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Medical assistance in dying in Canada: a multidisciplinary Pan-Canadian Delphi study to inform clinical practice guidance documents and plan a research agenda

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Abstract

Objective Medical assistance in dying (MAiD) requires careful attention to suffering, yet clinical practice guidance documents provide variable detail on how multidimensional suffering can be explored and addressed. This Delphi study sought expert consensus on potential improvements to clinical practice guidance documents and research priorities related to suffering in MAiD.

Methods A multidisciplinary panel of 54 experts participated in a modified e-Delphi study. Candidate items were developed from a previously published scoping review conducted by members of the research team and discussions from a National Knowledge Dissemination and Research Planning Meeting conducted as part of a broader knowledge-translation initiative. The resulting items were then prioritized through three Delphi survey rounds.

Results Consensus recommendations emphasized the need to move beyond MAiD assessment as a discrete eligibility determination and toward a more longitudinal, interdisciplinary approach to understanding and responding to suffering. The strongest priorities included earlier integration of psychosocial and palliative approaches throughout the illness trajectory, rather than only once MAiD is being considered; continued support for patients throughout the MAiD process, including those deemed ineligible; and greater attention to mental health stigma, social determinants of health, culturally responsive care, and the bio-psycho-social-existential dimensions of suffering.

Conclusion Findings provide a framework for strengthening MAiD guidance documents by supporting consistent, interdisciplinary approaches to exploring and addressing suffering. Embedding palliative and psychosocial care earlier in the illness trajectory may help ensure that potentially modifiable sources of suffering are identified and addressed while respecting patient autonomy and supporting high-quality, patient-centered MAiD care.

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Key message

-Current clinical practice guidance documents on medical assistance in dying (MAiD) do not provide clear guidance on how suffering should be assessed and addressed, particularly beyond physical symptoms.
-Findings from our study underline the importance of introducing psychosocial and palliative care early in the illness trajectory, rather than waiting until a MAiD request.
-MAiD clinical practice guidance documents would benefit from more systematic attention to psychosocial factors, including mental health, stigma, and social determinants of health, with appropriate involvement of social workers and other members of the interdisciplinary team when these issues contribute to suffering.
-Greater clarity is needed in clinical practice guidance documents regarding what constitutes "intolerable suffering," including its bio-psycho-social-existential dimensions, and how this should be approached in both life-threatening and non-life-threatening conditions.

Keywords Medical assistance in dying, Assisted dying, Delphi technique, Clinical guidance, Palliative care, Psychosocial care, Suffering, End-of-life care

Background

Medical assistance in dying (MAiD) has been available in Canada since 2016 and requires that individuals experience enduring and intolerable suffering that cannot be relieved under conditions acceptable to them. Although eligibility criteria define suffering as central to MAiD, how clinicians should explore and respond to its physical, psychological, social, cultural, and existential dimensions remains an evolving area of practice. Existing guidance documents provide important safeguards and procedural direction; however, the extent and specificity of guidance on addressing multidimensional suffering varies across contexts.

To provide informed consent, individuals must understand their diagnosis and prognosis, the treatments that are available, and options to ease suffering, including palliative care [1]. In practice, the reasons people ask for MAiD often extend beyond physical symptoms to encompass psychological, social, and existential concerns such as loss of autonomy, dignity, and participation in meaningful activities [2–5]. A growing body of research in Canada and other jurisdictions has shown that MAiD requests are shaped by interacting physical, psychological, social, and existential factors; clinicians may struggle to consistently assess these different dimensions in practice [6]. Notably, how the assessment of different domains of suffering are conceptualized and operationalized within clinical practice guidance documents remains variable and often under-specified [7].

Although some forms of suffering that drive MAID requests may be amenable to palliative or psychosocial interventions [8, 9], a previous scoping review of 537 clinical practice guidance documents from three Canadian provinces has shown that these interventions are not embedded into MAiD-related policy documents [7]. Existing clinical practice guidance documents have been shaped by a growing body of research from Canada and other jurisdictions, which has informed eligibility criteria, safeguards, and ethical frameworks. However, this work has provided more limited guidance on how to assess and address the multidimensional nature of suffering in practice [2, 7, 10]. As a result, it remains unclear whether current documents adequately support consistent and comprehensive evaluations of suffering.

Assessing and addressing unbearable suffering can be complex, as reported in other jurisdictions allowing euthanasia and physician-assisted suicide [2]. Together, these findings suggest a gap between the multidimensional nature of suffering described in the literature and its representation in clinical guidance.

Across jurisdictions, assisted dying debates have largely focused on legal thresholds, safeguards, and eligibility criteria. Far less attention has been paid to how suffering itself is assessed and addressed in routine clinical practice, particularly when suffering is driven by psychological, social, or existential factors rather than physical symptoms alone.

To address this gap, we conducted a national expert Delphi study examining how suffering could be better operationalized within MAiD clinical practice guidance documents and identifying research priorities. The aim was not to create prescriptive rules for determining suffering, but to identify areas where guidance could support clinicians and patients through complex conversations and care decisions.

Methods

The present study reports the Delphi consensus phase of a broader knowledge-translation initiative examining the assessment and management of suffering in MAiD. The first phase of this initiative consisted of a scoping review conducted by members of our research team examining how suffering was conceptualized and addressed within Canadian MAiD clinical practice guidance documents [7]. Findings from this review informed a 2-day National Knowledge Dissemination and Research Planning Meeting on July 14–15, 2022 involving clinicians, researchers,

policymakers, and people with lived experience. Discussions from this meeting were subsequently analyzed and used to generate candidate items for the Delphi process reported in the present manuscript. The resulting items were then refined and evaluated through three iterative rounds of Delphi surveys. This modified approach was selected to ensure the Delphi rounds were grounded in existing evidence and stakeholder priorities.

We drew on the Dialogue Model [11, 12], a participatory framework for knowledge transfer and priority-setting, to structure this project. In brief, the model emphasizes iterative exchange between stakeholders, explicit attention to the messages being communicated, and careful planning of the processes used to move from evidence to shared priorities. In our case, it guided the preparatory work (review of existing evidence and stakeholder engagement), the design of the National Knowledge Dissemination and Research Planning Meeting, and the subsequent steps of refining and prioritizing candidate recommendations for practice and research. A fuller description of how the Dialogue Model was applied in this initiative is available in our previous report [13].

All plenary and breakout discussions from the National Knowledge Dissemination and Research Planning Meeting (July 14–15, 2022) were audio-recorded, transcribed verbatim, and analyzed using thematic analysis [14]. Analysis was conducted between July 15th and August 12th, 2022 by two members of the research team (JA and SCCK), with oversight from a senior researcher (MH). Transcripts were independently reviewed and coded by the two coders using an inductive approach focused on identifying panelists' recommendations related to [1] potential improvements to MAiD clinical practice guidance documents and [2] priorities for future research. Initial codes were compared across coders, and discrepancies in interpretation or coding were discussed during consensus meetings. Any unresolved disagreements were reviewed with the senior researcher (MH) until consensus was achieved.

Codes were then iteratively discussed among the research team to create more abstract conceptual categories. Candidate themes were reviewed for their accuracy in reflecting panelists' perspectives and for being grounded in the original transcripts. The themes were checked against the original transcripts to ensure that they represented the views of the panelists. This process resulted in 79 unique panelist suggestions, which were refined into 37 proposed changes to clinical practice guidance documents and 42 potential research priorities. These items were grouped into 15 overarching themes and reformulated into Delphi survey items while preserving panelists' original wording whenever possible. The Delphi process was then conducted according to established guidelines, with items evaluated across three iterative rounds of online surveys [11, 12].

Panelists

For the Delphi panel, we invited individuals who had participated in the National Knowledge Dissemination and Research Planning Meeting, as well as additional people suggested by them (i.e., snowball sampling). All individuals, including those identified through snowball sampling, were required to meet the same eligibility criteria. Eligible panellists were clinicians, researchers, policymakers, and people with lived experience (e.g., patients or family caregivers) who had relevant experience in end-of-life care (including palliative care or MAiD), or relevant areas such as suicide prevention. In this study, "expert" referred to individuals with relevant knowledge or experience in these areas, whether through clinical, research, policy, or lived experience perspectives. Suggested people were reviewed by the research team to ensure they met these criteria prior to invitation. Direct involvement in MAiD provision or guideline development was not required, but familiarity with its clinical, research, policy, or lived experience context was considered important. Recruitment procedures were consistent across stakeholder groups. All materials were available in English and French.

We aimed for a heterogeneous panel of approximately 40–55 members having completed the Delphi study [11, 13, 15, 16], consistent with guidance for Delphi studies that seek to capture a broad range of perspectives. We aimed for diverse professions during recruitment (e.g., palliative care, intensive care, emergency medicine, family physician, nurse, physiotherapy, occupational therapy, spiritual care, psychiatrist, psychologist, social worker), province, disease focus (e.g., cancer, neurological, cardiovascular), and practice setting (e.g., hospital, community setting).

Data collection

Across three online survey rounds, panel members rated the importance of each proposed item on a 5-point Likert scale (1 = not important to 5 = very important) [11, 17]. In round one, the survey also included open-ended questions that allowed panelists to suggest additional items for clinical guidance documents and research, comment on wording, and describe perceived barriers, facilitators, and knowledge-translation tools to the implementation of clinical guidance documents' changes. For rounds two and three, panelists were shown anonymized summaries of the group's ratings from the previous round and were invited to reconsider their own ratings considering this feedback [11, 12]. Consistent with prior Delphi work, we defined consensus a priori as at least 70% of panelists rating an item as important or very important (score of 4 or 5) [12, 18]. To accommodate differences in

expertise, panelists were not required to rate every item. At the end of the Delphi process, interested panelists joined virtual follow-up meetings to discuss how high-priority items could be translated into concrete wording for clinical practice guidance documents, consistent with recommended approaches for Delphi studies that incorporate iterative consensus-building and refinement phases beyond survey rounds [18, 19].

Data analysis

Quantitative data were analyzed using IBM SPSS Statistics version 29 [20]. Median scores, means, and frequency distributions were calculated for each Likert-scale item.

Table 1 Sociodemographic and medical variables

Baseline Characteristic	*N* (%)
Sex	
Female	34 (63)
Male	20 (37)
Gender	
Woman	34 (63)
Man	20 (37)
Age	
20–30	4 (7)
31–40	8 (15)
41–50	15 (28)
51–60	13 (24)
61–70	10 (19)
71–80	4 (7)
Ethnicity	
Caucasian/ European	38 (70)
South Asian	2 (4)
Chinese	3 (6)
No response	11 (20)
Level of Education	
College Diploma	9 (17)
University Diploma	5 (9)
Professional School	15 (28)
Graduate Education	24 (44)
No response	1 (2)
Connection to MAiD	
Researcher	23 (43)
Clinician	21 (39)
Policy-Maker	9 (17)
Patient / Family Caregiver	1 (2)
Province / Territory	
Quebec	27 (50)
Ontario	13 (24)
British Columbia	10 (19)
Saskatchewan	1 (2)
Manitoba	1 (2)
Nova Scotia	1 (2)
No response	1 (2)

Results

Panelists

Panelists in the Delphi process are referred to as "panelists" throughout the manuscript. The final panel comprised 54 experts from six Canadian provinces (out of the 74 people invited; overall response rate 74%), including 23 researchers (43%), 21 clinicians (39%), 9 policy-makers (17%), and 1 panelist who identified primarily as both a patient and a family caregiver (2%). Thirty-two panelists had been part of the 2-day virtual National Knowledge Dissemination and Research Planning Meeting and 22 were referred by group members. Forty-six people participated in the first round of the Delphi study, 53 in the second round and 54 in the third rounds. There were no more than two missing responses on each clinical practice guidance documents or research priorities items. 63% of panelists ($n = 34$) identified as women and 37% ($n = 20$) as men. Just over half were based in Quebec (51%; $n = 27$), with the remainder mainly from Ontario (25%; $n = 13$) and British Columbia (19%; $n = 10$). Consensus was reached for 27 of the 38 proposed changes to clinical practice guidance documents and for 24 of the 51 research priorities. See Table 1 for sociodemographic characteristics of our sample.

Priority themes

Of the 15 overarching themes evaluated through the Delphi process, 12 themes (80.0%) reached consensus and were identified as priorities. The highest-rated theme was the early integration of palliative and psychosocial care within the MAiD trajectory, which achieved 89% consensus. Panelists also strongly endorsed the importance of maintaining supportive care throughout the 90-day assessment period before eligibility determination for Track 2 MAiD (86% consensus) and improving approaches to assessing and addressing mental health comorbidities in individuals requesting MAiD (84% consensus). Additional priority themes reflected the need for a more comprehensive and equitable approach to suffering, including greater integration of social determinants of health into MAiD assessments (79% consensus), development of culturally competent models of care (79% consensus), establishment of standards and quality indicators for palliative care (79% consensus), and improved access to supportive care for individuals experiencing suffering in the context of non-life-threatening conditions (79% consensus). Table 2 presents the priority themes that reached consensus, while Supplementary Table 1 presents themes that did not reach consensus.

Clinical practice guidance document improvements

Among the 38 proposed changes to clinical practice guidance documents that addressed areas not consistently covered in existing guidance, 27 items (71.1%) achieved

Table 2 Overall overarching themes that reached consensus

Overarching Theme	Round 1 Mean (Median) % *n* = 46	Round 2 Mean (Median) % *n* = 53	Round 3 Mean (Median) % *n* = 54
Introducing palliative and psychosocial care services early in the disease trajectory Description: Practice guidelines for most serious and incurable illnesses emphasize the importance of early or timely integration of palliative and psychosocial care services. There are barriers to timely integration of palliative and psychosocial care, including stigmata vis-à-vis opioids, palliative care, and mental health. There may be ways to address these barriers, including psychoeducation, patient representatives, and a recovery-oriented approach.	4.54 (5.00) 89%	--	--
Maintaining supportive care during the 90-day wait period until MAiD is accepted. Description: Healthcare providers have an obligation to provide ongoing care, including any indicated treatments, to patients who have requested MAID. Continuity of care may help improve suffering, which is beneficial even if the person ultimately proceeds with MAID.	4.27 (4.00) 86%	--	--
Reflect complexity in the evaluation of patients with mental health comorbidities requesting MAiD. Description: Patients requesting MAiD may have underlying comorbid psychiatric illnesses that may be unidentified or undertreated by the care team. MAiD assessors and providers are in a position to identify and help manage such illnesses and ensure that alternatives to MAiD have been offered.	4.26 (4.00) 84%	--	--
Social determinants of health need to be integrated into the evaluation of MAiD requests. Socio-economic deprivation and other forms of structural disadvantage can contribute to suffering and may be challenging to assess and address. Stigmatization and poor health literacy may also play a role in patients refusing palliative and psychosocial interventions. Different models need to be envisaged to increase access to care.	4.34 (5.00) 79%	--	--
Develop a model for MAiD that is culturally competent. Description: Medical education is paying increasing attention to cultural competency and sensitivity to diversity. Considerations of culture and diversity may be important when evaluating how patients, caregivers, and healthcare practitioners envision life, death, suffering, and the role of medicine.	4.29 (5.00) 79%	--	--
Create a core set of standards and ensuing quality indicators for palliative care specifically in Canada to be integrated into the general monitoring system for end-of-life care. Description: There is a need to develop standards and quality indicators for palliative care in Canada, allowing the country to initiate palliative care quality improvement and monitor quality end-of-life care. These indicators would be used throughout the provision of care in all major disease trajectories (e.g., cancer, cardiovascular, neurodegenerative disease). A core set of quality indicators would constitute standards for palliative care that are enforced through Accreditation Canada. These indicators are needed in all places where people receive care for chronic life-threatening illnesses, and need to be assessed again at the time of MAiD requests and can serve to inform care options provided or offered during MAiD assessments.	4.24 (4.00) 79%	--	--
Offer supportive care for people suffering from non-life-threatening conditions. Description: Additional safeguards are needed for patients whose deaths are not reasonably foreseeable, such as consultation of physicians specializing in the disease being treated, a 90-day assessment period, and access to supportive care addressing physical, psychological and existential symptoms with practical support.	4.13 (4.00) 79%	--	--
Offer interventions based on hope, dignity, and maintaining a sense of autonomy/control. Description: MAiD requests are often based on existential distress and a loss of a sense of control and autonomy. Interventions focused on these threats may help improve their suffering, whether they chose to proceed with MAiD.	3.97 (4.00) 66%	4.18 (4.00) 77%	--
Implementing an interdisciplinary approach to the care of a patient requesting MAiD. Description: The suffering that motivates MAiD requests is due to a combination of physical, psychological, practical/social, and existential issues. Considering the nature of suffering in MAiD, there may be a benefit to integrating an interdisciplinary approach in assessment and management of MAiD requests, including palliative care, psychiatrists, psychologists, social workers, nurse practitioners, physiotherapists, occupational therapists, and spiritual counselors. Continuity of care is a priority.	4.24 (5.00) 76%	--	--

Table 2 (continued)

Overarching Theme	Round 1 Mean (Median) % n = 46	Round 2 Mean (Median) % n = 53	Round 3 Mean (Median) % n = 54
Normalize palliative care as part of health care to help destigmatize it.	4.08 (4.00)	--	--
Description: The stigma surrounding palliative care may prevent individuals from utilizing palliative care themselves or from enrolling family members. A public health strategy with media campaigns designed to educate the public on palliative care in a way that associates it with life and promotes hopefulness may be helpful in overcoming this stigma.	74%		
Consider the effect of MAiD on healthcare provider burnout and emotional and psychological distress.	3.95 (4.00)	3.90 (4.00)	4.02 (4.00)
Description: Burnout in healthcare professionals has been increasing, especially following the onset of the COVID-19 pandemic. In the context of MAiD, healthcare providers can sometimes face challenges navigating patients' requests and adapting to changes in Canada's MAiD legislation. Providers may experience distress because of participating in MAiD assessment and provision, or as a result of being prevented from participating in MAiD assessment and provision (either through institutional policies or other means). Both participation and non-participation may conflict with a provider's values and beliefs. There is a need to ensure that healthcare providers are supported regardless of their involvement in MAiD.	68%	69%	74%
Create a core set of existential / psychosocial indicators to be integrated into the monitoring system for end-of-life care.	4.08 (4.00)	--	--
Description: According to the Annual Report on MAiD in Canada, MAiD requests are motivated principally by existential and psychological distress. There are validated measures of psychological and existential distress available, and some interventions may be effective to address this distress. Included in palliative care indicators, it would be important to develop a core set of psychosocial care quality indicators.	70%		

consensus and were considered priorities for integration into future guidance. The highest-rated recommendation was to offer psychosocial care for identified distress beginning at diagnosis and at key transition points throughout the illness trajectory (92% consensus). Panelists also prioritized incorporating a palliative approach early in care planning (89% consensus), ensuring continued follow-up and support for individuals found ineligible for MAiD (84% consensus), and addressing stigma related to mental health concerns among people requesting MAiD (84% consensus). Other highly rated recommendations focused on strengthening the assessment of multidimensional suffering, including incorporating basic psychosocial needs assessments within MAiD evaluations (79% consensus), involving social workers and other psychosocial professionals when social determinants of health contribute substantially to suffering (79% consensus), and providing greater clarification regarding the bio-psycho-social-existential dimensions of intolerable suffering across both life-threatening and non-life-threatening conditions (79% consensus) Fig. 1. Table 3 summarizes clinical practice guidance document recommendations that reached consensus, while Supplementary Table 2 presents items that did not reach consensus.

Research priorities

Of the 51 proposed research priorities evaluated, 24 items (47.1%) achieved consensus and were identified as important areas for future investigation. The highest-rated priority was improving understanding of patients' perspectives on different dimensions of suffering, including how suffering evolves throughout the MAiD trajectory (95% consensus). Other research priorities identified as important included understanding the role of mental health stigma in MAiD care (87% consensus), the impact of early palliative care integration on MAiD requests (85% consensus), and exploring the reasons why patients may delay or change their minds about MAiD after an initial request (82% consensus). Panelists also emphasized the need for research focused on communication practices during discussions about suffering in the context of MAiD (79% consensus) and the influence of cultural factors on MAiD requests, engagement with palliative care services, and assessments of suffering (79% consensus). Table 4 provides the full list of research priorities that reached consensus, while Supplementary Table 3 presents items that did not achieve consensus.

Implementation barriers, facilitators, and tools

Most panelists perceived their workplace as moderately (46%) or totally (35%) willing to adopt the consensus improvements. Key facilitators included leadership support, patient-clinician partnerships, educational resources on MAiD practice, and policy development by

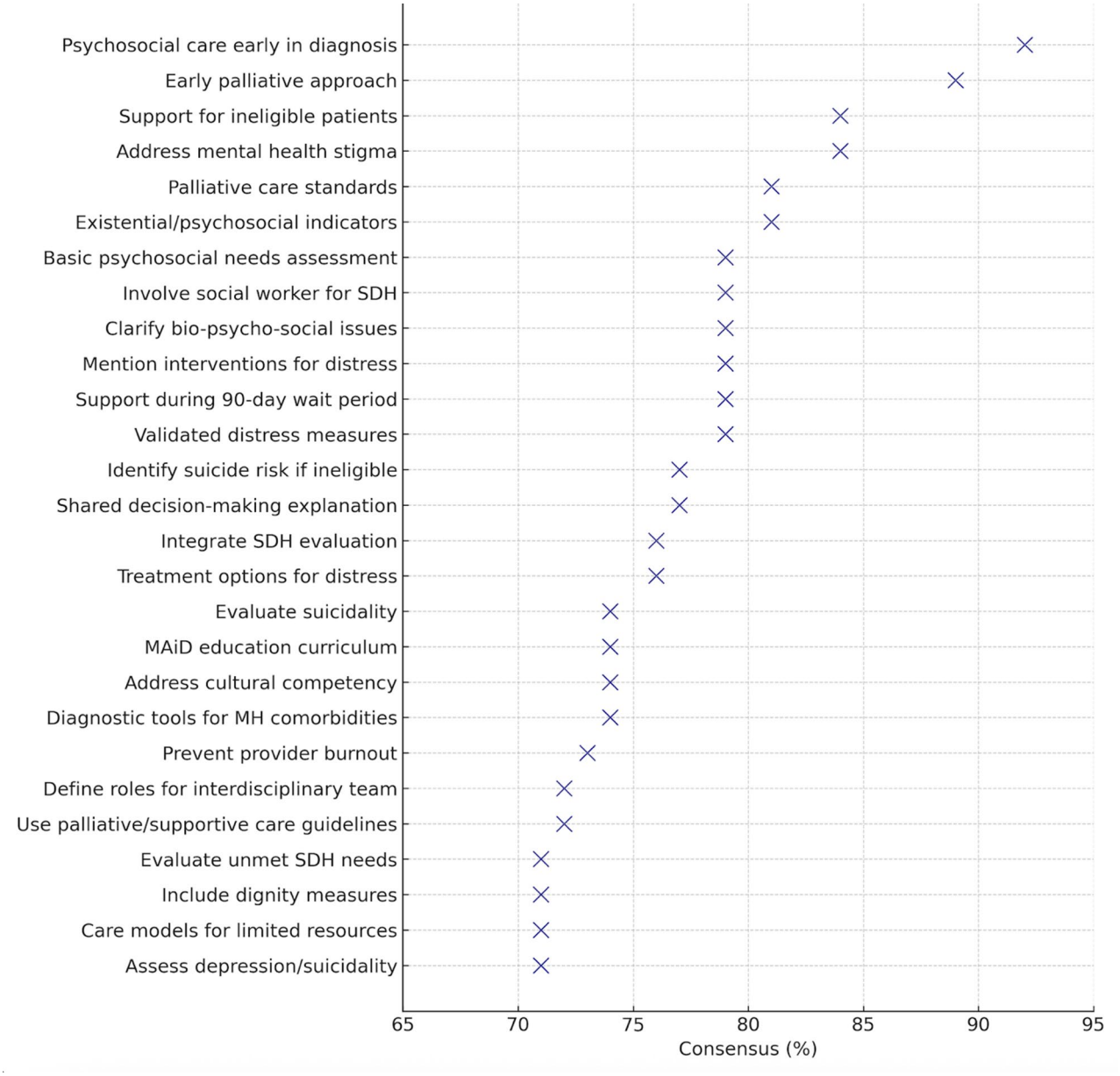

Fig. 1 Dot plot of consensus on MAiD clinical practice improvements

ministries of health, regulatory colleges, and CAMAP board. Barriers included time constraints, limited access to psychosocial services, inconsistent provincial policies, stigma towards MAiD in society, and fear of mistaking a valid request for MAiD with one based on social determinants of health. 82% of panelists were moderately willing (40%) or totally willing (43%) to disseminate these consensus improvements in their workplaces. They reported needing online training tools (e.g., short digestible videos and webinars), printable documents/materials, PowerPoint slides, and financial support. At the end of the Delphi study, panelists regrouped together for a series of three meetings to discuss concrete clinical practice changes that could be integrated into clinical practice guidance documents. The suggestions are presented in Suppl. Material Table 4.

Differences in item ratings across stakeholder groups

Given the multidisciplinary composition of the Delphi panel, exploratory analyses examined whether ratings differed across stakeholder groups (clinicians, researchers, and policymakers). Ratings differed significantly across groups for 22 clinical practice guidance and research priority items (Supplementary Table 5). However, these differences did not alter the overall consensus priorities identified through the Delphi process. Rather,

Table 3 Changes to guiding MAiD clinical practice documents at a policy level that reached consensus to guide clinical care

Items	Round 1 Mean (median) %	Round 2 Mean (median) %	Round 3 Mean (median) %
Offer psychosocial care for identified distress as early as the onset of diagnosis and at crucial times during the disease trajectory.	4.45 (5.00) 92%	--	--
Consider and discuss a palliative approach as early as the onset of diagnosis.	4.34 (4.50) 89%	--	--
Integrate follow-up and support for patients found to be ineligible for MAID at the time of the assessment.	4.26 (4.00) 84%	--	--
Address stigma towards mental health in patients requesting MAiD.	4.21(4.00) 84%	--	--
Integrate standards and quality indicators for palliative care specifically in Canada.	4.24 (4.00) 81%	--	--
Integrate a core set of existential / psychosocial care quality indicators in Canada.	3.97 (4.00) 81%	--	--
Include a basic psychosocial needs assessment within the context of a MAiD request, considering both patient and family needs.	4.24 (4.00) 79%	--	--
Involve a social worker and other psychosocial professionals when the MAiD evaluation reveals that social determinants of health are a significant component of suffering.	4.24 (4.50) 79%	--	--
Clarify bio-psycho-social-existential issues associated with intolerable suffering (including social determinants of health) in patients requesting MAiD in the context of life-threatening and non-life-threatening conditions.	4.21 (4.00) 79%	--	--
Mention interventions that may be effective to address existential and psychosocial distress in a patient requesting MAID.	4.18 (4.00) 79%	--	--
Reinforce the importance of providing or continuing support for patients and caregivers during the 90-day wait period for MAiD acceptance via community resources and psychological assistance.	4.13 (4.00) 79%	--	--
Include a core set of brief validated measures for psychological, practical/social, and existential distress for MAID assessors to use in their evaluation of MAiD requests.	3.79 (4.00) 66%	4.00 (4.00) 79%	--
Underscore the importance of identifying those who would be at risk of suicide if deemed ineligible for MAiD.	3.79 (4.00) 61%	4.08 (4.00) 77%	--
Implement explanations related to shared decision-making and advanced directives for MAiD requestors as a means to foster a sense of control and autonomy.	3.90 (4.00) 68%	4.03 (4.00) 77%	--
Integrate the evaluation of social determinants of health as part of a MAiD assessment.	4.21 (4.00) 76%	--	--
Outline the various treatment options (pharmacologic, psychotherapy) available for psychiatric illness and psychological distress in patients requesting MAiD.	4.18 (4.50) 76%	--	--
Evaluate suicidality, and whether suicidality may be affecting a wish to hasten death in patients requesting MAiD.	4.05 (4.00) 74%	--	--
Refer to educational curriculum venues for MAiD assessors and providers that comprehensively covers evaluating and addressing suffering in patients requesting MAiD.	4.03 (4.00) 74%	--	--
Address issues of cultural competency and sensitivity to diversity in addressing how patients, caregivers, and healthcare practitioners envision life, death, suffering, and the role of medicine in the context of a MAiD request.	4.13 (4.00) 74%	--	--
Integrate diagnostic tools to evaluate mental health comorbidities in patients requesting MAiD.	3.95 (4.00) 74%	--	--

Table 3 (continued)

Items	Round 1 Mean (median) %	Round 2 Mean (median) %	Round 3 Mean (median) %
Integrate strategies to prevent and manage MAiD healthcare provider burnout, such as providing organizational and mental health support.	4.00 (4.00) 66%	3.92 (4.00) 69%	4.04 (4.00) 73%
Establish clear roles, responsibilities, and clinical pathways for each member of the interdisciplinary care team to assess and address suffering in MAiD requests.	4.03 (4.50) 68%	4.08 (4.50) 72%	--
Integrate current evidence-based palliative and supportive care guidelines for management of symptoms and distress into the process of MAiD assessment and provision.	3.97 (4.00) 68%	3.97 (4.00) 72%	--
Establish care models that could be used when resources are lacking to address unbearable suffering in the context of MAiD requests.	4.13 (4.00) 71%	--	--
Integrate an evaluation of unmet needs related to social determinants of health underlying unbearable suffering in MAiD requests and indicate whether treatment and therapies exist and are available to the patient, at the hospital and community levels.	4.18 (5.00) 71%	--	--
Include dignity measures and exploration of patients' suffering during MAiD evaluations.	3.92 (4.00) 63%	3.92 (4.00) 69%	4.00 (4.00) 71%
Integrate the systematic evaluation of depression and suicidal ideation in the assessment of MAiD requests.	3.92 (4.00) 71%	--	--

they highlight areas where stakeholder perspectives may differ and where further discussion may be valuable during implementation of recommendations.

Discussion

This study provides consensus recommendations for the ideal content of MAiD clinical practice guidance documents. It emphasizes the importance of more systematically covering assessing and addressing psychological, existential, social, and cultural dimensions of suffering in the context of MAiD requests, as well as implementing clinical practice guidelines and standards on suffering in MAiD. Many of the priorities identified in this Delphi study, such as earlier integration of palliative care, attention to social determinants of health, and the need to better define and assess intolerable suffering, are consistent with findings from prior research in Canada and in jurisdictions where assisted dying and euthanasia have been more extensively studied, particularly in Europe [21]. This corpus of work has revealed the challenge of assessing suffering in practice, especially in situations where psychological, social and existential dimensions intersect with medical decision-making. However, much of this literature has focused on legal frameworks, ethical analysis, or retrospective accounts of practice, with less attention to how these challenges are translated into concrete clinical guidance. In this context, our findings extend existing work by identifying specific, consensus-based recommendations to support how suffering can be more consistently addressed within clinical practice guidance documents.

Several factors may explain why existing clinical practice guidance documents may provide variable levels of operational guidance on assessing and addressing suffering in MAiD. First, MAiD is a relatively recent and rapidly evolving practice in Canada, and early guidance documents were understandably developed with a primary focus on establishing legal eligibility criteria, procedural safeguards, and clinician responsibilities. Comparatively less attention has been devoted to translating the multidimensional nature of suffering into practical clinical approaches. Second, suffering itself is by nature complex, subjective and influenced by interactions between physical symptoms, psychological distress, existential concerns, social circumstances and cultural context. Developing standardized guidance that is sensitive to the autonomy of patients, while helping clinicians to explore potentially modifiable contributors to suffering, is therefore a major challenge. Third, gaps in guidance may also reflect wider implementation barriers, including variability in availability of interdisciplinary resources such as palliative care, mental health professionals and social services across jurisdictions. Finally, ongoing societal and professional debates surrounding MAiD may have

Table 4 Research priorities that reached consensus

Items	Round 1 Mean (median) % *n* = 46	Round 2 Mean (median) % *n* = 53	Round 3 Mean (median) % *n* = 54
Better understand the perspectives of patients with respect to different forms of suffering, their influence on MAiD requests, and how they change over the course of the MAiD trajectory (psychological, practical/social, existential, physical).	4.47 (5.00) 95%	--	--
Identify how mental health stigma affect the provision of optimal care in the context of MAiD.	3.92 (4.00) 69%	4.21 (4.00) 87%	--
Determine the impact of an early/timely palliative approach on requests for MAiD.	3.92 (4.00) 68%	4.21 (4.00) 85%	--
Understand what triggers a patient to delay MAiD or change their mind about MAiD following a request.	3.87 (4.00) 68%	4.08 (4.00) 82%	--
Better understand how doctor-patient communication best practices are applied to conversations around suffering within a MAiD request.	3.73 (4.00) 65%	4.23 (4.00) 79%	--
Understand the influence of cultural factors on MAiD requests, use of palliative care services, and the assessment of suffering.	4.16 (4.00) 79%	--	--
Develop effective, scalable, and acceptable treatments for existential and psychosocial distress in the context of MAiD requests.	4.05 (4.00) 79%	--	--
Understand the impact of social and cultural factors on the interpretation of suffering from the perspective of patients, families, and healthcare practitioners when MAiD is requested.	4.08 (4.00) 76%	--	--
Understand suffering in the context of MAiD requests associated with non-life-threatening conditions and how this suffering changes with time.	4.08 (4.00) 76%	--	--
Develop an educational curriculum for MAiD assessors and providers that comprehensively covers evaluating and addressing suffering.	4.05 (4.00) 76%	--	--
Better understand MAiD assessors' and providers' knowledge and skills in regard to complex assessments of suffering within MAiD requests.	4.05 (4.00) 74%	--	--
Engage national leaders and stakeholders to develop and enact a public health strategy on palliative care.	4.03 (4.00) 68%	4.10 (4.00) 74%	--
Understand the relative contribution of social determinants of health to suffering underlying track 1 versus track 2 MAiD requests.	4.05 (4.00) 74%	--	--
Better understand health service utilization when patients are found ineligible for MAID,	3.79 (4.00) 63%	4.05 (4.00) 74%	--
Evaluate the effect of treating underlying psychiatric illness on suffering reported by people requesting MAiD.	4.03 (4.00) 74%	--	--
Develop a core set of validated quality indicators for existential / psychosocial care in Canada to be integrated into the MAiD monitoring system through Health Canada and the Canadian Institute of Health Information.	3.79 (4.00) 61%	3.92 (4.00) 74%	--
Better understand the perspectives of MAiD clinicians with respect to different forms of suffering, their influence on MAiD requests, and how they change over the course of the MAiD trajectory (psychological, practical/social, existential, physical).	3.89 (4.00) 74%	--	--
Better understand the perspectives of family caregivers with respect to different forms of suffering, their influence on MAiD requests, and how they change over the course of the MAiD trajectory (psychological, practical/social, existential, physical).	3.84 (4.00) 74%	--	--

Table 4 (continued)

Items	Round 1 Mean (median) % *n* = 46	Round 2 Mean (median) % *n* = 53	Round 3 Mean (median) % *n* = 54
Understand burnout in MAiD assessors and providers, how suffering is addressed, and the impact on clinical practice.	3.84 (4.00) 66%	3.82 (4.00) 67%	3.94 (4.00) 73%
Better understand the impact of early conversations around MAiD on a sense of control and the eventual.	3.81 (4.00) 59%	3.85 (4.00) 69%	3.96 (4.00) 72%
Develop and evaluate a model of care that emphasizes support throughout the 90-day wait period for people requesting MAiD by track 2.	3.84 (4.00) 66%	3.95 (4.00) 72%	--
Understand how hope and hopelessness are addressed in patients requesting MAiD.	3.86 (4.00) 68%	3.95 (4.00) 72%	--
Determine the impact of early and timely psychosocial care on requests for MAiD.	4.08 (4.00) 71%	--	--
Characterize how the nature of suffering in the context of MAiD requests associated with non-life-threatening conditions may be different from that of MAiD requests associated with a life-threatening condition.	3.92 (4.00) 71%	--	--
Understand the extent to which knowledge of certain care processes (e.g., advanced directives, palliative sedation) provide patients with a sense of control and change their minds as to MAiD.	3.76 (4.00) 66%	3.79 (4.00) 69%	3.86 (4.00) 71%

influenced the pace at which professional organizations develop detailed clinical recommendations beyond eligibility assessment. Strengthening guidance in this area will therefore require not only refinement of clinical practice guidance documents, but also attention to implementation strategies, resource availability, professional education, and continued dialogue among stakeholders.

A central contribution of this Delphi study is the emphasis on shifting from a model focused primarily on MAiD eligibility assessment toward a broader longitudinal approach in which suffering is explored and addressed throughout the illness trajectory. The strongest signal from the panel concerned suggesting palliative and psychosocial support to be introduced earlier in the course of illness, rather than only once MAiD is being considered. Although the large majority of Canadian MAiD recipients have palliative care involvement prior to requesting MAiD, often for more than a month, there is still an opportunity to increase both the involvement and the duration of palliative care provision for people requesting MAiD. This recommendation aligns with the broader palliative care literature, where timely involvement of palliative and supportive care has been shown to enhance quality of life and, in some cases, even survival [21]. Psychosocial interventions throughout the MAiD process may alleviate some suffering and support meaningful quality of life; this is a benefit regardless of whether the person ultimately proceeds with MAiD or not. It also aligns with the Lancet Oncology Commission on the Human Crisis of Cancer, a call to increase attention to the humanistic dimensions of cancer care [22]. Misconceptions and negative perceptions of palliative care, such as the perception that it is only for end of life or a sign to lose hope, may lead to delayed acceptance or referral. These misconceptions can be addressed by educating patients and having patient-centred conversations sooner, which may help to enable timely access to supportive care [8, 9]. Importantly, these recommendations are not intended to embed additional steps or complexity to MAiD assessments, as overly burdensome processes may pose unintended barriers to access. Instead, quality indicators and evidence-informed approaches to palliative and psychosocial care could be incorporated into clinical guidance documents as practical tools to help clinicians identify and respond to the various dimensions of suffering. The feasibility of these recommendations will be determined by the availability of interdisciplinary resources, local models of care and approaches to implementation that balance comprehensive support with timely and equitable access to MAiD.

Models of integrated psychosocial care developed in serious illness contexts, including oncology, provide examples of how distress and unmet supportive care needs can be systematically identified and addressed

throughout the illness trajectory [23]. Although MAiD involves unique ethical and clinical considerations, similar principles of person-centered, interdisciplinary care may help inform guidance on how clinicians explore and respond to the multidimensional nature of suffering. Clinical practice guidance documents could therefore better support clinicians by describing approaches to assessing psychological, social, existential, and cultural dimensions of suffering and identifying when involvement of interdisciplinary team members may be beneficial.

Panelists also emphasized that MAiD assessments should consider the potential contribution of social determinants of health to experiences of suffering. Factors such as poverty, social isolation, inadequate supports, and barriers to accessing health and social services may interact with physical, psychological, and existential suffering [24–27]. Exploring these factors within MAiD conversations is not intended to question the validity of an individual's request, but rather to ensure that patients' values, preferences, and sources of suffering are fully understood and that available supports are identified. However, addressing social determinants of health cannot rest solely with individual MAiD assessors and providers; many of these factors require broader health system, policy, and social safety net responses to improve equitable access to care and supportive resources. Current ethical discussions point to the difficulty of balancing respect for autonomy with an awareness that structural vulnerabilities can shape the context in which healthcare decisions are made [28]. Increasing health literacy and appropriate mediatic coverage could counter misinformation regarding available supportive and palliative care options and improve awareness and access, especially in underserved populations [28].

Another theme emphasized the importance of culturally responsive care, especially in a country as diverse as Canada [29–31]. Previous work shows that cultural beliefs influence ideas about suffering, autonomy, end of life decisions, and engagement with palliative care services. Yet, policy documents do not provide guidance on how to translate these understandings into MAiD practice. Future work should explore models of culturally adapted care, barriers to access for diverse populations, and more direct engagement with patient and community perspectives [30]. These considerations align with broader models of culturally competent care that focus on responsiveness to diverse values, beliefs, and health practices [32].

Identifying specific, consensus-based recommendations is particularly important and relevant for Track 2 MAiD, where the assessment of suffering is more complex and variable [28]. Although the present study was not designed to address MAiD requests where mental illness is the sole underlying medical condition, several findings may be particularly relevant to ongoing discussions in this area. The consensus priorities identified by panelists, including the need for clearer approaches to assessing bio-psycho-social-existential dimensions of suffering, addressing mental health stigma, evaluating potentially modifiable contributors to suffering, and strengthening interdisciplinary models of care, highlight areas that may become increasingly important when the relationship between illness, psychosocial context, and suffering is more complex. Existing research from jurisdictions where assisted dying for psychiatric suffering is permitted highlights challenges related to assessing the persistence, severity, and potential alleviation of suffering over time [26, 33]. Future research is therefore needed to determine whether and how these recommendations apply to MAiD requests where mental illness is the sole underlying condition, including what forms of clinical guidance best support consistent assessment while respecting patient autonomy.

Lastly, research priorities included further understanding the suffering behind MAiD requests (type, level, duration/course), how patients make decisions around MAiD, and how early palliative interventions affect these decisions. Future research should investigate psychosocial interventions commonly used, care models that are culturally sensitive, and structured support for both patients and providers who are making MAiD decisions [26, 27].

The recommendations of this study may inform the strengthening of existing clinical practice guidance documents, adherence to ethical standards and patient-centered care in the MAiD context. These recommendations may be advanced through revisions to clinical guidance documents, continuing professional education and the development of quality metrics. Future work should draw on implementation science frameworks to identify appropriate strategies for integrating recommendations into practice while considering local context, resources, and barriers to adoption [34, 35].

Limitations

Several limitations must be noted. First, the virtual data collection methods may have contributed to limited engagement of panelists and may have influenced their responses due to distractions and fewer opportunities for in-person interaction [36]. Second, while the Delphi panel was purposefully inclusive of a range of stakeholders, including clinicians, researchers, policymakers and those with lived experience, the composition of the panel may have influenced the priorities for consensus identified. The diversity of perspectives captured is both a strength and a limitation of a multidisciplinary Delphi study, especially for a complex and evolving topic such as MAiD, where stakeholder groups may have divergent views. Our

sample consisted primarily of professionals and policymakers, with fewer participants with lived experience of MAiD, and not all clinicians were directly involved in MAiD provision. As such, findings are primarily reflective of professional and system level perspectives, and patient, family and MAiD provider perspectives may not have been fully captured. Future research that directly engages individuals with lived experience and clinicians involved in the provision of MAiD can help to further refine priorities related to clinical guidance, implementation barriers and supportive tools. Third, half of the panelists were based in Quebec, where MAiD is provided in a different provincial and federal framework. This may have influenced the prioritization of certain items, especially those related to care delivery and professional roles. As such, the findings may be somewhat context-specific to Quebec, and regional differences should be taken into account when considering and implementing these recommendations. Future work should also further explore how guidance needs may differ across MAiD contexts, including life-threatening and non-life-threatening conditions and areas affected by evolving legislation (e.g., advance requests, mental health, minors). Finally, item formulation could have impacted consensus, as some items referred to combined MAiD and palliative care contexts, potentially influencing acceptability ratings. Further qualitative studies could clarify why certain items did not reach consensus.

Conclusion

The Delphi study's conclusions offer recommendations for the content of MAiD practice guidelines and research, including content relevant to early psychosocial and palliative care interventions, considering social determinants of health, and using culturally sensitive, interdisciplinary assessments to clinical practice guidance documents if they are not already present. This study offers a transferable framework for strengthening clinical practice guidance documents by making suffering visible, assessable, and addressable within interdisciplinary models of care.

Standardizing the content of practice documents may contribute to more patient-centered, fair, and ethically grounded MAiD practices. We recommend that MAID programs review their clinical documents and policies to identify any current gaps, and that assessors pursue specific training to address areas where they might have learning needs. Apart from the research priorities identified in this study, future research should examine how these changes are implemented and how they affect patient outcomes and quality of care. As jurisdictions worldwide grapple with how to regulate and deliver assisted dying, attention to how suffering is understood and managed in everyday clinical practice will be essential to ensuring ethical, equitable, and patient-centered care.

Supplementary Information

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Supplementary Material 1.

Authors' contributions

All authors were involved in the conceptualization, methodology, and writing/editing of the study. MH was involved in funding acquisition.

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Data availability

The datasets related to the current study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

This study was conducted according to the World Medical Association Declaration of Helsinki. This manuscript conforms to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals. This study was approved by the CIUSSS West-Central Montreal Ethics Committee #2022–2936. Written informed consent was obtained from all panelists and consent documentation was stored on a Data Management System at the Lady Davis Institute for Medical Research.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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References

1. Government of Canada. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). 2016. Available from: https://laws-lois.justice.gc.ca/fra/LoisAnnuelles/2016_3/TexteComplet.html.
2. Dees M, Vernooij M, Dekkers W, van Weel C. Unbearable suffering of patients with a request for euthanasia or physician-assisted suicide: an integrative review. Psychooncology. 2010;19(4):339–52.
3. Wilson K, Dalgleish TL, Chochinov HM, Chary S, Gagnon PR, MacMillan K, et al. Mental disorders and the desire for death in patients receiving palliative care for cancer. BMJ Support Palliat Care. 2016;6(2):170–7.

4. Hudson PL, Kristjanson LJ, Ashby M, et al. Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. Palliat Med. 2006;20(7):693–701.
5. Government of Canada. Second Annual Report on Medical Assistance in Dying in Canada 2020. 2020. Available from: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2020.html.
6. Girard D, Tuinema M, van Wijngaarden E. Unravelling the meaning of suffering in the context of euthanasia and assisted suicide: a multiperspective meta-ethnography. Mortality; 2025. pp. 1–36. https://doi.org/10.1080/13576275.2025.2509510.
7. Henry M, Alias A, Bisson-Gervais V, Liu JY, Dargis L, Gauthier L, et al. Medical assistance in dying in Canada: A scoping review on the concept of suffering. Psychooncology. 2023;32(9):1339–47. https://doi.org/10.1002/pon.6196.
8. Cherny NI, Fallon MT, Kaasa S, Portenoy RK, Currow DC. Oxford Textbook of Palliative Medicine. New York, NY: Oxford University Press; 2021.
9. Chochinov HM, Breitbart W, editors. Handbook of Psychiatry in Palliative Medicine. 2nd ed. New York, NY: Oxford University Press; 2012.
10. Hsu CC, Sanford BA. The Delphi Technique. Pract Assess Res Eval. 2007;12(10):1–8.
11. Hasson F, Keeney S, McKenna H. Research guidelines for the Delphi survey technique. J Adv Nurs. 2000;32(4):1008–15.
12. Keeney S, Hasson F, McKenna HP. The Delphi Technique in Nursing and Health Research. Blackwell; 2011.
13. Henry M, Lemaire J, Johnson T, Rouly J, Alias A et al. Medical assistance in dying in Canada: Report on a pan-canadian multidisciplinary planning and dissemination meeting to improve practice documents and plan a research agenda. Retrieved December 16, 2025 from https://www.recherchesoinspalliatifs.ca/wp-content/uploads/2024/03/MH24004-RM_AssDying_V6.pdf.
14. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psych. 2006;3(2):77–101.
15. Taylor RM, Feltbower RG, Aslam N, Raine R, Whelan JS, Gibson F. Modified international e-Delphi survey to define healthcare professional competencies for working with teenagers and young adults with cancer. BMJ Open. 2016;6(5). https://doi.org/10.1136/bmjopen-2016-011361.
16. Blaschke S-M, Lambert SD, Livingston PM, Aranda S, Boltong A, Schofield P, et al. Identifying priorities for cancer caregiver interventions: Protocol for a three-round modified Delphi Study. BMJ Open. 2019;9(2). https://doi.org/10.1136/bmjopen-2018-024725.
17. Vagias WM. Likert-Type Scale Response Anchors. Clemson International Institute for Tourism & Research Development, Department of Parks, Recreation and Tourism Management. Clemson University; 2006.
18. Diamond IR, Grant RC, Feldman BM et al. Defining consensus: a systematic review recommends methodologic criteria for reporting of Delphi studies. J Clin Epidemiol. 2014;67(4):401–9.
19. Jünger S, Payne SA, Brine J, Radbruch L, Brearley SG. Guidance on Conducting and Reporting Delphi Studies (CREDES). Palliat Med. 2017;31(8):684–706.
20. IBM Corp. IBM SPSS Statistics for Windows (Version 27.0) [Computer software]. IBM Corp; 2020.
21. Vanbutsele G, Van Belle S, Surmont V, De Laat M, Colman R, Eecloo K, et al. The effect of early and systematic integration of palliative care in oncology on quality of life and healthcare use near the end of life: A randomised controlled trial. Eur J Cancer. 2020;124:186–93.
22. Rodin G, Skelton M, Bhoo-Pathy N, Dewachi O, Li M, Trapani D, Smyth E, Banegas M, Salins N, Unger-Saldana K, Zimmerman C, Sullivan R. (2023). Establishing a Lancet Oncology Commission on the humanitarian crisis of cancer. Lancet Oncol. 2023;24(8):835–837.
23. Canadian Partnership Against Cancer, Canadian Association of Psychosocial Oncology. Pan-Canadian practice guideline: Screening, assessment, and management of psychosocial distress, depression, and anxiety in adults with cancer. 2015. Available from: https://www.capo.ca/resources/Documents/Guidelines/3APAN-~1.PDF.
24. Shen MJ, Wellman JD. Evidence of palliative care stigma: The role of negative stereotypes in preventing willingness to use palliative care. Palliat Support Care. 2019;17(4):374–80. https://doi.org/10.1017/S1478951518000834.
25. Fleary SA, Joseph PL, Gonçalves C, Somogie J, Angeles J. The relationship between health literacy and mental health attitudes and beliefs. Health Lit Res Pract. 2022;6(4):e270–9. https://doi.org/10.3928/24748307-20221018-01.
26. Oczkowski SJ, Crawshaw DE, Austin P, Versluis D, Kalles-Chan G, Kekewich M, et al. How can we improve the experiences of patients and families who request medical assistance in dying? A multi-centre qualitative study. BMC Palliat Care. 2021;20(1):88. https://doi.org/10.1186/s12904-021-00882-4.
27. Brown J, Goodridge D, Harrison A, Kemp J, Thorpe L, Weiler R. Medical assistance in dying: Patients', families', and health care providers' perspectives on access and care delivery. J Palliat Med. 2020;23(11):1468–77. https://doi.org/10.1089/jpm.2019.0509.
28. Pesut B, Thorne S, Sharp H, McKenzie M, Chambaere K, Lachmann M, Onwuteaka-Philipsen BD, Thorpe L, Verigin L, Virani A. Assessors' decision-making regarding applicant eligibility for Track 2 medical assistance in dying in Canada: a qualitative study. CMAJ. 2026;198(1):E1–9. https://doi.org/10.1503/cmaj.251071 . PMID: 41526056; PMCID: PMC12768541.
29. Monette EM. Cultural considerations in palliative care provision: A scoping review of Canadian literature. Palliat Med Rep. 2021;2(1):146–56. https://doi.org/10.1089/pmr.2020.0124.
30. Givler A, Bhatt H, Maani-Fogelman P. Culturally competent palliative care: Addressing diversity in end-of-life care. J Palliat Med. 2023;26(1):116–20.
31. Herranz-Rubia N. Cultural competence in palliative care. Eur J Palliat Care. 2007;14(3):119–22.
32. Betancourt JR, Green AR, Carrillo JE. Cultural competence in health care: Emerging frameworks and practical approaches. Commonwealth Fund; 2002.
33. Verdegem S, Rens A, Vandenberghe J, Dezutter J, Vanhie T, Bemelmans L, Vanhooren S. Relating to life and death a qualitative study of individuals with a long-lasting death wish related to unbearable psychiatric suffering. Int J Qual Stud Health Well-being. 2025;20(1):2469361. Epub 2025 Feb 26. PMID: 40009633; PMCID: PMC11866764.
34. Graham ID, Logan J, Harrison MB, et al. Lost in knowledge translation: time for a map? J Contin Educ Health Prof. 2006;26(1):13–24.
35. Damschroder LJ, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice: a consolidated framework (CFIR). Implement Sci. 2009;4:50.
36. Donohoe H, Stellefson M, Tennant B. Advantages and limitations of the e-Delphi technique. Am J Health Educ. 2012;43(1):38–46. https://doi.org/10.1080/19325037.2012.10599216.

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