14	Royal Assent: June 2016	N/A	Statute of Canada
Parliament of Canada	Federal Government	Bill C-7	Royal Assent: March 2021	N/A	Statute of Canada

and its congruence with other rural health scholarship, we identified three key rural health considerations. The three considerations are: place, community, and relationships. By **place** we refer to the physical location of a rural community. This concept includes geographic isolation (Bourke et al., 2012; Simpson and McDonald, 2017) and the wide dispersal of rural populations (Collins and Leier, 2017; Schiller, 2017). The concept of **community** includes: 1) available health services (e.g., healthcare professionals, palliative care, information, professional development, timely MAiD assessments/provisions), 2) local health responses and resources (e.g., services like Meals-on-Wheels, health promotion projects, or involvement of non-profit/charitable organizations) (Bourke et al., 2012), 3) transportation arrangements (Collins and Leier, 2017), and 4) cultural or religious affiliations. **Relationships** includes family involvement in the MAiD process, social structures, and the intersection of personal and professional worlds in rural communities (also known as “dual relationships”, see Simpson and McDonald, 2017).

3.3. Analysis: process

Once we finalized our document list, we retrieved and independently reviewed each digital document with attention to the pre-defined three rural-specific considerations. We were not searching for particular terms, rather we were looking for explicit and implicit mention of the three concepts (e.g., “patients may benefit from receiving care from a provider who is known to them” rather than the term “relationships” itself). We identified the ways in which place, community, and relationships were considered or omitted, as well as the potential implications. We were looking for the existence of these concepts, rather than their frequency, since their inclusion or omission in MAiD policy and guidance documents has significance for rural health service delivery. Our research team is made up of scholars who have expertise and experience in bioethics, health policy, and law. Each team member prepared a chart of the findings in Microsoft Word. During this part of the process, we eliminated the two legal cases because they did not speak to our key concepts or offer rural-related implications. We then met as a team, shared our charts with one another, and discussed/consolidated our key findings related to the three rural health concepts. For instance, we discussed how something like the duty of non-abandonment might have implications for a concept such as “relationships” or “community” (recognizing that it may have implications for both). During this process, several organizations updated or removed documents because of the passage of Bill C-7. Our scan includes the most recent updates as of November 2021. These documents may continue to evolve to address Bill C-7. However, it is unlikely that these updates will impact our rural-focused analysis.

4. Findings

In this section, we outline the findings as they relate to the three rural health concepts of place, community, and relationships.

4.1. Place

The concept of place did not receive considerable attention in the MAiD policies and guidelines, especially in relation to rurality. There was little explicit discussion of geographic considerations or the provision of care for widely dispersed populations. However, place was mentioned in the context of the setting for the MAiD procedure, the site (s) of related healthcare, and the need to potentially make care or patient transfers between facilities. Many of the documents included in our review highlight the fact that a MAiD plan must include the location for the procedure. Potential locations can include the patient’s home, a long-term care home, hospital, hospice, or other setting. This is not solely something articulated in Bill C-14; the related policies enable this choice of location. For instance, most policies either require or strongly encourage that physicians or nurse practitioners be present to support

patients with a home death, if that is what is requested. The College of Family Physicians of Canada have suggested that an appropriate environment for MAiD provision contributes to enhanced dignity in the process (College of Family Physicians of Canada, 2015). CARNA encourages nurses to consider the resources that are available in different environments where MAiD might take place and ensure that the location satisfies the appropriate requirements (CARNA, 2017). In the event that a patient is seeking MAiD at an institution that is unwilling to provide it, the health service agency is responsible for timely transfers to willing sites (AHS, 2021; Covenant Health, 2018). However, there appears to be an implicit assumption that these transfers would be within the same region. Alberta Health Services also acknowledges that, like other healthcare services, MAiD-related services may not be available at every AHS location (AHS, 2021).

One document (CNA, 2017) featured a rural community in a case study example. They briefly noted that there may be unique challenges to accessing or providing MAiD in remote or isolated settings, with an emphasis on limited onsite professional resources, familiarity with related policies and procedures, and use of technology to communicate with health professionals in other communities. There was also mention of the fact that in rural communities, there may be fewer physicians comfortable with being involved in MAiD (CMPA, 2021) and thus fewer available assessors and providers. The implications of this fact were not explored. Overall, throughout the documents, there was some recognition that MAiD services are provided in specific geographic and physical settings and that place matters.

4.2. Community

Most documents reviewed in our scan touched on aspects of community. There was a consistent emphasis on ensuring that local health services were known and offered to patients. Notably, Alberta Health Services offers a Medical Assistance in Dying Care Coordination Service to act as a single point of contact for patients, families, and healthcare providers (AHS, 2016). This team can discuss all available end-of-life options, including MAiD, and connect patients to the healthcare provider or team who best meets their needs.

Physicians and nurse practitioners are expected to ensure that all palliative and end-of-life care options have been introduced and considered by patients requesting MAiD (CPSA, 2021; CARNA, 2017). It was also stressed that healthcare professionals should work to enable patients and their families to access a range of supports in the community (e.g. mental health care, disability and bereavement supports, spiritual care, aftercare, etc.) (CPSA, 2021; AHS, 2021; CARNA, 2017; CARNA, 2018). Many of the policies and guidance documents indicated that healthcare practitioners should seek to understand the patient’s circumstances, perspective, and reason for contemplating MAiD (CPSA, 2021), and identify if expressed requests are transient, temporary, or an expression of suffering due to unmet needs (CNA, 2017). Nursing documents dictated that nurses are to ensure that the patient is not seeking MAiD due to a lack of other health and social supports (CARNA, 2017; CARNA, 2018). However, these documents lack discussion of what healthcare providers should do in such circumstances. This may be particularly relevant for rural residents with limited community supports. As previously noted, scholars have raised concerns that MAiD may become a default option for rural residents due to a lack of available healthcare services (Collins and Leier, 2017; Pesut and Thorne, 2019).

Most documents recognized that if a patient chooses to pursue MAiD, they should not lose access to their primary care team (i.e., physicians and nurses), even if members of this team oppose MAiD. Several documents alluded to a duty of non-abandonment (CPSA, 2021; AHS, 2021; CARNA, 2017; Covenant Health, 2018). This duty requires medical practitioners to “continue to provide required healthcare to the patient until that physician’s or nurse practitioner’s services are no longer required or wanted by the patient or until another physician or nurse practitioner has assumed responsibility for the patient” (AHS, 2021,

p.12).

While handovers and transitions of care were recognized as sometimes unavoidable in instances of conscientious objection, these policies and guidelines attempt to ensure that any care unassociated with MAiD will still be provided as needed. This can be crucial for rural residents who may wish to avoid being transferred to other communities or urban centres for all of their care. Healthcare professionals are seemingly instructed to enable patients to obtain as much care as possible within their home community, even when their primary care provider might be a conscientious objector to MAiD. Although the duty of non-abandonment may be a promising practise and important principle of ethical care provision, it may also have implications for continuity of care.

Specific instructions regarding continuity of care are largely absent from the policies reviewed. Two exceptions included documents from Covenant Health and the Canadian Nurses Association. The Covenant Health policy stipulates that care will continue to be provided to a patient until the point of time when an external provider has explicitly requested to assume total care, and that patient/resident beds will be held until confirmation has been received from the Care Coordination Service (CCS) that the person will not be returning (Covenant Health, 2018). The Canadian Nurses Association acknowledges the importance of continuity of care and recommends that steps be taken to ensure that it is not compromised throughout the MAiD process. This includes ensuring good communication with other nurses in the community and with any physicians who provide weekly visits. The Canadian Nurses Association also encourages the use of well-documented healthcare team plans. (CNA, 2017). While these are encouraging steps in preserving continuity, more rural-specific considerations are needed.

4.3. Relationships

Several documents included in this review emphasize the significance of relationships in the MAiD inquiry, assessment, and provision processes. There was a consistent focus on the need to involve a patient's family members, close friends, and other care team members in planning, discussions, and debriefing after the procedure (CFPC, 2015; CNA, 2017; CMPA, 2021). This acknowledges the importance of intimate connections and the impact that end-of-life decisions have for a patient's social world. Simultaneously, these documents also speak to the importance of maintaining confidentiality around MAiD requests and provisions (CNA, 2017). This requirement acknowledges that relationships with family or community members may be fraught, or strained by differing opinions about MAiD, and places the patient's healthcare needs and preferences at the fore. Patients also determine who they would like to have present at the time of their death (CPSA, 2021).

As noted earlier, many documents articulate the requirement for there to be two independent MAiD assessors for the procedure (CPSA, 2021; AHS, 2021; CNA, 2017). The independence requirement stipulates, by law, that this service be performed by a practitioner who:

a) is neither a mentor to the other practitioner nor responsible for supervising the other practitioner's work; b) does not know or believe themselves to be a beneficiary under the will of the patient making the request, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death, other than standard compensation for services relating to the request; and c) does not know or believe themselves to be connected to the other practitioner or to the patient making the request in any other way that would affect their objectivity (CPSA, 2021, p.7).

This requirement necessitates that the parties involved *not* have particular types of relationships with the patient or fellow practitioners. There is no mention of how this requirement might be complicated in a rural community where social circles are smaller and personal and professional lives often intersect.

Several of the nursing documents point out that patient choice about MAiD (and other healthcare decisions) may be affected by nurse-patient

relationships (CARNA, 2017, 2018). As such, nurses are instructed not to impose their own views or values onto others nor use their position to influence, judge, or discriminate. They are encouraged to engage with patients professionally and compassionately. There is also mention of the opportunity for nurses to act as advocates for their patients (CNA, 2017). AHS' multi-disciplinary patient care teams must be committed to protecting vulnerable patients from discrimination, coercion, exploitation, and undue influence (AHS, 2021).

Multiple policies emphasize the need to respect different perspectives on MAiD – between care provider and patient, and also amongst care providers. Healthcare providers are encouraged to help prevent stigmatization, discrimination, and coercive actions within their fields and communities. There was a recurring call to respect differences of opinions, cultures, and religions and for solidarity and communication within and between health professions (CMA, 2017).

5. Discussion and recommendations

Rural health is often approached from a deficit perspective, with a primary focus on limited access to health services and health-promoting resources (Simpson and McDonald, 2017; Bourke et al., 2012). This can overlook features of rural life that impact health and healthcare, and neglects the underlying reasons and potential solutions for access issues in the first place. Although rurality can pose serious challenges for access, such issues are often related to place, community, and relationships. Using these key concepts, we were able to analyze MAiD-related policies in a manner more attentive to the nuances of rurality. In what follows, we outline the implications of our findings for MAiD in rural Alberta.

5.1. Emplacing MAiD: policy implications in rural settings

A region's geography has implications for residents' experiences of health and healthcare (Dummer, 2008; OECD, 2014; Kulig and Williams, 2012). Where a town is located within a province or territory, its proximity to other cities or larger urban centres, and the vastness of the land, can all impact access and outcomes. The relevance of geographic location remains true for MAiD as well. The MAiD documents and policies reviewed have place-based implications in three respects. These include opportunities for greater use of telemedicine, provisions for dying at home, and contending with a limited number of physicians.

5.1.1. Telemedicine

First, most policies and documents we reviewed gave little attention to telemedicine. This is a relevant omission for rural regions, given that they may have limited access to such technologies despite having a greater need for them (Jong et al., 2019). One exception was the Canadian Nurses Association, which acknowledged that access to MAiD can bring unique challenges in remote or isolated settings and that therefore, nurses must be familiar with technologies required to give patients access to their primary physician (e.g., through web conferencing) (CNA, 2017). Similar and further recommendations are needed in other policies. Such guidance should both note the need for telecommunication technologies in rural regions as well as direct health professionals as to how and when to best make use of them, while still maintaining privacy and confidentiality. Policies should also provide additional resources that assist with the implementation and usage of communication technologies so that physicians and nurses are not left unsupported. Although telemedicine is not a panacea for rural access issues, there are well-established benefits to its use in rural healthcare (Center for Disease Control and Prevention, 2020; Jong et al., 2019) and more people have become familiar and comfortable with virtual communication throughout the Covid-19 pandemic. In fact, the Canadian Association of MAiD Assessors and Providers (2020a); (2020b) has released guidance encouraging the use of telemedicine for assessments and detailing how to facilitate virtual witnessing for MAiD during the

Covid-19 pandemic. These benefits should compel policymakers to consider its role in MAiD policy and guidelines going forward.

5.1.2. *Non-displacement and dying at home*

Second, scholarship about a “good rural death” informs us that most dying individuals do not wish to be displaced. Many rural residents express a strong preference for ensuring that death and the preceding care occur within their community (Wilson et al., 2009; Rainsford et al., 2018). Reasons for this include the additional time and expense associated with transportation to other communities, a desire to avoid care from “strangers” in the busy hospitals of urban centres, and concern over the likelihood of medical error in a larger facility where no one knows the patient personally. Additionally, the displacement of seniors can result in feelings of loneliness (since visits from loved ones are less frequent) and increasingly negative prognoses (Wilson et al., 2009). Current MAiD documents and policies support this aspect of a good rural death. Many of the documents we reviewed indicate that patients may self-administer MAiD in their own home. Additionally, most documents help facilitate a safe in-home process by urging the providing physician and/or nurse practitioner to account for the place of the MAiD provision. This guidance includes ensuring the delivery of the lethal substance from the pharmacy and remaining present with the patient during the administration of the substance. These safeguards enable a safe assisted death because the medical professional can ensure that the lethal substance is ingested properly by the patient and not by anyone else, provide reassurance to the patient, and address any medical complications. This policy guidance is thus beneficial for rural residents who can be supported to die in a familiar and homelike setting, if they so choose.

5.1.3. *Practitioner availability*

Third, the geography of rural regions may directly impact MAiD provision because of the number of available physicians and nurse practitioners. Current MAiD policies and guidelines acknowledge the right of medical professionals to conscientiously object to participating in MAiD-related procedures. In order to maintain good access, medical professionals are obligated, at minimum, to refer patients to the AHS Care Coordination Service. Also, managers must ensure that a willing and appropriate healthcare provider is available to take on the objecting provider’s role (AHS, 2021). However, this may not always be possible in rural areas with limited physician availability. As of 2019, only 7% of Alberta’s physicians practise in rural areas, leaving residents in these regions under-served (Edwardson, 2019). Some communities, such as Milk River, may only have one physician (Campbell, 2020). For such regions the impact that conscientious objection has on MAiD availability can become quite significant. The result may be that in some cases, access to MAiD would require going out of town. This may come with additional costs (e.g., transportation), may place onerous burdens on the patient and family, may limit a patient’s ability to avail themselves of the benefits of their own community (friends, family, familiarity, religious or volunteer services, clubs/hobbies, etc.), and undermines the benefits of the dying-at-home policies previously mentioned.

In regions with few physicians and nurse practitioners, conscientious objection may have concerning and unaddressed implications. Perhaps one of the more significant and yet often overlooked issues pertains to continuity of care, which may be particularly affected in rural areas.

5.2. *Continuity of care*

Continuity of care refers to the “extent to which the care experienced by a patient is coherent, connected, and situated within his or her unique needs and personal circumstances” (Easley et al., 2016, p.823). In short, continuity refers to how well an individual’s healthcare is interconnected over time. It involves, for example, the processes by which a medical team communicates, shares information, and cooperates with one another in order to optimize decision-making and achieve high quality patient care. For instance, a standard and timely process for

sharing patient test results between a specialist and a family physician constitutes continuity of care. Sometimes the concept is broken down into three underpinning components: informational, management, and relational continuity (Haggerty et al., 2003). Continuity of care ensures better health outcomes, higher satisfaction rates, gives patients a sense of predictability and security, and even has been shown to make healthcare more cost effective (Jeffers and Baker, 2016; Haggerty et al., 2003; Sudhakar-Krishnan and Rudolf, 2007). The 2012 tragedy of Greg Price’s death in Alberta has become the paradigm case across Canada demonstrating how lapses in continuity of care can lead to serious harm or death (Born et al., 2014; Yourex-West, 2017). In this case, 31-year-old Greg Price was diagnosed with testicular cancer. However, his health care experience was plagued with multiple appointment delays, breakdowns in the referral process, poor communication of critical test results, and a lack of post-surgery instructions, leading to an otherwise avoidable death from a blood clot. This case has resulted in a teaching documentary outlining the danger present when there are gaps in a patient’s healthcare (Ward, 2018), and highlights that a focus on continuity of care is vital for a functional healthcare system. Unfortunately, healthcare policies and systems sometimes overlook this aspect of care.

5.2.1. *Handovers and transitions in MAiD care*

MAiD in rural areas presents a distinct challenge for continuity of care. As noted in our findings, various policies acknowledge that MAiD requests may require handovers and transitions in care. This may be due to conscientious objection, or in some rural regions, as a result of the patient needing access to a facility or medical specialists that are better equipped to handle their end-of-life care. To ensure that patients do not lose their family physician or primary nurse care, most policies specify some version of a duty of non-abandonment, as defined above. In fact, the regulatory bodies CPSA and CARNA, as well as AHS and Covenant Health, all oblige their medical and nursing professionals to ensure a patient is never left without care following their decision to pursue MAiD. This applies in cases of conscientious objection and requires continued provision of non-MAiD-related care (CARNA, 2017). This implies that even where MAiD-related handovers and transitions of care occur, a patient should still be able to rely on their primary physicians and nurses for standard care disassociated from MAiD, such as pain treatment.

This duty may create a fragmentation in care whereby different medical providers simultaneously deliver care to a patient but operate largely independent of one another in order to accommodate conscientious objectors. This may thus undermine continuity. For instance, at Covenant Health sites, care providers are not permitted to document the results of the MAiD assessment in the patient’s chart, only that an assessment was completed (personal communication, AHS staff, 2021). While MAiD policies acknowledge the potential need for handovers and transitions of care, few address how continuity of care ought to be maintained. We should be wary of policy that allows for fragmentation by enabling healthcare providers to only deal with discrete tasks instead of creating an environment that supports cooperative interactions between different parts of the healthcare system (Stange, 2009). At a minimum, policies should acknowledge continuity of care and at least require attempts to manage and mitigate such fragmentations. This may require policy standards regarding open communication and transparency between the different care providers, or joint decision-making in some circumstances.

For patients in rural regions, handovers and transitions of care may be accompanied by additional challenges that impact continuity. Rural-specific challenges may include a lack of resident medical staff, higher risks associated with handover communication, and difficulties surrounding the recruitment and retention of experienced staff (Piper et al., 2018). For rural patients, MAiD-related handovers may take patients to geographically distant locations, adding further complexities and potential communication breakdowns to an already strained continuity of care process. Given these additional risk factors, it remains questionable

that standard care needed by rural patients can be provided without compromising continuity, or requiring the patient to leave the community for their care.

We offer several recommendations regarding continuity of care. First, all policymakers, especially those working for the relevant regulatory bodies, should address continuity of care in their MAiD policies and guidelines. Second, policies should better address the handover/transition of care process in order to mitigate issues associated with fragmented care. This may include guidance stipulating that in cases where conscientious objection leads to partial transfers of care, facilities must take steps to ensure protocols are in place for effective communication with any new care providers and that processes for information-sharing are established. In some cases, co-decision-making between health professionals may be required. Third, even where transfers of care occur, health professionals should still be encouraged to provide as much care within the community as possible so as to reduce patient displacement. Such provisions will be necessary to maintain good continuity of care and best serve rural residents.

5.3. *Knowing and being known: implications for rural relationships*

5.3.1. *Dual relationships*

As noted above, in rural communities with small populations, it is common for residents' personal and professional lives to intersect. This is often known as "dual roles" or "dual relationships" (Simpson and McDonald, 2017). Dual roles can pose challenges for MAiD. For instance, they may jeopardize confidentiality and privacy, create biases and assumptions, and influence judgements (Brassolotto et al., 2021). The objectivity and independence requirements for MAiD assessors and witnesses (CPSA, 2021) are important safeguards to ensure that involved parties do not have conflicts of interest about a patient's decision to participate in MAiD. However, they also come with an urban-oriented assumption that healthcare primarily happens between strangers (Simpson and McDonald, 2017). Dual roles can also be an asset. Several of the nursing guidelines mention that a patient's relationship with their nurse(s) can inform their decision-making. These close connections, particularly as they exist in rural communities, can be a source of tremendous support during a patient's time of grievous and irremediable suffering. These strong and trusting relationships (as well as prior or contextual knowledge about a patient because of dual roles) can provide practitioners with more opportunity and information to assess the motivations behind a patient's request for MAiD. The potential for ethical conflicts associated with dual roles deserves attention and mitigation, particularly when the provision of service will end a patient's life. However, efforts to completely avoid dual roles may overlook the considerable benefits and meaningful relationships that can come with rural care provision. Professional bodies and rural care providers would do well to acknowledge these intersecting roles and navigate them with caution and care.

There are not only dual roles between patients and care providers, but also amongst staff members of care teams. It may be especially challenging to obtain multiple, independent, health professionals with the relevant expertise, who do not "believe themselves to be connected to the other practitioner" (CPSA, 2021, p.7) in a small community. The degree to which this is a problem may differ based on the size of the community, but the issue remains. Regulatory bodies and ethics committees may want to consider how to contend with this fact and offer guidance for practitioners in rural settings.

5.3.2. *Privacy*

Though several of the documents included in this review highlight the need to ensure privacy about a patient's inquiry or request for MAiD, this could prove particularly difficult in rural settings where privacy is more limited and people experience 'living in a fishbowl.' What health professionals do in their professional lives has a profound impact on their personal relationships and vice versa (Pesut et al., 2020).

Healthcare practitioners are highly visible in rural communities. As such, the decision to be a conscientious objector (or not) is very much influenced by local relationships (Pesut et al., 2020). Health professionals in communities with a limited number of nurses and physicians will be very aware that their choices will impact community perceptions and trust, as well as patients' ability to access MAiD. The policies and guidelines we reviewed indicate that this is a personal choice that is to be respected, but they do not acknowledge that these decisions are made in relational contexts or provide guidance for rural practitioners who may struggle with the implications of such decisions. The documents do not speak to what recourse or resources are available when there are instances of stigma, discrimination, and conflicts of views or values. This could present an excellent opportunity to involve clinical ethicists, who are skilled at navigating discussions with patients, families, and care staff; establishing the sources of tension and the values at play; and supporting an individual or team in arriving at a decision that attends to the values of those involved. Ethicists can be valuable members of a care team, but they receive little attention in most of the documents that we reviewed. Most rural communities do not have a local ethicist on site (they are usually appointed at the Zone level in Alberta), but remote consultations and, in some cases travel, can facilitate these engagements and help with difficult conversations or decisions. Service providing agencies and professional bodies should encourage the use of this valuable resource and make it known that care staff can call ethicists in scenarios with complex relational dynamics.

5.4. *Structural/systemic considerations*

5.4.1. *Conditions for living well*

Several nursing guidelines require nurses to ensure that their patient is not seeking MAiD because of a lack of other supports (CARNA, 2017, 2018). However, there is no guidance provided in terms of *how* to assess for adequate supports or vulnerability, nor are there recommendations for action in the event that a patient is seeking MAiD for this reason. This is a noteworthy equity consideration, especially given the growing concern that MAiD is easier for marginalized Canadians to access than palliative care or income, housing, disability, or extended health supports (Dosani, 2021; Lemmens and Krakowitz-Broker, 2020). It is unclear what the next steps should be for a rural resident who lacks those supports because of their geographic isolation. Rurality can also exacerbate the effects of other social determinants of health (Smith et al., 2008), putting patients at additional risk of marginalization. As a result, it is not clear that there are sufficient safeguards in place to address the concerns of scholars who worry that MAiD could become a default option for rural residents who lack access to palliative care or other support services (Collins and Leier, 2017; Pesut and Thorne, 2019).

5.4.2. *Contexts for MAiD requests: data collection and use*

There is also a need for systematic collection and analysis of data on the motivations and circumstances of patients requesting and receiving MAiD, particularly with the C-7 amendments that remove the reasonably foreseeable death criterion. Bill C-7 introduces changes to data collection and monitoring "to determine the presence of individual or systemic inequality or disadvantage in the context of or delivery of MAiD" (Government of Canada, 2021, para 20). This is potentially a positive step, but the extent and process of this data collection, as well as how it is used, remain unclear. This data should be used to guide which social and medical supports require greater investment, rather than solely reporting the demographics of service inquiry and usage. There is opportunity for inter-sectoral and interdisciplinary collaboration. We recommend that professional and regulatory bodies provide guidance on how to make assessments related to the social determinants of health and connect patients with social services when needed. Medical professional bodies are well-positioned for advocacy in terms of related health and social policy reforms.

5.4.3. Funding for rural health services

Lastly, there is need for recognition that rural health services in Canada have experienced significant reductions in funding and government support over the past few decades (Hanlon et al., 2007; Hanlon and Halseth, 2005; Skinner and Rosenberg, 2006). There has also been a growing centralization of services in urban centres. Policymakers and legislators ought to take seriously the concern that MAiD and other health and social services will be different for rural residents and care providers.

6. Conclusion

Our policy scan confirmed that there are indeed distinct rural considerations that warrant further attention in MAiD policies and guidelines. We found that there are some urban-oriented assumptions about social dynamics, the availability of healthcare providers, and access to health and social services. We identified an opportunity for greater use of telemedicine and noted the benefits of policies that support rural residents who wish to die at home. There is a need to address the implications of the rural physician shortage for MAiD assessments and provisions, as well as a need to ensure continuity of care during MAiD-related handovers and transitions. We have also identified the need to leverage the benefits of dual roles in rural care provision (e.g., strong support networks, intimacy of care, contextual knowledge about a patient) while mitigating their risks (e.g., conflicts of interest, undue influence or bias, privacy concerns). Lastly, we note that related policies and jurisprudence clearly indicate that MAiD is not meant to be used because of a lack of other supports, but there remains a need and opportunity for greater guidance, collaboration, and advocacy on this front.

Author statement

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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