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EXPERT REPORT FOR SOUTH AFRICA

Qualifications

Dr Ellen Wiebe

1. Dr Ellen Wiebe is a licensed physician practicing in Canada since 1976. She graduated from the University of British Columbia in 1975 and practiced as a general practitioner. Since 2016, she has assessed over 860 people for medical assistance in dying (MAID) and has provided MAID for over 480 people. She has published over 20 peer-reviewed research papers about MAID. She was a founding member of the Canadian Association of MAID Assessors and Providers (CAMAP) and was lead author of five guideline documents published on the CAMAP website. https://camapcanada.ca/. She is a member of the Clinical Advisory Committee for Dying with Dignity Canada.

Dr Stefanie Green

2. Dr Stefanie Green is a licensed physician practicing in Canada since 1995. She spent 10 years in general practice and another 12 years working exclusively in maternity and newborn care before changing her clinical focus in 2016 to medical assistance in dying (MAID). Dr. Green is the Founding President of the Canadian Association of MAID Assessors and Providers (CAMAP) and has worked in teaching, research, curriculum and guideline development. She is a medical advisor to the British Columbia Ministry of Health MAID oversight committee, moderator of CAMAP's national online community of practice, and has hosted several national conferences on the topic. She is clinical faculty at the University of British Columbia and the University of Victoria, and she is the author of the internationally bestselling book *This Is Assisted Dying- a doctor's story of empowering patients at the end of life*, which is currently available in 7 countries and 4 languages.

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Instruction

3. We have been instructed by Adams & Adams on behalf of DignitySA to address a few questions on the position of medical assistance in dying in Canada.

Questions and responses

"What is the legal and practical position with respect to assisted dying in Canada?"

4. Assisted dying became possible in Canada not through voter demand or government will, but through a constitutional court challenge based on the Canadian Charter of Rights and Freedoms (1). The Canadian Supreme Court unanimously determined, in 2015, that the previous blanket prohibition of assisted dying was unconstitutional. It determined that if a clinician provided an assisted death to a competent adult who was suffering intolerably from a grievous and irremediable condition, it would not be a criminal act. This decision was federally applicable, throughout all of Canada, and is considered a patient-centered, rights-based issue.

5. In response to this Court decision, the federal government legislated the details of how this care must be provided and includes rigorous eligibility criteria and robust safeguards (2)(3). Failing to follow these requirements carries significant criminal penalty.

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6. Although assisted dying legislation is federally applicable, health care is administered and delivered provincially/territorially in Canada, so variations do exist in how assisted dying is practically delivered in various jurisdictions (i.e., differing levels of support and care coordination, different forms and paperwork). Oversight of assisted dying is also provincially/territorially determined. Each province/territory also has its own professional standards of practice, determined by the licensing authority of the region, which clinicians must adhere to. Some provinces, but not all, also have provincial law regarding the implementation and practice of assisted dying. All of this has led to a lack of standardization across the country with respect to certain details, such as training requirements and oversight structure.

7. Regardless of these differing details, every request for assisted dying in Canada and every assisted dying procedure must be reported and monitored nationally. This data, along with more detail, is published in an annual report. (4)

"What are the safeguards and mechanisms in place to guard against abuse? Have these been successful?"

8. Assisted dying in Canada has a federally mandated process with required eligibility criteria and a number of procedural safeguards, which if not upheld, carries a criminal liability of up to 14 years in prison. Safeguards are robust and are as follows (3):

8.1. two independent medical or nurse practitioners must be of the opinion that the person meets the eligibility criteria

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8.2. the request for MAID must be signed and dated before an independent witness after the person has been told they have a grievous and irremediable medical condition

8.3. the person must give informed consent to receive MAID after having been informed of the means that are available to relieve their suffering, including palliative care

8.4. the person must be informed that they may, at any time and in any manner, withdraw their request for MAID

8.5. immediately prior to receiving MAID, the person is given an opportunity to withdraw their request, and the clinician ensures the person gives express consent to MAID at that time

8.6. if the person has difficulty communicating, all necessary measures must be taken to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision

9. If the person's natural death is not reasonably foreseeable, additional safeguards are also required to be satisfied, and they are as follows:

9.1. if neither of the two assessing clinicians has expertise in the condition causing the person's suffering, one of them must consult with a physician or nurse practitioner with that expertise and share the results of the consultation ;

9.2. the person must be informed about the means available to relieve their suffering (including, where appropriate, counselling services, mental health and disability support services, community services, and palliative care);

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9.3. the person must be offered consultations with relevant professionals who provide counselling services, mental health and disability support services, community services, and palliative care;

9.4. both clinicians must discuss with the person the reasonable and available means to relieve the person's suffering and agree that the person has given serious consideration to those means;

9.5. a minimum of 90 clear days pass between the day on which the first assessment of eligibility begins and the day MAID is provided. (An exception exists if the assessments have both been completed and both clinicians are of the opinion that loss of capacity is imminent, in which case any shorter period the provider considers appropriate is allowed).

10. In addition to these required safeguards, there exists federally mandated monitoring and reporting of every request for MAID and every procedure to help inform a publicly available annual report.

11. Regional oversight processes also exist, with some significant variation, but data to date suggest that over 90% of all cases have been individually reviewed (5). And regional licensing bodies/regulators produce and enforce professional standards of practice (6)(7). Public complaints are possible and have occurred. To date, in over fifty thousand MAID procedures, there has been no criminal charge of any clinician for abuse of practice.

12. Although not official, the Canadian Association of MAID Assessors and Providers, a national professional association that supports the diversity of professionals involved in delivering this care, promotes ongoing education (case-

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sharing, online symposia, national conferences, training workshops), guidance documents of the highest standards of practice, and a national community of practice (8). These clinician-led initiatives also promote a high level of care and diminish the likelihood of abuses and has been invaluable.

13. In summary, subject-matter experts have taken a lead on ongoing education and guidance of practice, regional licensing bodies have developed and enforce professional standards of practice, some provinces have written and passed enforced provincial legislation on various elements of practice, and the majority of MAID requests and procedures are overseen for veracity at a regional level. Every request and every procedure are mandated, by federal law, to be federally reported and monitored with resulting data publicly published and available for review and transparency.

"Has there been any evidence of abuse of medical assistance of dying to the detriment of vulnerable persons, with reference to the annual reports that have been published?"

14. The Annual Reports from Health Canada have not published any evidence of abuse by assisted dying providers. The provinces each handle oversight of assisted dying differently and these oversight bodies review cases to deal with both major infractions, such as a lack of meeting eligibility requirements, and minor infractions, such as incorrectly completed forms. The oversight authorities refer any serious infractions to the provincial licensing bodies (ex-College of Physicians and Surgeons) and/or law enforcement. The provincial licensing bodies publish reports of members who have had their licenses suspended or revoked due to unprofessional practice (9); there have been none struck off the register for their work in assisted dying. The criminal system is federal and there have been no trials of assisted dying practitioners.

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What has been the effect of the legalization of assisted dying on palliative care use and funding?

15. Since 2016, palliative care has arguably enjoyed the greatest increase in utilization in Canadian history with significant new investment in palliative care by our government. A few examples:

15.1. the federal government gave $3 billion to home care as part of the new health accords in 2016, which would have been a big boon to home-based palliative care (10);

15.2. in 2023 the federal government gave $2.1 billion to the Canadian Home Care Association (CHCA) to improve the quality of home-based palliative care (11);

15.3. Health Canada gave the Pan-Canadian Palliative Care Research Collaborative $2.5 million in 2023 for advancing research and building research capacity (12);

15.4. the Alberta government gave several million dollars in funding in 2020 to the Palliative Care Institute at Covenant Health to work on advance care planning (13);

15.5. there has been an unprecedented increase in palliative care staffing levels in most parts of the country, (i) in one Ottawa hospital, the palliative care division has more than doubled in size since 2018 (14) (ii) In Ontario, our largest province, the number of community hospice beds has essentially doubled since 2016 (15);

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15.6. overall, over the past 8 years in Canada, coincidental with the rise in MAID, the number of people receiving palliative care has increased, and the number of people dying at home with palliative care has also increased (16).

"Who accesses medical assistance in dying and what are reasons that patients seek medical assistance in dying? Can any correlations be drawn between requests for assisted dying and the demographics, socio- economic or education level of the person seeking assisted dying? If so, what is the correlation?"

16. The majority of the 15343 persons receiving MAID in 2023 had cancer (61.5%) reported as a main underlying condition, followed by cardiovascular, neurological and respiratory conditions (4). The most common source of suffering reported was loss of ability to engage in meaningful activities conditions, followed by loss of ability to perform activities of daily living and loss of dignity, with inadequate symptom control less common. Most people receiving MAID were over 65 years (86.2% of Track 1 and 76.5% of Track 2). The government does not require reporting about socio-economic or education levels, so we use data from various research studies. Several studies reported different rates of assisted dying from different jurisdictions and found that the highest rates were in areas with more wealthy, predominantly white, more highly educated populations.

17. Recently released reports from the Death Review Committee of the Office of the Ontario Coroner show that MAID recipients are in fact substantially less marginalized than people who die without MAID, and that those who die with MAID under track 2 (those whose death is not reasonably foreseeable) are no more marginalized than people who die naturally or with chronic illness. (18)(19)

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"What is your assessment of how assisted dying has been implemented in Canada? Please set out the noteworthy successes, failures and/or lessons learnt from medical assistance in dying in Canada that would be useful for South Africa to know as it embarks on this journey."

18. Canada took a bold but measured step in permitting assisted dying.

19. Since inception, there has been a steady annual increase in the number of people accessing and receiving this care (4). This is understandable and was fully expected as the public slowly became aware of the new law and new possibilities, as regional infrastructures to support referrals, assessments and procedures were developed and put into place, and as more clinicians became aware of and interested in and trained for getting involved. Our rising annual number of deaths attributed to assisted dying (4.1%) remains lower than in countries with comparable law (Netherlands- 5.5% of annual deaths).

20. Levels of public support for assisted dying have remained very strong: from the years prior to Canada's change in law to allow MAID (20), throughout the first 5 years after the law was implemented (21), and continuing every year since the law was amended in 2021 (22).

21. The mandating of federal reporting on every request and every procedure has allowed publication of a publicly available annual report on MAID. Ongoing debate exists about whether the data collected is sufficient for properly assessing the success or failure of the program. 6 years after beginning, new data began being collected to help better understand the personal and socioeconomic determinants of health of those receiving MAID (4).

22. Data has been reassuring that access to palliative care was available to 96% of all those who had an assisted death, and nearly 80% were receiving palliative care at

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the time of their assisted death (17). Coincidental to the implementation and rise of assisted dying, funding for palliative care research has grown (11)(12)(13), the number of people receiving palliative care in Canada has grown (16), the number of people receiving palliative care at home has grown (16), and there has been an increase in palliative care staffing levels.

23. The clinician-led advent of the Canadian Association of MAID Assessors and Providers (CAMAP) has played a pivotal role in providing support for the professionals engaged in this work, offering ongoing educational opportunities, encouraging the highest of clinical practice guidance, and creating a group of subject-matter experts who may consult locally, provincially or federally to inform stakeholders and governments on the work itself(8)- what is working, what is not, and what clinicians, patients and families are experiencing.

24. There is, in Canada, a variation in approach to care across the country. The variation in provincial governments, who are responsible for administration and delivery of health care, has seemed to lead to a variation in coordination of care efforts, levels of support for both clinicians and patients/families, training opportunities for clinicians, regional paperwork/administration requirements, and oversight processes. The development and launch of the Canadian MAID Curriculum (23) by CAMAP has helped standardize the clinical approach to assessment and delivery of MAID by clinicians across the country, but cannot address provincial variations in overall levels of support and coordination of program delivery.

25. There was a notable delay in developing sufficient regional supports for patients and families going through this process and to update and offer appropriate bereavement resources. Some of this has now been addressed by the arrival of at

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least 2 new national not-for profit societies (24)(25) along with the slower development of local resources.

26. A federally mandated review of MAID after 5 years (delayed but done) gave an opportunity for a large number of stakeholders to provide feedback to the government and a list of recommendations for moving forward (26). An earlier court-mandated amendment to federal law allowed the opportunity for government to seek consultations prior to the mandated review, and the need to adapt and alter some initial safeguards was heard and implemented.

"How is conscientious objection handled in Canada? In particular, may medical professionals conscientiously object to providing, or assisting in providing, medical assistance in dying and, if so, do they have any referral or other duties?"

27. Conscientious objection by a clinician is explicitly recognized and permitted by federal legislation- no one can be compelled to take part in administering or providing assisted dying (2). To date, it remains unclear if a brick-and-mortar facility can conscientiously object and abstain from providing this service.

28. Most provinces require that clinicians provide an "effective referral" (6)(7). That is defined as advising patients that other practitioners may be available to see them as well as a referral to an agency or clinician that can give the appropriate information and arrange for an assessment. For example, a clinician can refer to a MAID coordination service or to another clinician who does eligibility assessments.

"What are your views on the legal alternatives to assisted dying – conventional suicide, withdrawing or withholding of life-sustaining treatment or artificial feeding, voluntary starvation?"

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29. Suicide: Both the research studies we have done in Canada and our clinical experience with our patients show that 1) suicide is seen as uncertain and risky while assisted dying is certain, 2) suicide is often violent and impulsive while assisted dying is peaceful and planned, 3) suicide must be done alone to protect loved ones while assisted dying can be in the presence of loved ones, 4) suicide is shameful and hidden while assisted dying is acceptable to many (not all) loved ones, 5) with suicide, the police must be called, while with assisted dying, the funeral home can pick up the body directly. Many of our patients have contemplated or even unsuccessfully tried suicide and have rejected it.

30. In Canada, rates of suicide were slowly rising until 2015. Since then, and particularly as assisted dying numbers have climbed, suicide rates have fallen.

31. Withdrawing or withholding of life-sustaining treatment: These are part of some peoples' advanced directives and only for when they are unable to make decisions for themselves. A substitute decision maker makes those decisions. When a person can make their own decisions, they can refuse any treatment. For example, a person who is dependent on kidney dialysis, may stop dialysis and die slowly of kidney failure. The same person could stay on dialysis to prevent symptoms of kidney failure and then receive MAID at a time of their choosing when they still are well enough to say goodbye to their loved ones.

32. Voluntary stopping eating and drinking (VSED): depending on the condition of the person, 7-14 days of no liquids and no foods are required in order to die. Most people experience severe thirst in the first 5 days. The only way to do this comfortably is to be deeply sedated. Assisted dying is much faster and involves much less suffering.

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"In your opinion, should there be any difference between the assessment of capacity in the above circumstances and the assessment of capacity for purposes of medical assistance in dying?"

33. There are clear standards for doctors to assess a person's decision-making capacity, and there are clear elements that are required in order to provide an informed consent to *any* medical procedure. These are as follows:

33.1. They have an ability to understand relevant information including their diagnosis, prognosis and treatment options

33.2. They have an ability to appreciate the consequences of accepting or rejecting proposed treatments

33.3. In order to provide informed consent, the person must have the ability to communicate a choice and a rationale for this choice

"Is palliative care a true alternative to medical assistance in dying?"

34. There is a false narrative that better access to palliative care would prevent the need for assisted dying. But we know, in Canada, from both published annual national reports and published provisional data, that 96% of people receiving MAID have access to palliative care and 78% are receiving it at the time of their death (4).

35. We also know that cancer is by far the most common illness for those who access assisted dying. We know that, compared to those with other diagnoses, those with cancer will get better access to palliative care (in Ontario they are twice as likely), earlier access (median is 3 months before death vs 3 weeks before death), and likely of better quality (4 times as likely to receive palliative care at home). If you

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believe better access to palliative care would reduce the incidence of assisted dying, you expect a dramatically lower incidence of assisted dying in the group that is getting better palliative care. But in fact, you see exactly the opposite in the data. Higher numbers of people with cancer are asking for and receiving an assisted death than any other group.

36. You simply cannot conclude that assisted dying is being driven to any degree by lack of access to palliative care.

37. Palliative care, an approach to care which can be offered by most clinicians, can relieve symptoms, such as pain and vomiting, in about 95% of cases by using medication, palliative radiation, nerve blocks and other medical treatments. This leaves about 5% of patients requiring referral to specialized palliative care services due to ongoing symptoms and suffering. Other forms of suffering, such as existential suffering, can often be addressed by legacy work and dignity therapy but is generally not adequately treated. No approach can treat the increasing weakness that leaves people unable to do the things that gave their lives joy and meaning, and this is what leads many people to ask for an assisted death. Palliative sedation, sometime cited as an alternative to assisted dying, is an unregulated, un-monitored intervention usually decided upon by the medical team (as opposed to a competent adult, for themselves) and is not available to everyone who might wish it. In addition, many people do not like to imagine themselves unconscious for the last days or weeks of life and don't want their loved ones to witness this.

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"How can, or do, palliative care services and assisted dying work together in practice? How has this been done in Canada?"

38. At the beginning, there were only a few palliative care physicians, palliative care hospital units and hospices that worked in a collaborative manner with assisted dying clinicians. National organizations of palliative care practitioners insisted that there should be a clear separation. Over the years, this has improved, with more and more clinicians working together to give patients and their families a seamless transition of end-of-life care.

39. The number of palliative care physicians involved in MAID has steadily climbed since 2016: at last survey, 16% of the clinician members of the Canadian Association MAID Assessors and Providers are self-identified palliative care practitioners; in Ontario, almost 10% of all assisted dying cases are now performed by a palliative care practitioner. (unpublished data)

"Insofar as the three to five most "common" terminal illnesses that result in patients seeking medical assistance in dying are concerned, please describe, to the extent that it falls within your expertise."

40. Stage 4 cancer: Each person and each cancer are different, but by the time a cancer has metastasized widely, the person is usually considered to be terminally ill. Their symptoms usually include pain, nausea, weight loss and weakness. The pain and nausea can usually be controlled by medications (about 95% of the time). Nutrition can be supported with supplements, but they can expect to become weaker and weaker and eventually bedridden. They often find that life is no longer worth prolonging since they cannot do anything that used to give them meaning and joy.

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41. Motor Neuron Disease (Amyotrophic Lateral Sclerosis): This is a neurological disease with a 2–4-year prognosis after diagnosis. During that time, the person loses motor function until they can no longer care for themselves, no longer walk or talk or eat. Death usually occurs from sepsis once they are too weak to fight off infections. Painful muscle spasms can be treated, feeding tubes can be inserted to maintain nutrition, breathing can be supported with machines, electronic means of communicating can help, but people often feel that living in bed, dependent on machines, is not an acceptable quality of life.

42. End stage chronic obstructive pulmonary disease (COPD): This starts with chronic bronchitis until so much lung is damaged, that they cannot maintain oxygenation. They usually have painful coughing, are severely short of breath, (even on oxygen) and cannot do their normal activities. Oxygen and medications help, but low oxygen saturation and the medications to help with the cough, pain, and shortness of breath usually interfere with cognition. Commonly, people find the sensation of not getting enough oxygen to be terrifying, unless they are well-medicated.

"Do you consider there to be a conflict between your ethical and professional duties as a medical professional and providing medical assistance in dying? Please explain your answer."

43. We see no conflict.

44. As physicians, we help people diagnose problems. When possible, we help fight illness. If given the opportunity, we help prevent illness and promote wellness. And just as often, when there is nothing more to "do," we try to stay present, provide a listening ear, and answer questions as best we can. As the expression goes, we cure sometimes, we care often, and we comfort always. A clinician is meant to help people.

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45. The work that surrounds assisted dying fits well within these professional obligations. We hear people's stories, we act as a clinical resource, we explore and inform them of their options, and we aim to empower them to make their own best decisions. We strive to provide patient-centered care at the end-of-life, so that people have choices about their living and their dying. In our provisions, we aim to help their dying to be as comfortable as possible.

"To the extent that you are of the view that there is anything further which falls within your expertise that in your view ought to be addressed in your expert report, please do so."

46. The most therapeutic thing we do in this work is empower people with choice. We have witnessed countless patients transform with the knowledge of the possibility an assisted death. Once informed they are eligible, people stop focusing on the fear of how they will die and start focusing instead on how they wish to live the time they have remaining.

47. Legalized assisted dying not only reduces suffering at the end of life for those people who choose it. Even more people benefit by knowing it is available, if they should ever find that their suffering becomes unbearable.

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1. https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/14637/index.do
2. http://eoldev.law.dal.ca/wp-content/uploads/2016/07/Bill-C-14-Royal-Assent.pdf
3. https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent

4. https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#a3
5. Every case is reviewed in British Columbia, Ontario and Quebec, representing the majority of MAID performed in Canada. Only Quebec publishes an annual report https://csfv.gouv.qc.ca/en/publications
6. examples form British Columbia: https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf
7. and Ontario https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying
8. camapcanada.ca
9. example from, Ontario https://opsdt.ca/hearings/outcomes
10.
11. https://www.canada.ca/en/public-health/news/2023/09/government-of-canada-announces-more-than-21-million-to-improve-home-based-palliative-care.html
12. https://pcpcrc.ca/new-funding-to-a-pan-canadian-research-network-supports-quality-palliative-care-across-the-country/
13. https://www.alberta.ca/palliative-and-end-of-life-care-engagement
14. as per Division Head Dr James Downar (2024)
15. https://www.auditor.on.ca/en/content/annualreports/arreports/en14/308en14.pdf compared to https://news.ontario.ca/en/release/1005056/ontario-expanding-access-to-palliative-care
16. https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf (See appendix D on page 28)
17. https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html
18. https://arpacanada.ca/ontario-maid-death-review-committee-reports-2024/

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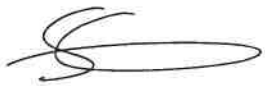
19. https://valuejudgments.substack.com/p/the-ontario-chief-coroners-reports
20. https://www.ipsos.com/en-ca/most-84-canadians-believe-doctor-should-be-able-assist-someone-who-terminally-ill-and-suffering
21. https://www.ipsos.com/en-ca/news-polls/Attitudes_Towards_MAID-2020-02-06
22. https://www.dyingwithdignity.ca/wp-content/uploads/2023/03/DWDCanada-Final-Report_June-30-2023.pdf
23. https://camapcanada.ca/curriculum/
24. bridgeC14.org
25. https://maidfamilysupport.ca/
26. https://www.parl.ca/DocumentViewer/en/44-1/AMAD/report-2/



Dr Stefanie Green

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14. https://www.ipsos.com/en-ca/most-84-canadians-believe-doctor-should-be-able-assist-someone-who-terminally-ill-and-suffering
15. https://www.ipsos.com/en-ca/news-polls/Attitudes_Towards_MAID-2020-02-06
16. https://www.dyingwithdignity.ca/wp-content/uploads/2023/03/DWDCanada-Final-Report_June-30-2023.pdf
17. https://camapcanada.ca/curriculum/
18. bridgeC14.org
19. https://maidfamilysupport.ca/
20. https://www.parl.ca/DocumentViewer/en/44-1/AMAD/report-2/

2026/03/19

Ellen Wiebe

DKI

UNIVERSITY OF BRITISH COLUMBIA

CURRICULUM VITAE

March 19, 2026

1. SURNAME: WIEBE FIRST NAME: Ellen MIDDLE NAME: Ruth

2. DEPARTMENT: Family practice

3. FACULTY: Medicine

4. PRESENT RANK: Clinical Professor SINCE: 2000

5. POST-SECONDARY EDUCATION:

University or Institution	Degree	Subject	Dates
Trinity Western	-	Science	1968-9
UBC	-	"	1969-71
"	MD	Medicine	1971-75
College of Physicians & Surgeons	BC licence	"	1976
College of Family Physicians	CCFP	"	1981
"	FCFP	"	1987

6. EMPLOYMENT RECORD

Self-employed in full-time family practice in Vancouver 1976 to 2006. Currently owner and medical director of Willow Women's Clinic and staff physician at Everywoman's Health Centre.

7. LEAVES OF ABSENCE

Maternity leaves: March - April 1975, December 1980 to January 1981, August to December 1986.

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8. TEACHING

Medical school undergraduates	- third and fourth year students in family practice electives in the office - third year students seminar "Care of sexual assault victims"
Residents in Family Practice and Gynaecology	- seminars on care of sexual assault victims and abortion care -- electives in the office
Continuing Medical Education	- giving lectures on "Sexual assault and abuse" in 42 hospitals around BC - lectures in the annual courses held by the Sexual Assault Service and the department of Family Practice at Women's Hospital. - lectures on medical abortion/spontaneous abortion/medical management of ectopic pregnancy for the Obstetrical and Gynecology Updates.

9. SCHOLARLY AND PROFESSIONAL ACTIVITIES

Grants:

Agency	Subject	COMP	$	Year	Principal Investigator	Co-Investigator
Vancouver Foundation	Back pain in pregnancy	yes	27,000	1989	James White	Ellen Wiebe
"	Pain control in abortion	"	38,000	1993	Ellen Wiebe	-
"	Drug induced abortion	"	43,000	1995	Ellen Wiebe	-
BC gov't	Sexual Assault	"	15,000	1993	Ellen Wiebe	-Susan Comay

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UBC	sexual assault, spontaneous abortions	"	summer student	1990 1998	Ellen Wiebe	-
College of Family Physicians	spontaneous abortions		$3000	1997	Ellen Wiebe	Patti Janssen
Department of family practice BCWH	spontaneous abortions		$3000	1997	Ellen Wiebe	Patti Janssen
Pfizer NAPCRG	spontaneous abortions		$10,000 (US)	1997	Ellen Wiebe	
MRC	mifepristone		$3000	1997	Ellen Wiebe	
Wyeth	depression in medical students		$13,000	1998	Ellen Wiebe	Jane Garland
Dept of Family Practice VGH	Fentanyl in abortion		$1600	1998	Mollie Rawling	Ellen Wiebe
Department of family practice BCWH	prevention of depression in adolescents		$3000	1999	Ellen Wiebe	Jane Garland
UBC	O/Cs in Chinese Canadians		$2700	2000	Ellen Wiebe	Jessica Chan
BC Gov't	Methotrexate vs mifepristone for abortion		$52,000	2000	Ellen Wiebe	Sheila Dunn, Edith Guilbert, Francis Jacot

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Population Council	Oral vs vaginal misoprostol + mifepristone for abortion		$80,000	2001	Ellen Wiebe	Sheila Dunn, Edith Guilbert, Francis Jacot, Lisa Lugtig
VGH Dept of Family Practice	Chinese Canadian women's perception of birth control		$2336	2001	Ellen Wiebe	Iris Fung
VGH Dept of Family Practice	prevention of depression in medical students		$2025	2001	Ellen Wiebe	
VGH Dept of Family Practice	anemia in early pregnancy		$2700	2002	Ellen Wiebe	Konia Trouton
University of Rochester	anxiety in abortion		$5000	2002	Ellen Wiebe	Konia Trouton
College of FP	CBT for FPs		$3000	2002	Ellen Wiebe	Michelle Greiver
North York General Hospital	CBT for FPs		$4540	2002	Ellen Wiebe	Michelle Greiver
IBIS (Boston)	buccal vs vaginal misoprostol		$5000	2002	Ellen Wiebe	Konia Trouton
VGH Dept of Family Practice	Attitudes to abortion in women presenting for abortion		$2300	2003	Ellen Wiebe	Konia Trouton

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Vancouver Foundation	Community based clinical investigator		$150,000	2004-2006	Ellen Wiebe	Konia Trouton
VGH Dept of Family Practice	Contraception in Korean women		$3000	2004	Ellen Wiebe	
IBIS reproductive health	Comparing methotrexate followed by misoprostol to misoprostol alone for early abortion		$18,000	2005	Ellen Wiebe	Konia Trouton
VGH Dept of Family Practice	ABORTION AND RELATIONSHIPS Experience with IUD use in women who have never had children		$6400	2005	Ellen Wiebe	
UBC Dean's Office	What women want from abortion services in Vancouver		$3750	2006	Ellen Wiebe	
ISAF	Quinicrine sterilization		$35,000	2006	Ellen Wiebe	
VGH Dept of Family Practice	Contraceptive failure		$2500	2007	Ellen Wiebe	
Vancouver Foundation	Community based clinical investigator		$75,000	2007-2010	Ellen Wiebe	

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VGH Dept of Family Practice	Sexual and mood side effects from hormonal contraceptives		$5000	2009	Ellen Wiebe	
Social Accountability and Community Engagement Initiative Award	Support for women in abortion clinics: Use and benefits of mobile cell phone use for emotional support by patients in abortion clinics		$1250	2010	Ellen Wiebe	Kelsey Kozoriz, Jasmine Lam
VGH Dept of Family Practice	BARRIERS TO ACCESS AND USE OF CONTRACEPTION IN IMMIGRANT WOMEN		$5000	2011	Ellen Wiebe	
Sue Harris Family Practice Research Grant	Chronic Pain: An exploration of female sex trade worker experiences around access to supports, management, and barriers to care		$2500	2012	Stephanie VandenBerg	Ellen Wiebe
FMWC MARF	feasibility trial to use dextrose cream for vulvodynia		$1300	2013	Ellen Wiebe	Helene Bertrand
VGH Dept of Family Practice	A pilot study to assess the feasibility of seeing family practice patients by Skype		$2000	2013	Ellen Wiebe	Rosanna Lima, Shannon Hill
Division of Family Practice (Doctor's Den)	A pilot study to assess the feasibility of seeing family practice patients by Skype		$2500	2013	Ellen Wiebe	

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College of Pharmacists of BC (CPBC)	Enhanced Training in Emergency Contraception for Oral Levonorgestrel and Copper IUDs Program Funding		$60,000	2014	Judith Soon	Ellen Wiebe, Konia Trouton
Sue Harris Family Practice Knowledge Dissemination Grant	Chronic Pain: An exploration of female sex trade worker experiences around access to supports, management, and barriers to care		$2500	2014	Stephanie VandenBerg	Ellen Wiebe
Dying with Dignity Canada	The Experience of Volunteer Witnesses for Medical Assistance in Dying (MAiD) Requests		$1000	2018	Ellen Wiebe	M Kelly ,Z Praslickova
Peter Wall Institute for Advanced Studies UBC	MAiD at the Edge			2018	Ellen Wiebe	Michaela Kelly
Dying with Dignity Canada	Forced transfers for Medical assistance in dying		$3000	2019	Ellen Wiebe	M Kelly, Brian Sum
SHRC	Prisons: end of life options			2019	Jessica Shaw	Ellen Wiebe
Peter Wall Institute for Advanced Studies UBC	Assessing Capacity for patients requesting MAiD		$2500	2020	Ellen Wiebe	Michaela Kelly

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Peter Wall Institute for Advanced Studies UBC	Oversight of MAiD		$2500	2020	Ellen Wiebe	Michaela Kelly

INVITED PRESENTATIONS

Leukemia Bone Marrow Transplant Education session "Assisted death" Nov 24/26

St Paul's Hospital CME Patient and Provider Experiences with Assisted death November 17, 2016
Dying with Dignity webinar November 1 20, 2016 "Sharing MAiD Cases"

Family Medicine Forum, Vancouver November 9-121, 2016 Sex and birth control: are they connected? Difficult IUD insertions.

MAiD Update for MHSU Physicians October 27, 2016 Surry

Provincial Health Services Authority Education session Sept 28, 2016 "Assessments for MAiD" and "Approach to Provision of MAiD"

Vancouver Department of Family Practice rounds VGH September 27, 2016 "Assisted Death"

The Society of Notaries Public of British Columbia Annual meeting Kelowna September 25, 2016 Medical Assistance in Dying

UBC Alzheimer Disease and Related Disorder Program September 23, 2016 "Assisted death"

Dying with Dignity webinar September 20, 2016 "Sharing MAiD Cases"

Dying with Dignity webinar August 23, 2016 "Sharing MAiD Cases"

UBC Department of Family Practice Scholarship Day Keynote June 14, 2016 "Controversial Family Practice research"

Dying with Dignity webinar June 8, 2016 "Pearls from Euthanasia 2016"

Dying with Dignity seminar Toronto May 28, 2016 "Assisted death"

Simon Fraser University City Conversations April 7, 2016 "Conversations about Assisted death"

Dying with Dignity webinar March 23, 2016 "Assisted death"

BC Pharmacy Association webinar March 10, 2016 "Assisted death"

Family Medicine Forum, Toronto Nov 11-14, 2015 Sex and birth control: are they connected, Telemedicine in family practice, unplanned pregnancy, Difficult IUD insertions.

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Department of Family Practice rounds VGH Sept 29, 2015, Medical Marijuana and Family Doctors

Family Medicine Forum, Quebec 2014 Sex and birth control: are they connected, Telemedicine in family practice, unplanned pregnancy, Difficult IUD insertions.

Forum on Family Planning Miami Oct 12, 2014. Searching Outside the USA for a Better Copper IUD: Products in Use and in Development.

FIAPAC Ljubljana Oct 3, 2014 Frequently asked questions in abortion care.

Department of Family Practice VGH May 6, 2014 Telemedicine for family doctors

CART meeting Vancouver May 5, 2014 Medical abortions: How to and what's next?

National Abortion Federation Annual Meeting San Francisco April 2014, Difficult cases in abortion care

National Abortion Federation Annual Meeting San Francisco, April 2014, Viewing ultrasound

Family Medicine Forum Vancouver 2013

Family Practice OB Update Difficult IUD insertions October 3, 2013.

National Abortion Federation Annual Meeting New York Apr 30, 2013 Difficult cases in abortion care

National Abortion Federation Annual Meeting New York Apr 29, 2013 Medical abortions by Skype

Canadian Abortion Providers Annual Meeting New York Apr 27, 2013 medical abortions at Willow Women's Clinic

Family Practice Forum Toronto Nov 2012"Difficult IUD insertions", "Sex and Birth Control: Are they connected?"

Western Canadian Sexual Health Conference May 2012 Vancouver The Connections Between Contraception and Sexual Pleasure

National Abortion Federation Annual Meeting Vancouver April 2012, Difficult cases in abortion care

Post Graduate Seminar Feb 2012 Vancouver Using methotrexate and misoprostol for early pregnancy in your office.

Annual Scientific Assembly, Alberta College of Family Physicians, Banff February 2012 Difficult IUD insertions, Sex and Birth Control: Are they connected?

Family Practice Forum Montreal Nov 2011"Difficult IUD insertions"

Forum of Family Planning Washington DC Oct 2011 "Sex and birth control: are they connected?"

National Abortion Federation Annual Meeting Chicago April 2011
"IUDs in Abortion clinics", "Difficult Cases" "Should we be offering follow-up phone-calls for women having abortions?" "BARRIERS TO ACCESS AND USE OF CONTRACEPTION IN IMMIGRANT WOMEN PRESENTING FOR ABORTION"

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Annual Women's Health Update Vancouver BC May 14, 2011,"IUD/endometrial biopsy Workshop"

FIAPAC October 2010 Seville Spain, "Verifying successful aspiration"

Family Practice Forum Oct 2010 Vancouver Difficult IUD insertions, Using Misoprostol for early pregnancy in your office, Sex, contraception and family planning: Are they related? Unplanned pregnancy counseling,

Dept of family practice and midwifery BCWH Jun 4, 2010 "Sex, Mood and the Pill"

C2E2 Mar 22, 2010 "Sex, Mood and the Pill"

Family Practice Forum "Difficult IUDs", "Medical abortion", "CIBC program " Calgary October 2009.

Vancouver General Hospital Family Practice Rounds March 24, 2009 – "Sex and mood and the 'pill"

FIAPAC Berlin October 2008 Contraceptive Failure related to estimated menstrual day of conception

National Abortion Federation Annual Meeting, Minneapolis, April 2008, Difficult cases.

3er symposium misoprostol y mifepristona en gineco-obstetricia "Methotrexate + misoprostol for first trimester abortion" Valencia Spain October, 2007.

National Abortion Federation Annual Meeting, Boston, April 2007, Difficult cases.

Canadian Abortion Providers meeting Boston April 2007 The effect of abortion on relationships

Women's Health Conference, Vancouver April 2007 IUD workshop

Pain Control in Abortion, FIAPAC Rome October 2006-10-6

National Abortion Federation Annual Meeting, San Francisco, April 2006, Difficult cases.

Canadian Abortion Providers meeting, Montreal, April 2006, Abortion in Moslem women, Contraception in Asian women.

Caring for Moslem women in abortion clinics January 2006 BC Women's Hospital

National Abortion Federation Annual Meeting, San Francisco, April 2006, Difficult cases.

Update for family physicians Vancouver Feb 2004 Medical abortions

Wellness Program Vancouver Feb 2004 Recognizing depression in colleagues.

8th Annual Update in Office Gynecology and Women's Health, Vancouver, May 2003, Skill building workshop: IUD insertion

National Abortion Federation Annual Meeting, Seattle, April 2003, Difficult cases.

7th Annual Update in Office Gynecology and Women's Health, Vancouver, May 2002, Update on Medical TAs.

SOGC, Banff, March 2000, Emergency Contraception. Medical management of spontaneous abortions.

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Obstetrics for Family Physicians, Vancouver, November 1998, "Medical treatment of spontaneous abortions".

National Abortion Federation Annual Meeting, Vancouver, May 1998, "Local anesthetics for abortion".

Gynecology for Family Physicians, Vancouver, May 1998, "Medical management of spontaneous abortions and ectopic pregnancies".

Vancouver General Hospital Family Practice Update "Medical management of spontaneous abortions. Vancouver March 1998.

Obstetrics for Family Physicians, Vancouver, November 1997, "Conservative management of spontaneous abortions and ectopic pregnancies".

Abortion Symposium, October 1997, medical abortions.

St Pauls Hospital, June 1997, Conservative management of Spontaneous abortions.
Obstetrics for Family Physicians, Vancouver, October 1996, "Conservative management of spontaneous abortions and ectopic pregnancies".

Obstetrics for Family Physicians, November 1995, Vancouver "Drug-induced abortions"

Women's College Hospital, October 1995, Toronto "Medically Induced Abortions"

Federation of Medical Women, October 1994 Careers Night

National Abortion Federation, September 1994, Philadelphia "Local anesthetics for abortion"

Kelowna General Hospital, June 1994 "Care of Sexual Assault Victims"

Psychiatric Update, April 1992, Vancouver "Physician Sexual Misconduct"

Obstetrics for family physicians, October 1990, Vancouver "Alternative Birth positions"

SCIENTIFIC PAPERS PRESENTED

Dying with Dignity Canada Meeting Nov 26, 2018. The experiences of volunteer witnesses for medical assistance in dying (MAiD)

Family Medicine Forum Toronto Nov 14, 2018 Assessments and Provisions of Medical Assistance in Dying in Canada in 2017, Perceptions and Experiences of End of Life Care and Medical Assistance in Dying within Marginalized Populations, Patient and doctor experiences of MAiD refusal
FIAPAC Nantes, France Sept 14, 2018 AntiD and Early Abortion

National Abortion Federation April 21, 2018 Seattle Telemedicine Abortions

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MAiD 2018 Research Forum Ottawa May 3, 2018 Patient and doctor experiences of MAiD Refusals, CAMAP Survey Data

Family Medicine Forum Montreal Nov 8, 2017 Reasons for Requesting Medical Assistance in Dying (MAiD) in Canada, Experiences with medical assistance in dying (MAiD): Patients' and loved ones' perspectives

Family Medicine Forum Vancouver, November 9, 2016. Experiences of family and friends of patients who requested an assisted death in Canada,(poster) Practice Perspectives: Providing Medical Assistance in Dying in British Columbia. (poster) A Qualitative Study Examining the Experiences of Patients Requesting Physician Assisted Dying in Canada (oral presentation)

Forum of Family Planning (FFP) Chicago November 2015 A pilot study of the one-year retention rate of the IUB (SCu380A), Using marijuana to cope with the pain and other symptoms of medical abortions and menstrual periods

Family Medicine Forum Toronto Nov 11, 2015, Women's experience using marijuana for the symptoms of menstrual periods

National Abortion Federation Baltimore April 20, 2015 (poster) Using natural methods to cope with the pain and other symptoms of medical abortions

Family Medicine Forum, Quebec, Nov 12, 2014 (posters) Barriers to Providing Copper IUDs for Emergency Contraception: A Qualitative Study of Community Pharmacists and Invisible men: The experience of men with abortion

FIAPAC Ljubljana Oct 3-4, 2014. Posters: Knowledge and attitudes about contraception and abortion in women of 5 countries: US, Canada, UK, France and Australia, The feasibility of offering medical abortions by telemedicine: two years experience." Oral presentation: A pilot study of the insertion and early expulsion rate of the Intrauterine Ball."

ESC Lisbon May 29-31. Posters Pain of IUD insertion: A comparison of different IUDs, IUD strings: A comparison of male partners' reactions to different IUDs,Insertion of frameless copper IUDs: A comparison of early expulsion rates of IUDs inserted immediately post-abortion or at unrelated times

National Abortion Federation Annual Meeting San Francisco, April 2014 Telemedicine abortion: 20 months experience.

FFP (Forum on Family Planning) October 6, 2013 Attitudes and knowledge about abortion and contraception in women from Canada, US, UK, France and Australia: An internet survey using Survey Monkey Audience (poster)

National Abortion Federation Annual Meeting New York Apr 29, 2013 Attitudes and knowledge about abortion and contraception in women from Canada, US, UK, France and Australia: An internet survey using Survey Monkey Audience (poster)

Family Medicine Forum Toronto Nov 6, 2012 "Misconceptions about abortions" Nov 7, 2012 "How can we best train primary care providers to insert IUDs?" (poster)

FFP (Forum on Family Planning) October 28, 2012, Denver, "How can we best train primary care

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providers to insert IUDs?" (poster) "Misconceptions about abortion risks in pro-choice and anti-choice women having abortions" (poster), "Viewing ultrasounds before first and second trimester abortions: Women's choices and perceptions" (poster)

FIAPAC October 19, 2012, Edinburgh, "Viewing ultrasounds before first and second trimester abortions: Women's choices and perceptions" (oral presentation) and "How can we best train primary care providers (PCPs) to insert IUDs?" (poster)

ESC (European Society for Contraception) June 2012 Athens "Can we safely avoid fasting before abortions with low dose procedural sedation?
A retrospective cohort chart review of anaesthesia-related complications in 47,748 abortions" and "How can we best train primary care providers (PCPs) to insert IUDs?" (posters)

National Abortion Federation Annual Meeting Vancouver April 2012. "Women's perceptions of viewing ultrasound before abortion: Comparing first and second trimester", "Can we safely avoid fasting before abortions with low-dose moderate sedation? A retrospective cohort chart review of anesthesia-related complications in 47,748 abortions".(poster).

Forum on Family Planning (FFP) Washington DC Oct 2011 "Who uses anal sex for birth control?" (poster) "Should we be offering follow-up phone calls for women having abortions?"(poster)

Society of Obstetricians and Gynaecologists of Canada Annual Meeting Vancouver May 2011 "Does using tampons or menstrual cups increase early IUD expulsion rates?" (poster)

Society of Obstetricians and Gynaecologists of Canada Annual Meeting Vancouver May 2011 Barriers to access and use of contraception in immigrant women presenting for abortion.(poster)

National Abortion Federation Annual Meeting Chicago April 2011 Environmental benefits of Manual Vacuum Aspiration.(poster) Support for women in abortion clinics: Use and benefits of mobile cell phone use for emotional support by patients in abortion clinics (poster)

FIAPAC (International Federation of Professional Abortion and Contraception Associates) Oct 2010 Seville, Spain Barriers to contraception: Comparing immigrant women to those born in Canada.(oral presentation) Sexual and mood side effects of hormonal contraception: Comparing different ethnic groups (poster)

ARHP (Association of Reproductive Health Professionals) September 2010 Atlanta Sex and Birth Control: Are they connected?

APCOC (Asian Pacific Congress on Contraception) June 2010 Beijing, Mood and sexual side effects from hormonal contraceptives: Comparing Caucasian and Asian women (poster) Asian and Caucasian women delaying motherhood by having abortions (poster)

ESC (European Society for Contraception) May 20, 2010 The Hague The Experience of Delaying Motherhood After Age 33 by Having an Abortion (poster), Sexual and mood side effects of hormonal contraception: What do the women tell us? (poster)

National Abortion Federation Philadelphia Apr 2010 The Experience of Delaying Motherhood After Age 33 by Having an Abortion (oral presentation), Mood and sexual side effects from hormonal contraceptives (poster)

Family Practice Forum October 2009 Calgary The Experience of Delaying Motherhood After Age 33 by Having an Abortion, Sex, Mood and the "Pill", Natural Family Planning:

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Physicians' knowledge, attitudes and practice related to Standard Days, Cervical Mucus, Basal Body Temperature and Lactational Amenorrhea Methods.
(3 posters)

National Abortion Federation. Portland April 2009 Using methotrexate with or without misoprostol to terminate pregnancies with no gestational sac visible by ultrasound.
(Poster)

Canadian Abortion Providers. The Experience of Delaying Motherhood After Age 33 by Having an Abortion (oral presentation). Portland April 2009.

APCOC Comparing continuation rates and side effects of hormonal contraceptives in East Asian and Caucasian women after abortion. (Poster) Macao December 2008

FIAPAC Women's perceptions viewing ultrasounds before and products of conception after abortion. Berlin, October 2008.

ARHP (Association of Reproductive Health Professionals) Contraceptive failure related to early ovulation.(poster) Washington DC, September 2008

ESC (European Society for Contraception) Contraceptive failure related to early ovulation. May 2008, Prague

National Abortion Federation Poster: Women's perceptions of viewing ultrasounds before and products of conception after an abortion. April Minneapolis 2008

Canadian Abortion Providers Access to Abortion: What women want from abortion services. Minneapolis April 2008.

National Abortion Federation Poster: Contraceptive failure related to early ovulation. April Boston 2007

FIAPAC Rome October 2006 Poster "Comparing side effects of hormonal contraceptives in East Asian and Caucasian women"

Association of Reproductive Health Professionals/Society of Family Planning La Jolla 2006 Poster "Comparing side effects of hormonal contraceptives in East Asian and Caucasian women"

National Abortion Federation 2006, San Francisco. Comparing methotrexate followed by misoprostol to misoprostol alone for early abortion, Poster: What is the best timing for IUD insertion after medical abortion?

College of Family Physicians of Canada Forum 2005 Vancouver, Poster: Intrauterine Contraceptive Device; a suitable option for nulliparous women.

North American Primary Care Research Group 2005 Quebec Barriers to contraception in teens presenting for abortion, Contraception in Chinese Canadians

National Abortion Federation 2005, Anti-choice attitudes in women having abortions, Poster: Intra-cervical vs intravenous fentanyl for abortion

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North American Primary Care Research Group, Banff, November 2003, Attitudes to abortion in women presenting for abortion

National Abortion Federation, Seattle, April 2003, Anxiety in abortion: comparing women having medical and surgical abortions, Comparing phone calls from patients having medical or surgical abortions, Comparing buccal to vaginal misoprostol in medical abortions.

North American Primary Care Research Group, New Orleans, November 2002, Depression in Medical Students

North American Primary Care Research Group, New Orleans, November 2002, The effect of lorazepam on pain and anxiety in abortion.

National Abortion Federation, San Jose, April 2002, Vaginal versus oral misoprostol used after mifepristone for early abortion.

North American Primary Care Research Group, Halifax, 2001, Comparison of abortions induced by methotrexate or mifepristone followed by misoprostol.

National Abortion Federation, Chicago, April 23, 2001, Comparison of abortions induced by methotrexate or mifepristone followed by misoprostol.

North American Primary Care Research Group, Florida, November 2000, Preventing depression in medical students.
North American Primary Care Research Group, Florida, November 2000, Universal screening for domestic violence in abortion.

National Abortion Federation, Pittsburgh, April 2000, Pain control in medical abortion.

National Abortion Federation, Pittsburgh, April 2000, Universal screening for domestic violence in abortion.

North American Primary Care Research Group, San Diego, November 1999, Time loss from work in women choosing medical or surgical abortions.

National Abortion Federation, Atlanta, April 1999, Time loss from work in women choosing medical or surgical abortions.

North American Primary Care Research Group, Montreal November 1998, "Reducing surgery in management of spontaneous abortions by family physicians"

National Abortion Federation, Vancouver May 1998, "Oral versus injected methotrexate for medical abortion".

North American Primary Care Research Group, November 1997, "Methotrexate plus misoprostol compared to methotrexate alone for medical abortion"

BC College of Family Physicians Annual meeting, November 1997, "Natural History of spontaneous abortion".

National Abortion Federation, Boston, May 1997, Vaginal misoprostol prior to first trimester abortion.

North American Primary Care Research Group, November 1996, ""Conservative management of

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spontaneous abortions"

National Abortion Federation, September 96, Scottsdale Arizona, "Complications of Medical Abortions".

BC College of Family Physicians Annual Scientific Assembly, November 1995, Vancouver "Conservative management of spontaneous abortions"

National Abortion Federation, April 1995, San Diego "Abortions induced with methotrexate and misoprostol, 100 cases"

National Abortion Federation, April 1994, Cincinnati "Pain control in abortion" and "Abortions induced with methotrexate and misoprostol, 20 cases"

BC College of Family Physicians Annual Scientific Assembly, November 1992, Vancouver "Comparing deep and superficial injections for abortion"

National Abortion Federation, April 1992, San Diego "Comparing deep and superficial injections for abortion"

10. SERVICE TO UNIVERSITY

Mentor to a group of medical students 1990 - 2009
Department of Family Practice Committee on Clinical Faculty Appointments 2002 - 2006

11. SERVICE TO COMMUNITY

Memberships and offices held:
Member, Board of Directors, PACE 1994- present
President, College of Family Physicians (B.C. Chapter) 1982-1983.
Member, Executive Committee CFPC I979-I985.
Chairman, Editorial Advisory Board of Medifacts, I983-I987.
Member, Editorial Advisory Board of Medifacts, I978-I987
Co-Director, Sexual Assault Service I988-1998.
Member, Sexual Assault Service I983 - 2002.
Active Staff, Vancouver Hospital, Active Staff, Children and Women's Hospital,
Member of BCMA 1976 – present
Member Committee physician sexual misconduct: BC College of Physicians and Surgeons 1992-3
Member, Committee on standards for abortion care: Canadian Abortion Providers 1995-6
Member, Vancouver City Special Advisory Committee on Disability Issues 1997 - 2002.
Member, Board of Directors, North American Primary Care Research Group 2000-2003
Member, National Abortion Federation, 1995-present
Member: Canadian Association of MAiD Assessors and Providers 2016-present

12. AWARDS AND DISTINCTIONS

Best Scientific Paper, National Abortion Federation 1993
Award of Excellence, BC College of Family Physicians 1994
Woman of Distinction, YWCA (Health, Science and Technology) 1995
Practice of Excellence Award for Practice Innovation, Family Practice 1995
Second prize, Best practitioners paper, NAPCRG, 1996

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Pfizer Investigator in Practice Award, North American Primary Care Research Group, 1997
Pfizer Research Scholarship Award, North American Primary Care Research Group, 1997
Roberts Reproductive Medicine Award, Federation of Medical Women, 1998.
Marion Powell Award, 2001.
Outstanding service award, North American Primary Care Research Group, 2003
Vancouver Foundation Community Based Clinical Investigator Award 2004
Vancouver Medical Association Primus Inter Pares 2005
Vancouver Foundation Community Based Clinical Investigator Award 2007
Bayer Schering Pharma Talents Encouragement Award 2008
Best Poster Award, ESC (European Society for Contraception) Athens June 2012
The Queen's Diamond Jubilee Medal January 17, 2013
Best poster Award, NAF, SanFrancisco April 2014.
Enid Johnston Award Federation of Medical Women Hamilton September 24, 2016
Dangerous Ideas First Place Family Medicine Forum November 10, 2016.

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UNIVERSITY OF BRITISH COLUMBIA
PUBLICATION RECORD

SURNAME: WIEBE FIRST NAME: Ellen MIDDLE NAME: Ruth

REFEREED PUBLICATIONS

1. Wiebe, ER. Retention of Products of Conception After Therapeutic Abortion. Can Med Assoc J I986;134:505

2. Wiebe ER. New benefit of beta-blockers? Can Med Assoc J 1989;139:198.

3. Herbert CP, Wiebe ER. That notwithstanding clause again. Can Med Assoc J 1989;141:97-8.

4. Wiebe, ER. Post-partum Misery: A family physician's perspective. Can. Fam. Phys. 1990;36:1285-1287

5. Wiebe ER, Elwood E. Tuberculosis of the ribs: A report of three cases. Resp Med 1991;85(3):251-3

6. Wiebe ER. Genital injuries in sexual assault victims. Can Med Assoc J. 1991;144(6)644,647

7. Wiebe ER. Comparison of the efficacy of different local anesthetics and techniques of local anesthesia in therapeutic abortions. Am J Obstet Gynecol I992;167:131-4

8. Wiebe ER, Wiebe A. Fragile X Syndrome. Can. Fam. Phys. 1994;40:290-295

9. Wiebe ER, Rawling M. Pain Control in abortion. Int J Gynec Obstet. 1995;50:41-46

10. Wiebe ER. Abortions induced with methotrexate and misoprostol. Can Med Assoc J. 1996;154(2):165-70

11. Wiebe ER, Rawling M, Janssen P. Comparison of the effectiveness of 0.5% and 1% lidocaine for first trimester abortions. Int J Gynecol Obstet.1996;55:71-2.

12. Wiebe ER. N of 1 trials: Managing patients with chronic fatigue syndrome: two case reports. Can Fam Phys 1996;42:2214-7.

13. Wiebe ER. Choosing between surgical abortions and medical abortions induced with methotrexate and misoprostol. Contraception 1997;55:67-71.

14. Wiebe ER. Abortion induced with methotrexate and misoprostol: A comparison of various protocols. Contraception;1997;55:159-63.

15 Wiebe ER, Janssen PJ. Management of spontaneous abortions in family practices and hospitals. Fam Med 1998;30:293-6.

16. Wiebe ER, Rawling M. Vaginal misoprostol to prepare the cervix before first trimester abortion. Int J Gynecol Obstet 1998;60:175-6.

17 Rawling M, Wiebe ER. Pain control in abortion clinics. Int J Gynecol Obstet 1998;60:293-5.

18. Wiebe ER. Comparing abortion induced with methotrexate and misoprostol to methotrexate alone. Contraception 1999;59:7-10.

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19. Creinin M, Wiebe E, Gold M. Methotrexate and misoprostol for early abortion in adolescent women. J Ped Adolesc Gynecol 1999;12:71-7.

20. McGregor MJ, Le G, Marion SA, Wiebe ER. Examination for sexual assault: Is the presence of documented physical injury associated with charge laying? CMAJ 1999;160:1565-9.

21. Wiebe ER. Oral methotrexate compared to injected methotrexate when used with misoprostol for abortion. Am J Obstet Gynecol 1999;181:149-52.

22. Wiebe ER, Janssen PJ. Reducing surgery in management of spontaneous abortion by family doctors. Can Fam Phys 1999;45:2364-9.

23. Wiebe ER. Tamoxifen compared to methotrexate when used with misoprostol for abortion. Contraception 1999;59:265-70.

24. Wiebe ER, Janssen PJ. Women's experiences with conservative management of spontaneous abortions. Can Fam Phys 1999;45:2355-60.

25. McGregor MJ, Wiebe ER, Marion SA, Livingstone C. Why don't women report sexual assault to police?: 5 years of data from the Vancouver Sexual Assault Service. Can Med Assoc J 2000;162:659-60.

26. Wiebe ER, Janssen P, Hales S. Time lost from work in women choosing medical or surgical abortions. J Am Med Women's Assoc 2000;55:202.

27. Wiebe ER, Comay S, McGregor MJ, Ducceschi S. Offering HIV prophylaxis to sexual assault victims - sixteen months experience in a sexual assault service. Can Med Assoc J 2000;162:641-5.

28. Wiebe ER. A randomized trial of aromatherapy to reduce anxiety before abortion. Effect Clin Pract 2000;4:166-9.

29. Wiebe ER, Switzer P. Arteriovenous malformations of the uterus associated with medical abortion. Int J Gynecol Obstet 2000;71:155-8.

30. Wiebe ER, Janssen PJ. Time lost from work among women choosing medical or surgical abortions. Women's Health Issues 2000;10:327-32.

31. Rawling MJ, Wiebe ER. Randomized controlled trial of fentanyl for abortion pain. Am J Obstet Gynecol 2001;185:103-7.

32. Wiebe ER. Misoprostol administration in medical abortion. A comparison of three regimens. J. Reprod Med 2001;46(2):125-9.

33. Wiebe ER, Janssen PJ. Universal screening for domestic violence in abortion. Women's Health Issues 2001;11:436-41.

34. Trussell J, Wiebe E, Shochet T, Guilbert E. Cost savings from emergency contraceptive pills in Canada. Obstet Gynecol 2001;97:

35. Wiebe ER. Pain control in medical abortion. Int J Gynecol Obstet 2001;74:275-80.

36. Wiebe ER, Dunn S, Guilbert E, Jacot F, Lugtig L, Winikoff B, Shannon C. Comparison of abortions induced by methotrexate or mifepristone followed by misoprostol. Obstet Gynecol 2002;99:813-819.

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37. Wiebe ER, Sent L, Fong S, Chan J. Barriers to use of oral contraceptives in ethnic Chinese women presenting for abortion. Contraception 2002;65:159-63.

38. Wiebe ER, Podhradsky L, Dijak V. The effect of lorazepam on pain and anxiety in abortion. Contraception 2003;67:219-21.

39. Wiebe E, Guilbert E, Jacot F, Shannon C, Winikoff B. A fatal case of Clostridium sordellii septic shock syndrome associated with medical abortion. Obstet Gynecol 2004;
104:1142-4.

40 Wiebe E, Trouton K. Comparing vaginal and buccal misoprostol when used after methotrexate for early abortion. Contraception 2004;70:463-66.

41. Wiebe ER, Janssen PA, Henderson A, Fung I. Ethnic Chinese women's perceptions about condoms, withdrawal and rhythm methods of birth control. Contraception 2004;69:493-6.

42. Wiebe ER, Trouton KJ, Fielding SL, Grant H, Henderson A. Anxieties and attitudes to abortion in women presenting for medical and surgical abortions. J Obstet Gynecol Can 2004;26:881-5.

43. Wiebe ER, Trouton KJ, Fielding SL, Klippenstein J, Henderson A. Anti-choice attitudes to abortion in women presenting for medical abortions. J Obstet Gynecol Can 2005;27:59-63.

44. Wiebe ER, Greiver M. Family Physicians' experiences with implementing Cognitive Behavioural Therapy in their practice: a qualitative study. Can Fam Phys 2005;51:992-3.

45.Wiebe E, Fowler D, Trouton K, Fu N Comparing patients' phone calls after medical and surgical abortions. Contraception 2006;73:271-3.

46. Wiebe ER, Trouton KJ, Savoy E. Intra-cervical vs intravenous fentanyl for abortion Hum Reprod 2005;20:2025-8.

47. Shannon C, Wiebe E, Jacot F, Guilbert E, Dunn S, Sheldon WJ, Winikoff B Regimens of Misoprostol with Mifepristone for Early Medical Abortion: a Randomized Trial. Brit J Obstet Gynecol 2006;113:621-8.

48. Wiebe ER, Henderson A, Choi J, Trouton K. Ethnic Korean women's perceptions about birth control. Contraception 2006;73:623-7.

49. Wiebe ER, Trouton KJ, Eftekhari A. Anemia in early pregnancy among Canadian women presenting for abortion. Int J Gynecol Obstet 2006;94:60-1.

50 Wiebe ER, Trouton K, Lima R. Comparing methotrexate followed by misoprostol to misoprostol alone for early abortion. Int J Gynecol Obstet 2006;95:286-7.

51. Moreno-Ruiz NL, Borgatta L, Yanow S, Kapp N, Wiebe ER, Winikoff B. Alternatives to mifepristone for early medical abortion. Int J Gynaecol Obstet. 2007;96:212-8

52. Wiebe E. A 15 year old Chinese IUD J Obstet Gynaecol Can. 2007;29:615-6.

53. Wiebe ER, Hempstock W. Comparison of four regimens of misoprostol after methotrexate for early

IDKI

abortion. Int J Gynaecol Obstet. 2008;101:192-3.

54. Wiebe ER, Sandhu S. Access to abortion: what women want from abortion services J Obstet Gynaecol Can 2008;30:327-31.

55. Wiebe ER, Trouton K, Fang ZA. Comparing continuation rates and side effects of hormonal contraceptives in East Asian and Caucasian women after abortion. Contraception. 2008;78:405-08.
56. Wiebe ER Trussel J. Contraceptive failure related to estimated cycle day of conception relative to the start of the last bleeding episode. Contraception 2009;79:178-81.

57.Wiebe ER, Adams L. Women's experience of viewing the products of conception after an abortion. Contraception 2009;80:575-7.

58. Wiebe ER, Adams L. Women's perceptions about seeing the ultrasound picture before an abortion. Euro J Contracept Reprod Health Care 2009;14(2):97-102.

59. Wiebe ER Using methotrexate with or without misoprostol to terminate pregnancies with no gestational sac visible by ultrasound. Int J Gynecol Obstet 2009;107:64-5.

60. Wiebe ER, Trouton KJ, Dicus J. Motivation and experience of nulliparous women using IUDs (Intrauterine Contraceptive Devices) J Obstet Gynaecol Can.2010;32:335-8.

61. Choi J, Chan S, Wiebe ER. Natural family planning: Physicians' knowledge, attitudes and practice related to four evidence-based Natural Family Planning methods: Standard Days, Cervical Mucus, Basal Body Temperature, and Lactational Amenorrhea Methods. 2010 J Obstet GynaecolCan;32:673–678

62. Wiebe Ellen R, Najafi Roya, Sohail Naghma, Kamani Alya. Muslim women having abortions in Canada: Attitudes, beliefs and experiences. (2011) Can Fam Phys 57:e134-e138.

63. Wiebe ER, Trouton KJ "Does using tampons or menstrual cups increase early IUD expulsion rates?" J Obstet Gynaecol Can 2011;33:S44

64. Wiebe E Barriers to access and use of contraception in immigrant women presenting for abortion J Obstet Gynaecol Can 2011;33:S45

65. Wiebe E, Hamidizadeh R. Should we be offering follow-up phone-calls for women having abortions? Contraception 2011;84(3):309.

66. Wiebe ER, Byzcko B, Johnson M. Benefits of manual vacuum aspiration for abortion 2011 Int J Gynecol Obstet;114:155-6

67. Wiebe ER, Kaczorowski J, MacKay J. Why are response rates in surveys of clinicians declining? Can Fam Phys 2012 vol. 58 no. 4 e225-e228

68. Wiebe ER. Who uses anal sex for birth control?? Int J Gynaecol Obstet. 2012 May;117(2):185-6.

69. Wiebe ER. (Invited commentary) Adolescent girls undergoing medical abortion have lower risk of haemorrhage, incomplete evacuation or surgical evacuation than women above 18 years old. Evid Based Med. 2012 Feb;17(1):30-1.

70. Wiebe ER, Brotto L, MacKay J. Characteristics of women who complain of mood and sexual side effects from hormonal contraception J Obstet Gynaecol Can 2011:33;1234-40

PFI

71. Wiebe ER, Trouton KJ. Does using tampons or menstrual cups increase early IUD expulsion rates? Contraception. 2012 Aug;86(2):119-21

72. Wiebe ER, Kaczorowski J, MacKay J. Mood and sexual side effects of hormonal contraception: Physicians' and residents' knowledge, attitudes, and practices. Can Fam Phys 2012;58:e677-83.

73. Wiebe ER, Yager H, Chalmers A. Delayed motherhood: Understanding the experiences of women over age 33 who are having abortions, but plan to become mothers later. Can Fam Phys 2012 58: e588-e595

74. Wiebe ER, Kaczorowski J, Byczko B. Can we safely avoid pre-procedure fasting for abortions with low-dose moderate sedation? A retrospective cohort chart review of anesthesia-related complications in 47,748 abortions. Contraception 2013;87:51-54.

75. Wiebe ER. Contraceptive practices and attitudes in immigrant and non-immigrant women in Canada. Can Fam Phys 2013;59(10):e451-5.

76. Wiebe E, Littman L. Misconceptions about abortion risks in pro-choice and anti-choice women having abortions. Contraception 2012;86:303.

77. Wiebe E, Yousefi R, Ramji F, Isbister A, Trouton K. How can we best train primary care providers to insert IUDs? Contraception 2012;86:321-2.

78. Wiebe E, Trouton K. Women's perceptions of viewing ultrasound before abortion: comparing first and second trimester. Contraception 2012;86:321.

79. Wiebe ER. Broken IUD. J Obstet Gynaecol Can. 2012 Dec;34(12):1121.

80. Wiebe ER. *Invited Commentary:* How can we reconcile the findings of this study "Hormonal contraception use is associated with reduced depressive symptoms: A national study of sexually active women in the US" with the experience of our patients in clinical practice? American Journal Of Epidemiology 2013 doi: 10.1093/aje/kwt186.

81. Wiebe ER. Use of telemedicine for providing medical abortions. Int J Gynaecol Obstet 2013;07:038

82. Wiebe ER, Littman L, Kaczorowski J, Moshier E. Misperceptions about the risks of abortion in women presenting for abortions: Comparing women who believe abortions should be restricted to women who do not. J Obstet Gynaecol Can 2014, 36, 3, 223-230.

83. Wiebe ER. Pain of IUD insertion: A comparison of different IUDs. Euro J Contracept Reprod Health Care, 2014; 19 Supplement 1: S92–S239

84. Wiebe ER IUD strings: A comparison of male partners' reactions to different IUDs. Euro J Contracept Reprod Health Care, 2014; 19 Supplement 1: S92–S239

85. Wiebe ER Post-abortion insertion of frameless copper IUDs: A comparison of early expulsion rates of IUDs inserted immediately post-abortion or at unrelated times
Euro J Contracept Reprod Health Care, 2014; 19 Supplement 1: S92–S239

86. Wiebe ER, A comparison of the insertion pain associated with three different types of intrauterine device, Int J Gynecol Obstet (2014), http://dx.doi.org/10.1016/j.ijgo.2014.11.004

PKI

87. Wiebe ER, A comparison of male partners' reactions to different intrauterine device strings, Int J Gynecol Obstet (2014),http://dx.doi.org/10.1016/j.ijgo.2014.09.020

88. Wiebe E. The feasibility of offering medical abortions by telemedicine: 20 months of experience. Contraception 2014;90:s300.

89. Wiebe E. A comparison of early complication rates in three IUDs — LNG-IUS, copper T and frameless copper Contraception 2014;90:s312.

90. Wiebe E. Serosal-anchor measurements immediately and 6–8 weeks postinsertion of frameless copper intrauterine devices: are these related to early complications? Contraception 2014;90:s312.

91. Raymond E, Grossman D, Wiebe ER, Winikoff B. Reaching Women Where They Are: Eliminating The Initial In-Person Medical Abortion Visit. Contraception 2015;92(3)190-3.

92 Costescu D, Guilbert E, Bernardin J, Black A, Dunn S, Fitzsimmons B, et al. Medical Abortion. J Obstet Gynaecol Can. 2016 Apr;38(4):366-89.

93. Wiebe ER, Littman L, Kaczorowski J (2015) Knowledge and Attitudes about Contraception and Abortion in Canada, US, UK, France and Australia. Gynecol Obstet (Sunnyvale) 5: 322. doi:10.4172/2161-0932.1000322

94. Allen C, Murphy A, Kiselbach S, VandenBerg S, Wiebe E. Exploring the experience of chronic pain among female Survival Sex Workers: a qualitative study. BMC Fam Pract. 2015 Dec 21;16(1):182,015-0395-6.

95. Wiebe E, Trussell J. Discontinuation rates and acceptability during 1 year of using the intrauterine ball (the SCu380A). Contraception. 2016 Apr;93(4):364-6.

96. Shaw J, Wiebe ER, Nuhn A, Holmes S, Kelly M, Just A. Providing Medical Assistance in Dying: Practice Perspectives. Can Fam Phys 2018;64(9)e394-9.

97. Holmes S, Nuhn A, Kelly M, Shaw J, Just A, Wiebe ER. A Qualitative Study Exploring the Journey of Supporting a Loved One through a Medically-Assisted Death in Canada Can Fam Phys 2018;64(9)e387-93.

98. Nuhn A, Holmes S, Kelly M, Just A, Shaw J, Wiebe ER. Experiences and perspectives of people who pursued Medical Assistance in Dying (MAiD) in Vancouver, Canada Can Fam Phys 2018;64(9)e380-6.

99. Wiebe ER, Shaw J, Green S, Trouton K, Kelly M. Reasons for Requesting Medical Assistance in Dying (MAiD) Can Fam Phys 2018;64(9)674-9.

100. Wiebe ER, Byczko B, Jafari S, Zelmer J. Women's experiences using natural methods to cope with the pain and other symptoms of medical abortions. JReprodMed 2018 63(2):137-140

101. Wiebe E, Green S, Schiff B. Teaching residents about medical assistance in dying. Can Fam Physician. 2018 Apr;64(4):315-6.

102. Ellen R. Wiebe, Mackenzie Campbell, Abigail R.A. Aiken, Arianne Albert, Can we safely stop testing for Rh status and immunizing Rh-negative women having early abortions? A comparison of Rh alloimmunization in Canada and the Netherlands, Contraception: X, Volume 1, 2019, 100001, ISSN 2590-1516, https://doi.org/10.1016/j.conx.2018.100001.

103. Wiebe E, Shaw J, Wright A, Kelly M. Suicide vs Medical Assistance in Dying (MAiD): a secondary qualitative analysis. Death Studies 2019 doi: 10.1080/07481187.2019.1614110. [Epub ahead of print]

104. Shaw, J., Harper, L., Preston, E., Wright, A., Kelly, M., & Wiebe, E. (2019). Perceptions and Experiences of Medical Assistance in Dying Among Illicit Substance Users and People Living in Poverty. OMEGA - Journal of Death and Dying. https://doi.org/10.1177/0030222819889827

105. Dion S, Wiebe E, Kelly M. Quality of care with telemedicine for medical assistance in dying eligibility assessments: a mixed-methods study. doi: 10.9778/cmajo.20190111 cmajo December 13, 2019 vol. 7 no. 4 E721-E729

106. Praslickova Z, Kelly M, Wiebe E. The Experience of Volunteer Witnesses for Medical Assistance in Dying (MAiD) Requests Death Studies 2020, DOI: 10.1080/07481187.2020.1716884

107. Wiebe E, Ramasamy H, Campbell M, Kelly M. Comparing telemedicine to in-clinic medication abortions induced with mifepristone and misoprostol. 2020 ContraceptionX https://doi.org/10.1016/j.conx.2020.100023

108 McMorrow T, Wiebe E, Liyanage R, Tremblay-Huet S, Kelly M, Interpreting Eligibility Under the Medical Assistance in Dying Law: The Experiences of Physicians and Nurse Practitioners McGill J Law Health 2020 (2020) 14:1 McGill JL & Health 51.

109. Wiebe ER, Green S, Wiebe K. Medical assistance in dying (MAiD) in Canada: practical aspects for healthcare teams. July 2020 Annals of Palliative Medicine 9(6):38-38. DOI: 10.21037/apm-19-631

110. Sabrina Tremblay-Huet, Thomas McMorrow, Ellen Wiebe, Michaela Kelly, Mirna Hennawy, Brian Sum, The impact of the COVID-19 pandemic on medical assistance in dying in Canada and the relationship of public health laws to private understandings of the legal order, Journal of Law and the Biosciences, Volume 7, Issue 1, January-June 2020, lsaa087, https://doi.org/10.1093/jlb/lsaa087

111. Kelly M, Hodgson S, Wiebe E. An inside perspective of the opioid overdose crisis in Vancouver: A secondary qualitative study. Can J Addict (in press)

112. Wiebe E, Kelly M, McMorrow T, Tremblay-Huet S, Hennawy M. Assessment of capacity to give informed consent for Medical Assistance in Dying (MAiD): A qualitative study of clinicians' experience. CMAJO 2021(in press)

113. Wiebe E, Sum B, Kelly M, Hennawy M. Forced and chosen transfers for medical assistance in dying (MAiD) before and during the COVID 19 pandemic: a mixed methods study. Death Studies 2021 (in press)

114. Byram, A. C., Wiebe, E. R., Tremblay-Huet, S. & Reiner, P. B. Advance Requests for MAiD in Dementia: Policy Implications from Survey of Canadian Public and MAiD Practitioners. Canadian Health Policy Journal (2021).

115. Wiebe E, Kelly M, Lalonde K. Oversight of Medical Assistance in Dying (MAiD) in Canada: A Mixed-Methods Report of What We Have and What We Should Have Canadian Health Policy, August 2021. ISSN 2562-9492

DKT

116. Wiebe E, Kelly M. Community characteristics and MAiD uptake in Ontario: an ecological study Canadian Health Policy, August 2021. ISSN 2562-9492

117. Stukalin I, Olaiya OR, Naik V, Wiebe E, Kekewich M et al. Medications and Doses used in Medical Assistance in Dying (MAiD): A Retrospective Cohort Study" 2021 Can Med Assos J Open 0268.R2

118. Ellen R. Wiebe, Michaela Kelly, Laura Spiegel, Jean-Frederic Menard, Emily Hawse & Rebecca Dickinson (2022) Are unmet needs driving requests for Medical Assistance in Dying (MAiD)? A qualitative study of Canadian MAiD providers, Death Studies, DOI: 10.1080/07481187.2022.2042754

119. Gerson SM, Gamondi C, Wiebe E, Deliens L. Should Palliative Care Teams be Involved in Medical Assisted Dying? J Pain Symptom Manage. 2023 Aug;66(2):e233-e237. doi: 10.1016/j.jpainsymman.2023.04.004. Epub 2023 Apr 16. PMID: 37072103.

120. Cheng AL. Self-Treatment of Chronic Low Back Pain Based on a Rapid and Objective Sacroiliac Asymmetry Test: A Pilot Study. Cureus. 2021 Nov 11;13(11):e19483. doi: 10.7759/cureus.19483. PMID: 34912624; PMCID: PMC8665897.

NON-REFEREED PUBLICATIONS

1. Wiebe ER. Pelvic arthropathy during pregnancy no cakewalk. Medical Post 1989 May 16

2. Wiebe ER, Immega G. Birth positions: Science or culture? Can J Ob\Gyn & Women's Health Care 1991;3:4:190-192

3. Wiebe ER. Ice and Exercise. Recovery 1992 Vol 31

4. Wiebe ER. Go north, middleaged doctor. BCMJ 1995;27:729-30

5. Wiebe ER, Cook D. Feasibility of HIV testing of vaginal secretions in victims of sexual assault. Soc Obstet Gynec Can J May 1996.

6. Wiebe ER, Barber L. Medical management of spontaneous abortions. CME May 1999.

7. Wiebe ER. Management of pregnancy induced nausea. Can Fam Phys 1999;45:303.

TEXTBOOK CHAPTERS

1. "Local Anesthetics" A Clinician's Guide to Abortion, Churchill Livingstone, 1998.

2. Oxford Textbook of Primary Medical Care 2004: "Unwanted pregnancy and termination of pregnancy." Volume 2: 8.12
3. Abortion Care: "Pain control" Wisepress 2014
4. Abortion Care: "Telemedicine" Wisepress 2014

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PROFESSIONAL EXPERIENCE

2016- present	**Practitioner** of medically assisted deaths, British Columbia **Founding President and co-founder** of the Canadian Association of MAiD assessors and providers (CAMAP) CamapCanada.com **International Speaker** on the topic of medical assistance in dying (MAiD)- to both the public and within the health care and academic community. Interviewed on radio, television, documentary film, online and in print, local, provincial, national and international media **Clinical Faculty,** University of British Columbia and University of Victoria
2021-present	**Co-Lead of the Canadian MAiD Curriculum Project-** a multi-year, federally funded, nationally accredited, bilingual MAiD training program for Canada. **Clinician Advisor** to project 2024-present
2019- present	**Medical Advisor,** Province of British Columbia MAiD Oversight Committee
2020, 21, 22, 24	**Expert Witness,** testified before Canadian House of Commons and Senate judiciary committees on subject of MAiD to inform proposed legislative changes **Expert Witness,** Scottish Parliament's Health, Social Care and Sport Committee to provide evidence as part of its scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill
2002-16	**Family Physician,** expertise in maternity and newborn care **Staff Physician,** Department of Family Medicine, Victoria General Hospital, Victoria, BC *-Practicing Family Physician with hospital and obstetrical privileges* *-Instructor and Preceptor for medical students and medical residents* *-Founder of Quintessence Maternity Group* *-Owner of Gentle Touch Circumcision- provider of infant male circumcisions* **Clinical Faculty,** University of British Columbia and University of Victoria
1999- 2001	**Director,** Family Medicine Obstetrics, Department of Family and Community Medicine, St. Michael's Hospital, Toronto

PEI

STEFANIE GREEN

1997- 2001	**Faculty Lecturer,** Department of Family Medicine, University of Toronto *- Instructor for medical students and residents in Family Medicine* **Staff Physician,** Department of Family and Community Medicine, St. Michael's Hospital- Wellesley Central Site, Toronto *- Practicing Family Physician with hospital and obstetrical privileges* *- Focus on well child and women's health, multicultural, and urban medicine*
1996	**Faculty Lecturer,** Department of Family Medicine, McGill University, Montreal *- Instructor for medical students and residents in Family Medicine* **Clinical Assistant**, Department of Family Medicine, Sir Mortimer B. Davis Jewish General Hospital, Montreal *- Attending staff-member on the Family Medicine ward* *- Practicing Family Physician with obstetrical privileges, multicultural focus*

AUTHOR

- *This Is Assisted Dying- A Doctor's Story of Empowering Patients at the End of Life* (Scribner 2022)
  Currently available in 8 countries and 4 languages
- Afterword of *Last Week* by Bill Richardson (Groundwood Books 2022)

SUCCESSFUL GRANTS

- Canadian MAiD Curriculum Project; $3.3 million
  Co-applicant, on behalf of Canadian Association of MAiD Assessors and Providers, 2022

AWARDS

World Federation of Right to Die Societies - Health Professional Award 2018
For the healthcare professional who has set a helpful precedent for the international right-to-die movement.

LICENSING

2002- present	British Columbia License and Billing number
1996- 2002	Ontario Medical License and Billing number
1995	Certification Examination in Family Medicine (CCFP)
1995	Certification Examination to practice medicine in Quebec
1995	Licentiate of the Medical Council of Canada (LMCC)
1993	Professional Licensing Examination of United States of America (FLEX)

DEI

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EDUCATION

1996 Palliative Care Fellowship, Sir Mortimer B. Davis Jewish General Hospital, Montreal
1995 Michael Klein Maternal and Child Health Fellowship, McGill University, Montreal
1995 Family Medicine Residency, McGill University, CLSC Côte-des Neiges, Montreal
1993 Medical Degree (MDCM), McGill University, Montreal
1989 Bachelor of Science, *with distinction*, University of Toronto
1986 High School Diploma *with honours*, Queen Elizabeth High School, Halifax, Nova Scotia

PROFESSIONAL ASSOCIATIONS

- Canadian Association of MAiD Assessors and Providers (CAMAP)
  Co-founder and Founding President
- College of Family Physicians of Canada
- Doctors of B.C.
- Canadian Medical Association

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STEFANIE GREEN

MEDIA List of media appearances and experience available upon request (for samples see StefanieGreen.com/media/)

OTHER ACTIVITIES

2025	Committee Member for Master's Thesis of an architectural student UBC
2024- present	Member of Advisory Council for the Completed Life Initiative, USA
2022	Developer/Owner of website StefanieGreen.com (StefanieGreen.com)
2019	10 day speaking tour of New Zealand on Canadian model of assisted dying
2016- present	Member of Clinician Advisory Council for Dying With Dignity Canada
2016- present	Founder and developer of Solace BC, care in assisted dying (SolaceBC.ca)
2012- present	Owner/Provider of Gentle Touch Circumcision, Victoria BC (gentlecirc.ca)
2014-16	Expert Witness for obstetrical malpractice cases, as requested
2002-14	Founder and member of Quintessence Maternity Group, Victoria BC
2005-14	Rater of Literature for MORE program
2003- 6	Participant MacMaster Small group PBL program
1999	Lecturer on nausea and vomiting in pregnancy-"A Cry for Help" *sponsored by Duchesney pharmaceutical company*
1998	Seminar on Domestic Violence Educated on "teaching the teachers"
1995- 96	Author and developer of *Dear Doc* Internet Website for health-related information
1994	Co-facilitator, Holocaust Survivor Support Group
1993- 94	Co-leader, small group component of first and second year medical student courses *Introduction to the Patient and Introduction to the Practice of Medicine*

FOKI

STEFANIE GREEN

PUBLICATIONS

1. DeBiasio C, Green S, Kirchhof MG.
Medical Assistance in Dying in Canada: A Review for Canadian Dermatologists. Journal of Cutaneous Medicine and Surgery. (November 2025)

2. Downar, Green, Hoffman, Pope
Sorry, Not Sorry; Canadian MAiD is Voluntary, Safe, Carefully regulated, and Valued
American Journal of Bioethics 25:5, 33-35 (May 2025)

3. G. Shapiro, K. Hunt, H. Braund, N. Delgano, A. Panjawi, S. Stevens, J. Mulder, S. Sheth, A. Stere, S. Green, G. Gubitz, M. Li
Development of a Canadian Medical Assistance in Dying Curriculum for Healthcare Providers
Journal of Medical Education and Curricular Development (August 2024)

4. J. Downie, S. Green
For People with Dementia, Changes in MAiD Law Offer New Hope
Policy Options IRPP (April 2021)

3. E.R. Wiebe, S Green, K. Wiebe
Medical Assistance in Dying (MAiD) in Canada: Practical Aspects for Healthcare Teams Annals of Palliative Medicine (August 2020)

4. J. Downar, S. Green, A.Radhakrishnan, J. Wales, G. Kim, D. Seccareccia, K. Wiebe, J. Myers, S. Kawaguchi MD
An Entrustable Professional Activity Descriptor for Medical Aid in Dying: a mixed-methods study CMAJ Open 6 (4) 2018

5. E.R. Wiebe, J. Shaw, S. Green, K. Trouton, M. Kelly
Reasons for Requesting Medical Assistance in Dying (MAiD) Can Fam Phys (September 2018)

6. E.R. Wiebe, S. Green, B. Schiff
Teaching Residents About Medical Assistance in Dying, Can Fam Phys (April 2018)

7. J. Downie, S. Green
A Step Forward for Self-Administered MAID in Canada, Impact Ethics (December 2017)

8. W.D. Robertson, J. Pewarchuk, J. Reggler, S. Green, T. Daws, K. Trouton
Six Month Review of Medically Assisted Deaths on Vancouver Island, BCMJ (August 2017)

9. (multiple authors)
What Matters Most, CMAJ May 2017

10. Green, S., Shrier, I., Solin, J., Khanlou, N. (1995)
7th Annual Quebec Research Day in Family Medicine
Knowledge of and Attitudes Towards Patient Confidentiality within a Family Medicine Teaching Unit

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