Track 2 Medical Assistance in Dying (MAID): A BC Research to Policy Project

Report to the British Columbia Ministry of Health Interior University Research Coalition Tri-University Partnership

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Interior University Research Coalition
CORE STRENGTH FOR AN INNOVATIVE BRITISH COLUMBIA

THE UNIVERSITY OF BRITISH COLUMBIA
Okanagan Campus

Executive Summary

Background

In 2021, the federal legislation permitting Medical Assistance in Dying (MAID) was amended to allow this procedure for persons whose natural death is not reasonably foreseeable (RFND). This amendment created a new pathway that is commonly referred to as MAID Track 2. There is currently little qualitative evidence about the development of Track 2 in the BC provincial context. Such data is important for deepening our understanding of the data that has been collected through provincial and national reporting requirements.

Purpose

This project developed evidence in response to the following call issued by the BC Ministry of Health:

1. Develop prospective, longitudinal evidence in the BC context about Track 2 clients' experiences and decision-making processes in relation to MAID.
2. Identify practice supports necessary to provide high quality coordination, care, assessment, and provision of MAID for this population.
3. Pilot research approaches for a project that will be national and international in scope.

Participants and Method

Seven persons with lived experience of illnesses that could potentially make them eligible for Track 2 each participated in a minimum of 3 interviews and 2 focus group discussions. Twenty health care providers knowledgeable about Track 2 participated in a single interview.

Overall Findings and Recommendations

Recommendation #1: Establish a funded case consultation process for complex MAID assessments, including both Track 1 and Track 2.

1. There continues to be some variation in what constitutes a RFND, the defining criterion for a Track 2 applicant according to the legislation.
2. There is strong clinical consensus about what makes an applicant's condition sufficiently complex to warrant the Track 2 safeguards.
3. Persons with Lived Experience (PWLE) provide compelling evidence of this complexity.
4. Participants agree on the necessity of a consultation process for complex cases.

Recommendation #2: Modify Track 2 remuneration to reflect the clinical complexities associated with Track 2 assessments, and the time and expertise needed to complete such assessments rigorously and safely.

1. The assessment required for Track 2 applicants is considered by practitioners to be both morally weighty and legally risky.
2. The 90-day assessment periods are, and should be, labour intensive.
3. Current remuneration schedules do not adequately compensate for the time required to institute best practices for Track 2 assessments.
4. Inadequate remuneration of practitioners is one of many significant deterrents to providing Track 2 assessments.
5. PWLE affirmed the critical nature of these assessments.

Recommendation #3: Develop a standardized and funded model for MCCs across the province.

1. The BC Ministry of Health was acknowledged for its leadership in establishing MAID in BC, including the creation of MAID Coordination Centres (MCCs).
2. There are significant differences across the province in the role and scope of MCCs.
3. The creation and funding of MCCs carries a degree of risk.
4. Health Care Providers (HCPs) who conduct Track 2 assessments noted the importance of having the support of MCCs.
5. PWLE envisioned a preferred model of care that could best be implemented through MCCs.

Conclusion

Overall, findings indicated that healthcare providers leading Track 2 implementation in BC have developed robust practice supports in a relatively short period of time. There is good evidence that Track 2 assessments are being conducted with due care and in compliance with the legal eligibility criteria and safeguards. Further, the Ministry of Health was acknowledged for their leadership regarding MAID within BC. In light of this context, the recommendations contained in this report are designed to accomplish three quality and safety goals:

1. To develop further clinical consensus across the province on the interpretation of the legal eligibility criteria to be applied to Track 2 applicants.
2. To adequately remunerate assessors and providers who engage in Track 2 care.
3. To develop a model of MAID interdisciplinary care excellence for healthcare providers, applicants, and family by leveraging the value of MCCs.

Summary Report Track 2 Medical Assistance in Dying (MAID): A BC Research to Policy Project

Background

In 2021, the 2016 MAID legislation was amended to permit assisted dying for those persons whose natural death is not reasonably foreseeable. This resulted in two tracks through which persons can apply for MAID: Track 1 for applicants who have a reasonably foreseeable natural death (RFND), and Track 2 for applicants who do not have a RFND. The revised legislation specifies additional safeguards specific to Track 2 applicants. Neither the 2016 nor the 2021 legislation provided a definition of a RFND. As a result, MAID assessors have been required to interpret what constitutes a RFND and to construct best practices around that understanding. This study provided an opportunity to qualitatively explore the implementation of Track 2 in BC and to develop recommendations for the BC Ministry of Health and BC Health Authorities to optimize health system policies and clinical best practices in the care of Track 2 MAID applicants.

Mandate and Objectives

This project developed evidence in response to the following call issued by the BC Ministry of Health:

1. Develop prospective, longitudinal evidence in the BC context about Track 2 clients' experiences and decision-making processes in relation to MAID.
2. Identify practice supports necessary to provide high quality coordination, care, assessment, and provision of MAID for this population.
3. Pilot research approaches for a project that will be national and international in scope.

Methods

Objectives 1 & 3

We recruited seven persons with lived experience of illness, disease or disability (hereafter referred to as PWLE) that could potentially make them eligible, or had already made them eligible, for MAID under Track 2.

These PWLE had two roles in the project:

1. To share their evolving experiences of illness, disease, or disability and how those experiences could inform MAID-related policy and care. PWLE participated in a minimum of three interviews with the research team in which they: (1) shared their experiences of illness; (2) reflected upon their perceptions of MAID; and (3) provided best practice advice for the process of MAID-related care based upon their experiences.
2. To inform the development of research methods for a national study that will include applicants for MAID under Track 2. PWLE participated in two focus groups in which they discussed and helped to refine the research recruitment and data collection for the larger national study. This national study has now been funded by the Canadian Institutes of Health Research (2024-2028) and was cited in the Fourth Annual Report on Medical Assistance in Dying.

The seven PWLE who participated in the study had a variety of conditions (e.g., complex illness syndromes, mental health conditions, and progressive neurological diseases). Participants indicated age ranges within categories of 25-34 to 55-64. They had differing views on MAID but all were living with conditions that could potentially make them eligible for Track 2 at some point if their health declined. A limitation of this sample is that all participants identified as white and had at least some post-secondary education (43%) or a graduate degree (57%). As such, this group was both well-educated and homogenous.

Objectives 2 & 3

We recruited 20 health care providers (HCPs) knowledgeable about Track 2 from all five geographic health authorities of the province (excluding the Provincial Health Services Authority). The HCPs represented service to urban, rural, and remote communities. Nine were assessors/prescribers, nine were in an administrative/coordinator role, and two were key stakeholders. All assessors/prescribers had experience with Track 2 cases. Given the small numbers of persons involved in Track 2 in BC, and the potential risk to privacy and confidentiality of the HCP participants, additional demographic information will not be provided.

HCPs participated in a semi-structured individual interview. The focus of these interviews was to understand current practice and to identify the practice supports necessary for high quality coordination, care, assessment, and provision of MAID for clients under Track 2 (e.g., human resources, care processes, and clinical tools).

Findings and Recommendations

Integrated data from across the two participant groups yielded three overarching recommendations for improving practice supports for MAID Track 2 care in BC. PWLE provided examples related to their own experiences that provided important evidentiary support for these recommendations.

Recommendation #1: Establish a funded case consultation process for complex MAID assessments, including both Track 1 and Track 2.

There continues to be some variation in what constitutes a RFND, the defining criterion for a Track 2 applicant according to the legislation.

The language used to specify eligibility criteria in the MAID legislation, such as RFND, have intentionally been left undefined. Therefore, it has become the responsibility of MAID assessors to operationalize the practical interpretation of the law. This has resulted in clinician assessors across BC defining the boundaries between Track 1 and Track 2 differently. Clinical consensus of what constitutes a RFND is more typically developed within a health region and so may be different across health regions (e.g., Island Health may define a Track 1 vs Track 2 applicant differently than Interior Health). It is also evident that expert MAID communities of practice have each developed clinical consensus about Track 2 that may differ from those who conduct Track 2 assessments outside of that particular community of practice (e.g., primary care physicians).

Practically, the time frame for a RFND ranged from 3 months to a number of years among assessors we interviewed. An important factor to consider when thinking about this variability is that, while working under the original legislation (Bill C-14), clinicians had already established that a RFND could include a time frame of up to 10 years for certain medical conditions. Once that clinical calibration occurred, and became broadly accepted, it made little sense for clinicians to revise it under subsequent legislation (Bill C-7). The practical impact of this pre-existing calibration is that the RFND concept may be difficult to use to delineate between Track 1 and Track 2. To overcome this issue, assessors instead use a holistic perspective to identify the impact of the applicant's clinical condition on their well-being, including their suffering, trajectory of decline, and frailty.

Ultimately, this manner of identifying whether a patient has a RFND can lead to differing opinions on whether an applicant is eligible for MAID, and if so, under what Track they are eligible. The assignment of an applicant to a particular Track is critical because of the different safeguards in place for each. This lack of standardization across assessors can be particularly troubling for those who are seeking an assisted

death, and may lead to "assessor shopping," the practice of seeking assessments until an applicant is found eligible for MAID. Such inconsistencies can also lead to a damaging public perception that the assessment process is not rigorous, but rather is based upon the whim of an individual assessor. A case consultation process would facilitate consensus regarding what delineates Track 1 from Track 2 applicants, and thus provide a more defensible practice.

There is strong clinical consensus about what makes an applicant's condition sufficiently complex to warrant the Track 2 safeguards.

Despite inconsistent interpretations of what constitutes a RFND, there is agreement among clinicians about what constitutes a sufficiently complex case that would make the applicant conceivably benefit from a Track 2 designation, including the additional time for clinical assessment. Such applicants manifest the following characteristics: unclear medical diagnosis that cannot be confirmed through diagnostic tests (e.g., syndromes with multiple manifestations); younger age; complicated psychosocial history (e.g., challenges with healthcare that may have hindered treatment); long medical history with multiple specialist involvement; co-morbid psychiatric conditions; and extenuating factors related to the social determinants of health (e.g., poverty or marginally housed). These complexities are evident in both Track 1 and Track 2 cases and require additional diligence in clinical assessment and support to avoid creating undue barriers for eligible patients who may exhibit these kinds of complexities. Our findings suggest that the uncertainty and weight of decision-making for complex cases is morally and emotionally challenging for clinicians and is a significant deterrent to providing Track 2 assessments and provisions. A case consultation process would support clinicians to make these morally difficult decisions.

PWLE provide compelling evidence of this complexity.

PWLE interviewed for this project provided insights into the complexity of their illness, disease, or disability and its impact on their daily life. They described an illness journey in which finding and accessing treatment from multiple specialists and therapists had, in some instances, become a full-time job. Some of these PWLE had no primary care provider and so by necessity had to navigate and coordinate their own care to the best of their ability. All participants described interactions with healthcare providers in which they had been characterized as lazy, faking symptoms, or irresponsible in relation to their health. This resulted in perceived pressure on the PWLE to communicate and present themselves in ways that would be most likely to get them the help they needed. Ultimately, these kinds of negative interactions with health care professionals could lead to a reluctance to seek help. A compassionate and humanistic consultation process would provide applicants with important assurance that they had done the best they could in alleviating their suffering under difficult circumstances.

Participants agree on the necessity of a consultation process for complex cases.

The complexities described by both healthcare providers and PWLE highlight the importance of formalizing a case consultation process. There was consensus that the most important safeguard for ensuring quality and consistency of Track 2 MAID assessments is to facilitate adoption of an interdisciplinary learning systems model in which clinicians come together to discuss specific cases. The knowledge that would be generated would be useful in informing the case at hand, but would also be of broader utility in developing rigorous professional practice standards. The availability of a case consultation model would have the added benefit of minimizing public misperceptions of a lack of rigour in MAID eligibility determinations.

Based upon our findings, we recommend the following principles to guide this consultation process:

- The purpose of the case consultation process would be to further build clinical consensus around the eligibility criteria and safeguards across complex cases and in anticipation of emerging legislation.
- Consultation should be conducted before the applicant is found eligible, as opposed to an oversight process in which the appropriateness of the decision is reviewed after MAID has already been provided.
- Because the complexities that cross Tracks 1 and 2 pose both legal and safety risks, more nuanced criteria could be developed by those leading the consultation process to help clinicians understand what types of applicants would most benefit from the case consultation process.
- The purpose of the consultation would be for learning and clinical calibration of decision-making, not to determine the eligibility of the applicant under review; that decision would remain the responsibility of the assigned assessors.
- The consultation committee should be kept reasonably small to maximize participation and ensure that a collegial environment is created in which assessors feel encouraged to bring forward their cases.
- Consultation participants should be chosen strategically based upon their expertise and they should be appropriately remunerated for their time. Study participants highlighted the importance of including persons with psychiatric and mental health expertise.
- PWLE suggested that it might be appropriate for applicant perspectives to be included in the consultation process.
- Appropriate measures to ensure privacy and confidentiality of applicants would be needed.
- A provincial case consultation process could improve standardization across the province.
- Once the system is established, it should be made available to all assessors in BC.

Recommendation #2: Modify Track 2 remuneration to reflect the clinical complexities associated with Track 2 assessments, and the time and expertise needed to complete such assessments rigorously and safely.

The assessment required for Track 2 applicants is considered by practitioners to be both morally weighty and legally risky.

Track 2 applicants are the most complex clinical clients that healthcare providers encounter in practice. Applicants' histories often include treatment by multiple specialists, co-morbid mental health conditions, challenging family and social dynamics, stigmatizing psychosocial impacts, and in some cases, no clear medical diagnosis. It is not uncommon for people with complex health histories to have a distrust of the medical system. These extensive medical histories also lie within a deeply siloed record keeping system. Clinicians must determine how much information they require, from whom and where they will seek it, how far back they will need to travel in an applicant's medical history, and how they will weigh conflicting or ambiguous accounts of events and experiences. This morally and legally weighty assessment process is labour intensive.

The 90-day assessment periods are, and should be, labour intensive.

Skilled assessors know the importance of taking time to develop the trust required for participants to candidly share their story of suffering. Only in this way can they understand the treatments of which applicants are aware, what has previously been tried, and what applicants feel to be reasonable treatments. Importantly, in the context of Track 2, assessors may be required to navigate access to interventions that

may potentially relieve suffering but have not yet been tried. Minimally, this could include recommendations back to the primary care provider. But in the absence of a primary care provider, some assessors find they must take on the role of assisting applicants to gain access to the treatments they need. This results in an ongoing applicant/assessor relationship that extends through, and in many cases well-beyond, the 90 day assessment period required by legislation.

Assessors further conduct this assessment with the understanding that finding an applicant ineligible will also carry weighty obligations. Once applicants have made the momentous decision to apply for MAID, being found ineligible can lead to serious emotional sequelae, including a heightened risk of suicide. Assessors take great care when finding someone ineligible. In most cases, assessors will tell applicants that they "are not eligible yet" rather than an outright determination of ineligibility. One of the purposes of the 90-day assessment period in the legislation was to allow assessors the time to work through these complexities.

Current remuneration schedules do not adequately compensate for the time required to institute best practices for Track 2 assessments.

According to our healthcare provider participants, the clinical time required to conduct assessments for Track 2 applicants is typically in the range of 5 to 20 hours, but may extend well beyond that range in complex cases that have been managed over months or years. Participants discussed the extensive amount of time required to complete a thorough review of the complex medical history of each Track 2 applicant, involving careful medical record review, literature review, and seeking additional consultations with specialty care clinicians. While provincial billing practices allow for extra billing under Track 2, this billing is more likely to be audited; this therefore requires additional paperwork and time investments for the assessor. Assessors described under-reporting the time spent in completing a Track 2 assessment in order to avoid the scrutiny of "excess" billing through audits. Practically, this means that the most legally and morally risky clinical care that a clinician can undertake is conducted without adequate recognition of the time required and without adequate compensation. Unfortunately, this also means that there is no way to use current assessor billings to accurately measure the time clinicians are spending, which also means the true cost of Track 2 care remains unknown in BC.

The risk of continuing with this form of billing is that the thoroughness that constitutes best practice in clinical assessment for a Track 2 applicant could inadvertently encourage expedient assessments in an attempt to balance accessibility to Track 2 MAID assessments with a clinician's other responsibilities. This is also highly problematic from the perspective of public accountability.

Inadequate remuneration of practitioners is one of many significant deterrents to providing Track 2 assessments.

Health care provider participants suggested that the synergistic effects of inadequate remuneration alongside the moral burden and social stigma that attends Track 2 care has led a large proportion of existing MAID assessors and providers to limit their practice to Track 1 MAID cases only. Those who are willing to undertake Track 2 cases have further been deterred by media accounts that misrepresent the work being done and malign those who are participating. This means that there are simply not enough assessors and prescribers; accessibility to Track 2 MAID then becomes a problem for applicants.

PWLE affirmed the critical nature of these assessments.

PLWE described an arduous journey of trying to relieve their suffering. They provided compelling accounts of their abilities to self-manage, self-educate, and to explore and try both conventional and non-

conventional treatments. Understanding this illness journey took significant time during the research interviews, providing some insight into the time required of assessors in clinical practice. Further, for assessors, this story must be heard alongside the narrative contained in the medical records that have documented this journey. However, it is also important to note that PWLE described the contentious and impactful nature of their health records. More specifically, they described how even a single recorded judgement of a clinician, such as "opioid seeking" or "no pain behaviours", could influence their care over a lifetime. As a result, they highlighted the importance of MAID assessments being conducted in a relational manner without undue time pressures, particularly with so much at stake.

An important finding was the experiences of PWLE who were not believed by healthcare providers, and the resulting need to "prove" their condition in healthcare contexts. They expressed concern that a MAID application would entail the same disbelief and require an even higher burden of proof. Participants reflected on strategies of "working the system", in an effort to be assured that assessors would approve their eligibility should they decide to seek MAID. This has important implications for ensuring that there is strong clinical consensus regarding who should be found eligible under Track 2 and that applicants become important partners in this process.

Based upon our findings, we recommend the following:

- Conduct a review of the time required for Track 2 assessments and modify remuneration accordingly. In many cases medical directors and assessors already have this data available.
- Request that medical directors collect prospective data on time spent on Track 2 assessments as we can anticipate that these cases will become ever more complex.
- Create a MAID-specific billing code to be used when the assessor/provider takes on the role of navigating necessary legal access to treatments, services, and resources because the applicant has no primary care provider. This will help to ensure that all MAID-related time is transparent and accounted for.
- Discontinue regular audits of supplementary billing for complex applicants when the assessor has accepted a role in helping applicants obtain access to treatments, services, and resources to alleviate their suffering.
- Collect quality assurance data from Track 2 applicants regarding their experiences with assessments.

Recommendation #3: Develop a standardized and funded model for MAID Coordination Centres (MCCs) across the province.

The BC Ministry of Health was acknowledged for its leadership in establishing MAID, including the creation of MAID Coordination Centres (MCCs).

Health care provider participants noted that the BC Ministry of Health had provided an important leadership role in relation to establishing MAID standards and care. They particularly acknowledged the Ministry for appointing leaders within the Ministry to support health regions in providing accessible and safe MAID care. The establishment of MCCs was an important step in ensuring accessibility to MAID if the applicant's primary care provider was unable or unwilling to address their MAID request. However, we also learned that the role and scope of these MCCs could be further delineated and enhanced with increased coordination across MCCs. These steps would increase equitable, high quality, and compassionate care for those seeking MAID, for their families, and for the healthcare providers across the province who participate in that process.

There are significant differences across the province in the role and scope of MCCs.

What began as an initiative to support MAID accessibility in BC has evolved organically into different services depending upon the geographic context and the philosophy of influential leaders. A number of assumptions have formed the development of these MCCs – even if those assumptions have not always been made explicit. How influential leaders have responded to the following questions has determined the role and scope of the MCC:

1. *What is the purpose of the MCC*? MCCs across the province engage in the following activities to varying degrees: public education; healthcare provider education; gathering essential information from applicants; collecting relevant healthcare records; managing inquiries and pre-screening of applicants; keeping accurate records and statistics; engaging in quality improvement and/or research; keeping a registry of applicants; triaging, assigning assessments and provisions; and supporting patient and family navigation.

2. *Which disciplines are essential to meeting that purpose*? In some MCCs, nurses are the primary employees based upon the assumption that they have the most relevant clinical expertise. In other MCCs, social workers are hired because of their expertise in counseling and supporting access to social services and resources. Some MCCs have the involvement of interdisciplinary teams. It is important to note that, across the country, MCC coordinators have established a community of practice through the Canadian Association of MAID Assessors and Providers (CAMAP) and in doing so are establishing a specialized area of practice.

3. *Should the MCC become a specialized service or is it only a point of connection to other services*? There is an important distinction to be made between an MCC whose mandate is to promote accessibility to MAID and an MCC whose mandate includes full scope service for applicants, healthcare providers, families, and others who are impacted by MAID. Just one example of this would be whether the MCC hires its own social workers to support applicants or refers to social workers in the broader system. These are important considerations, each carrying their own practical consequences. Some MCCs are reluctant to provide these services for fear that they will be overwhelmed with applicants who learn that the MCC can be another point of access to healthcare, and perhaps fast track access. Other MCC leaders are concerned that the optics of a highly resourced MAID system could lend support to the erroneous idea that MAID is being used as a way to cut costs and reduce the burden on a strained healthcare system.

4. *Should all MAID assessors and providers be encouraged to work with the MCC*? As discussed under Recommendation #1, the creation of clinical practice standards related to legislative eligibility criteria and safeguards is a critical part of MAID legislation. In BC, these standards have been developed within a community of practice of clinicians who are closely connected to the MCCs in each health region. However, the practice standards developed by these clinicians may not be readily available to those outside of their own community of practice who also have the option of acting as assessors and providers of MAID. One way to calibrate best practices across sectors is to ensure stronger links between all healthcare providers who participate in MAID and the MCCs who have the expertise to develop best practices.

An important step forward in enhancing MAID-related care in BC would be to standardize the concept of an MCC in relation to these four questions and to maximize the MCC's potential contribution to high quality care.

The creation and funding of MCCs carries a degree of risk.

The primary risk associated with MCCs is whether further development of MCCs will be seen as promoting MAID at a time when a number of healthcare challenges are co-occurring (e.g., aging population, shortages in the primary care system, budget shortfalls). Another risk is whether the work done within the MCCs will be seen as subject to legal challenge because they may be viewed as adding a layer of regulation beyond what the actual legislation requires. For example, a practice standard developed within an MCC could be perceived as more restrictive than what the legislation stipulates, thus subjecting it to legal challenge. However, this type of informal regulation, in which the actors responsible for interpreting and enacting the law work together to calibrate norms, is essential to ensuring high quality, safe care. The development of MCCs could also be viewed as an important safety and risk management strategy to respond to claims identified in the literature and in pending legal action that assessors are enacting wrongful deaths.

HCPs who conduct Track 2 assessments noted the importance of having the support of MCCs.

HCPs noted that Track 2 assessments are lengthy and that applicants could benefit from support throughout the process, which occurs over a minimum 3-month period. Teams that have social work or staff assigned to applicant support identify these as high value services. Social workers and/or nurses with relevant background bring familiarity with navigation of referrals to relieve suffering, comorbid mental health conditions, and management of complex family dynamics. They can also have a role in early bereavement support. HCPs identified that such supports were applicable to both Track 2 applicants and complex Track 1 cases. HCPs also noted that social work colleagues were an important contributor to the well-being of the HCPs themselves and to the function of MAID teams. Social work support appears to serve as an important adjunct to MAID assessment and these preliminary data suggest that the availability of such services may improve the experience for patients and families, relieve work for assessors at lower cost, and potentially increase retention of MAID assessors and providers.

PWLE envisioned a preferred model of care that could best be implemented through MCCs

Just as PWLE described the importance of navigating their illness experiences, they envisioned a team-based navigation and support process that would commence once they began to consider MAID. Specifically, they expressed concern about receiving MAID services delivered in a manner akin to their frequent experiences of health care encounters that had been rushed, dismissive of patient experience, and lacked continuity of care. PWLE hypothesized they would want an ongoing relationship with a practitioner who could answer their questions and provide emotional support; help them to find and access options to relieve their suffering (not just offer a phone number or website address); and to explore options that have a focus on maximizing quality of remaining life. For example, participants hypothesized that the opportunity to try riskier interventions than would normally be allowed would be important in light of their choice to request MAID. Participants noted the need for psycho-social-emotional-spiritual support for themselves and/or their family members. What these participants described as their preference for a philosophy of care is remarkably akin to a palliative approach to care. However, Track 2 applicants are not eligible for palliative care and it is critical to recognize that we currently have no system to provide this type of support to them. MCCs could provide an important starting point for a new model of care designed to address palliative needs in a population who are not on a natural dying trajectory.

Based upon our findings, we recommend the following:

- Convene regional medical directors and coordinators to establish a provincial scope and role for MCCs.

- Legitimize the informal regulatory role that these MCCs are already enacting. Support the development of policies and procedures that would provide accountability for all assessors and providers in the province.
- Consider using MCCs to provide formal training in MAID-related care for both healthcare providers and the public.
- Adapt the role and scope of the MCCs to the unique circumstances of rural and remote contexts.
- Provide funding to MCCs that is commensurate with the role and scope developed on consensus.
- Establish organizational accountabilities between the MCCs and the case consultation process (see Recommendation #1).
- Support MCCs to provide navigation and support services for patients and family as they consider, apply for, and receive MAID. An important role of applicant navigators would be to leverage available community-based resources and advocate for those required within the community.
- Include patient and family partners as key advisors during the development of the MCC process.

Conclusion

Overall, findings indicated that healthcare providers leading Track 2 implementation in BC have developed robust practice supports in a relatively short period of time. There is good evidence that Track 2 assessments are being conducted with due care and in compliance with the legal eligibility criteria and safeguards. Further, the Ministry of Health was acknowledged for their leadership regarding MAID within BC.

In light of this context, the recommendations contained in this report are designed to accomplish three quality and safety goals:

1. To develop further clinical consensus across the province on the interpretation of the legal eligibility criteria to be applied to Track 2 applicants. This should not be misconstrued as suggesting that assessments are currently being conducted in violation of the law, but rather that the law has a degree of latitude in interpretation that can lead to discrepancies regarding whether an applicant will be deemed eligible, depending upon who assesses them.

2. To adequately remunerate assessors and providers who engage in Track 2 care. These are the most complex medical cases that physicians and nurses will encounter in healthcare. Conducting assessments and, more specifically, determining irremediability, can take months of longitudinal follow-up. Assessors who do this work feel the moral weight of potential years lost if they ultimately find these applicants eligible for MAID. Providing adequate remuneration for this work is one of the single most important safeguards for both assessors and applicants.

3. To develop a model of MAID interdisciplinary care excellence for healthcare providers, applicants, and family by leveraging the value of MCCs. Evidence from this study suggests that MCCs have the potential to reduce the burden on those conducting assessments, to provide collegial moral support for healthcare providers engaged in this work, and to improve care for applicants and family. Such a supportive model is particularly important in our current healthcare climate where applicants experiencing intolerable suffering from disease or illness, but who are not dying, may not have access to systems that can provide a palliative approach to care.

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