

The Evolving Complexities of MAID Care in Canada From a Nursing Perspective

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Abstract

Medical Assistance in Dying (MAID) legislation has evolved rapidly in Canada with significant impacts on nursing practice. The purpose of this paper is to describe evolving complexities in legislative context and practice standards that influence the experiences nurse practitioners and registered nurses have with MAID. Qualitative interviews were conducted with 25 registered nurses and 10 nurse practitioners from diverse contexts across Canada. Participants described their practices and considerations when discussing MAID as part of advance care planning; their use of, and challenges with, waivers of consent; their practice considerations in negotiating the complexities of clients for whom death is not reasonably foreseeable; and their moral wrestling with the inclusion of MAID for persons whose sole underlying medical condition is mental illness. Findings illustrate the moral complexities inherent in the evolving legislation and the importance of robust health and social care systems to the legal and ethical implementation of MAID in Canada.

Keywords

end of life, euthanasia, legal issues, interpretive description, nursing, research, qualitative, death and dying, Canada

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Introduction

As they expand the criteria, they have to look at the needs that follow. NP13

Nursing practice evolves to meet the needs of an ever more complex patient population and healthcare system. Generally, nursing practice calibrates over time to meet these emerging needs. However, significant technological or legal developments present disruptions that have the potential to change the ways in which nurses practice with far-reaching consequences. The legalization, and subsequent evolution, of Medical Assistance in Dying (MAID) in Canada has been one such development. The aim of this study was to explore the evolving practices related to MAID in Canada from the perspective of nurses with the goal of understanding the implications for nurses, MAID applicants, and the healthcare system. Data collected for this study was part of a larger longitudinal program of research, the purpose of which is to describe the evolution of strategies to relieve suffering at end of life in Canada.

The legislation providing for and regulating MAID in Canada (the MAID legislation) is set out in the Criminal Code,¹ where it creates an exception to activities that would otherwise be criminal offences. As defined in the Code,

MAID means the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes that person's death, or the prescribing or providing by a medical practitioner or nurse practitioner of a substance to person, at their request, so that they may self-administer the substance and in doing so cause their own death. The language of Medical Assistance in Dying (as opposed to physician assisted dying) reflects the fact that this legislation authorizes nurse practitioners (NPs), who are registered nurses with additional specialized post-graduate education, in addition to medical practitioners, to act as independent assessors and providers of MAID (i.e. without a requirement of physician over-sight) (Dobec, 2022).

MAID has expanded rapidly in Canada in terms of both legislative developments and uptake (Health Canada, 2023a;

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Nicol & Tiedeman, 2021). The initial MAID legislation (which came into force in 2016) made provision that only persons whose natural death was reasonably foreseeable would be eligible to receive MAID (Nicol & Tiedemann, 2018). The 2016 legislation also provided that persons had to be capable of giving consent immediately before receiving MAID. The requirement of consent immediately prior to MAID created a dilemma for persons who feared the loss of that ability, and so might feel compelled to ask for MAID while they were still capable of giving consent, but before they would otherwise choose to do so (Variath et al., 2022). One high profile Canadian case of this kind involved Audrey Parker, a woman living with advanced cancer, who created a video in which she described requesting MAID prematurely because of her fear of losing the capacity to consent (Nicol & Tiedeman, 2021). Healthcare providers also experienced challenges in determining when patients might lose capacity and felt responsible for the disappointment of patients and family when the preferred MAID death for which they were otherwise eligible could not be achieved (Variath et al., 2022). Conversely, expediting MAID provisions also proved morally challenging for healthcare providers (Variath et al., 2022).

In 2021, the legislation was amended to expand eligibility criteria to those whose death was not reasonably foreseeable (Nicol & Tiedeman, 2021). This led to a two-track approach (Track 1 referring to persons whose death was reasonably foreseeable; Track 2 referring to persons whose death was not reasonably foreseeable) with different eligibility criteria and safeguards applying to each track. The 2021 amendments allowed for final consent (consent given immediately before receiving MAID) to be waived for Track 1 MAID.² This waiver of final consent arrangement or advance consent arrangement allows a person to waive the final consent requirement if they had entered into a written arrangement with the medical practitioner or nurse practitioner that the medical practitioner or nurse practitioner (i.e. the same person they entered into the arrangement with) would administer MAID on a specific day, even if they (the patient) had lost their capacity to consent on that day. The advance consent arrangement cannot be followed if the person demonstrates refusal or resistance to having MAID administered by “word, sounds, or gesture.”³

At the time of the 2021 amendments, the government undertook to amend the legislation further to provide for MAID in cases where mental illness was the sole underlying condition. The legislation currently provides that a mental illness is not considered to be an illness, disease, or disability for the purposes of meeting the eligibility criteria for MAID (which require that a person be experiencing an illness, disease, disability or state of decline that causes them intolerable suffering and that cannot be relieved under conditions they find acceptable).⁴ This period has been extended with further legislative amendments expected in 2024 allowing time for additional consultations and providing the provinces

with additional time to build capacity for the complex assessments that these cases would entail (Department of Justice Canada, 2023).

Alongside these legislative changes, the uptake of MAID in Canada has been rapid. The most recent report on MAID in Canada (Health Canada, 2023a) indicates that in 2022 there were 13,241 MAID provisions reported in Canada representing 4.1% of all deaths. This is a 31% growth over 2021; a growth rate that has remained fairly steady from 2019 to 2022. The proportion of the total MAID provisions that were for Track 2 cases was 2.2% in 2021 and 3.5% in 2022. The vast majority of provisions were clinician-administered.

The developments described above, impacting the scope of MAID, the processes and procedures through which it is delivered, and the number of patients seeking MAID, have significant implications for nursing practice. When our team began researching MAID and nursing in 2017, there was little published literature about nurses' experiences (Pesut, Thorne, Greig, et al., 2019). On the basis of that literature, one might have assumed that the role of nurses in providing MAID was minimal. The statistics relating to MAID show that this is not the case. NPs administered 9.4% of the total MAID deaths in 2022 (Health Canada, 2023a). This is significant, all the more because it represents a proportion higher than the proportion of NPs to physicians in Canada. In 2022 there were 7,113 NPs compared to 96,020 physicians (Canadian Institute for Health Information, 2023a). NPs are positioned strategically for MAID in the Canadian health-care system in that they often provide primary care to palliative, end-of-life, and long-term care clients. In their capacity as primary care providers, one of their key roles is advance care planning—having those important conversations about patient wishes and the options available to them in the face of declining health (Rietze et al., 2016).

Registered nurses (RNs) also play a key role in the MAID system, acting as MAID program coordinators, clinical leaders, and intravenous initiators for MAID provision (Pesut, Thorne, Schiller, Greig, Roussel, & Tishelman, 2020). In 2022, nurses were the most consulted healthcare professionals during the assessment process (41.7%) followed by primary care providers (32.7%) and social workers (24.7%) (Health Canada, 2023a). Where MAID is provided in a patient's home (39.5% of MAID cases), and within institutions such as hospitals, hospices and residential care facilities (59% of MAID cases) (Health Canada, 2023a) nurses provide the close continuing care for clients and family. Despite their important roles at all stages of the MAID process, RNs are often placed in an uncertain legal and regulatory position (Pesut, Thorne, Stager, et al., 2019). For example, although advance care planning may be considered an important part of their nursing role, their regulatory body might explicitly state that they cannot introduce the topic of MAID if a patient has not requested such a conversation for fear of violating a criminal code prohibition against counseling a person toward this option (Pesut, Thorne, Stager, et al.,

2019). Likewise, RNs who initiate the intravenous agent might be considered to be participating in MAID with all the attending legal requirements that entails, but without having access to relevant documentation to assure themselves that patients have met the eligibility criteria and safeguards (Canadian Nurses Protective Society, 2021; Pesut, Thorne, Schiller, Greig, & Roussel, 2020; Pesut et al., 2021). Without access to the relevant documentation, nurses' practice becomes one of an employee who acts upon instructions rather than that of a professional with independent accountability. The role of RNs was notably absent in the recent Federal Model Practice Standards for Medical Assistance in Dying (Health Canada, 2023b). Such examples attest to the difficult, yet essential, places that nurses find themselves in as they attempt to negotiate this evolving practice of MAID. The purpose of this paper is to describe the experiences of NPs and RNs with MAID generally and, in particular, with advance planning, waivers of consent and the unfolding Track 2 context (i.e., those whose death is not reasonably foreseeable including those with mental illness).

Methods

The current study was a qualitative study using Interpretive Description (Thorne, 2016). Interviews were conducted with RNs and NPs involved with MAID across the Canadian context. The study was conducted according to the World Medical Association Declaration of Helsinki and received ethical approval through the Behavioural Research Ethics Board of the University of British Columbia [# H20-00486]. Participants were recruited through a combination of convenience, purposive, and snowball sampling. The study was advertised through the Canadian Association of MAID Assessors and Providers. Some participants had been interviewed in a previous study and had agreed to be recontacted for this study. Participants were also asked to provide information about the study to other nurses within their networks. The primary eligibility criterion was experience with MAID in the clinical context. Nurses were interviewed by ZOOM using a semi-structured interview guide developed, tested, and revised by the research team (see Supplemental Material). Participants were asked generally about their roles in relation to MAID and specifically about their experiences with the new legislation and their thoughts about the impending changes related to MAID when mental illness is the sole underlying medical condition. The principal investigator (a nurse) and two research staff members (a social worker and social scientist) conducted the interviews. Interviewers had no prior relationship with research participants. The length of the interviews was on average 60 minutes. Interviewers were instructed to try to keep the interview within a one-hour time frame if possible as this was the length of time participants had committed to on the consent form. Interviews were audio-taped, transcribed by a transcriptionist, and uploaded into NVIVO for analysis.

Analysis was conducted following the principles of Interpretive Description (Thorne, 2016). In keeping with this approach, findings were interpreted within a nursing disciplinary lens with the intent of informing nursing practice. Three study team members read six interviews to develop an initial open coding framework. This framework was then used to code a subsequent sample of interviews through which the open codes were further negotiated and revised. This framework was then used to code the data set in its entirety. During the coding process two team members independently coded several transcripts and compared findings at strategic points to ensure that the coding framework was applied consistently. Codes were developed into themes using a process of constant comparative analysis (Glaser & Strauss, 1967). Those themes were then developed into an interpretive account of the new insights arising from this data set. This interpretive account was then reviewed by all study team members to ensure that it was well grounded within the data and revised accordingly. Extensive discussions among the team members about data and the writing of field notes after each interview supported investigator reflexivity.

Findings

Thirty-five nurses were interviewed between February and July 2023 (see Table 1 of participant demographic information). In describing the findings, we will use the terms she/her. Our participants overwhelmingly identified as female; further, there are not enough men doing this nursing work in Canada to ensure the confidentiality of their responses. Participants will all be referred to as nurses below. The participant numbers will identify them as a registered nurse (RN) or nurse practitioner (NP). Thematic findings are organized according to what we inductively observed as four key aspects of emerging legislation and evolving practice of relevance to nurses: introducing MAID discussions as part of advance care planning, living beyond capacity and waivers of consent, hastening death when death is not foreseeable and anticipating MAID for mental illness.

Introducing MAID as Part of Advance Care Planning

One of the more controversial developments in MAID in Canada has been the question of whether MAID should be introduced as an end-of-life option as part of advance care planning. Should healthcare providers introduce the topic of MAID in the absence of a specific patient request when discussing available end of life options? Participants in this study acknowledged that in the early days of MAID there were concerns that introducing the topic in the absence of an explicit request by a patient would constitute counseling to commit suicide which remains a criminal offense in Canada. "I can remember the first times physicians were talking about it with patients and they were nervous about it legally"

Table 1. Participant Demographics (N=35).

Variable	Options	N	%
Nurse designation	NP	10	28.6
	RN	25	71.4
Province of practice	British Columbia	23	65.7
	Alberta	1	2.9
	Saskatchewan	1	2.9
	Manitoba	1	2.9
	Ontario	8	22.9
	New Brunswick	1	2.9
Geographic context of work ^a	Urban (population of \geq 10,000)	28	80.0
	Rural (population < 10,000)	17	48.6
	Remote	6	17.1
Years in practice (n=34)		mean 22.3	SD 11.7
Gender	Female	33	94.3
	Male	2	5.7
Ethnicity (n=34)	White	29	85.3
	Black or African Canadian	1	2.9
	Asian	2	5.9
	Other	2	5.9
Age	25–34	3	8.6
	35–44	10	28.6
	45–54	10	28.6
	55–64	8	22.9
	65 or older	4	11.4
Spiritual/Religious	Religious and spiritual	7	20.0
	Spiritual but not religious	18	51.4
	Not religious or spiritual	10	28.6
Number of patients who have gone through the process of MAID services since 2016 (n=34)	0–4	3	8.8
	5–9	3	8.8
	10–14	2	5.9
	15–19	0	0
	20–24	5	14.7
	25 or more	21	61.8

^aParticipants could select more than one category.

[RN 29]. Some nursing regulatory bodies in Canada, responsible for both RN and NP practice, had explicit prohibitions around introducing the topic of MAID outside of an explicit patient request. “The initial statements that came out from most colleges across Canada . . . was that nurses couldn’t bring it up. The patients had to use explicit terminology” [RN 62]. However, NPs in particular provided compelling reasons for why MAID should be discussed as part of advance care planning and for some it was a normal part of their practice. “I offer it as an option to discuss and some people are a hard no right off the bat. But yes, as a legal care option I offer the discussion to everybody” [NP 36].

One of the most compelling reasons for introducing the topic was that many patients were still not aware that this was an option for them and some physicians were reluctant to provide that information. As a result, participants stressed the importance of educating patients about all of their options and that this was an accepted part of their nursing role.

It is within our skill set and expectation that we talk about all end-of-life options . . . MAID is not part of the palliative care job description but for many of us it’s a natural part of our skill set and our conversations. [NP 84]

From this perspective, not introducing all the available options could be considered a breach of good practice. This patient education was particularly important when physicians were reluctant to provide referrals for MAID. For example, a participant described having to intervene when physicians would not make referrals to the MAID team. “So I’ll say Dr. So and So, patient x has indicated that they have tried to reach out to you a couple of times regarding MAID and having a conversation or an assessment and they haven’t gotten anywhere” [RN 82]. Therefore, including MAID as part of regular advance care planning was seen to support patient choice and to overcome some of the barriers patients might otherwise experience within the system.

A second reason for including MAID as part of advance care planning was related to the timing of these conversations. Participants described the importance of not having the MAID conversations during critical transition times in their illness journey because it could send the wrong message to patients during a time of vulnerability. For example, one participant indicated that there was always a risk that introducing the conversation during a transition time could convey the impression that you are at the end and there is nothing more that we can do for you. “I think it’s really important that it is presented not as a ‘well we are at the end of the rope now and do you want MAID’ because it is such a delicate balance” [NP 104]. Another participant who was a MAID assessor shared a hard lesson she had learned about discussing MAID during a vulnerable transition. The family had received a grave diagnosis and she was called at the family’s request to discuss MAID and so she did so. However, when she returned the next day after the crisis had resolved it was apparent that she was not welcome. “I did go in and see the person the next day she just said ‘angel of death, angel of death, go, go’” [NP 18]. One of those vulnerable transition points can be entry into long term care. “The patients that we admit from hospital to long term care are here for increasing palliative needs and then they request MAID” [NP 18]. Nurses felt that, under such circumstances, patients may express a desire for MAID because of their preconceptions of what life will be like in long term care and their desire to avoid it at all cost.

In contrast to talking about MAID during critical transition times, participants stressed that proper conversations around wishes are ideally completed during times of relative stability well in advance of the time decisions need to be made. It is during those times that such a choice is more likely to be congruent with long and deeply held values. “If I can get to these people earlier to start talking about the future and what that looks like and how to respect their goals and values and beliefs, I find the transition goes better” [NP 18]. Such conversations are educative, but more importantly, they give permission to persons to talk about difficult subjects such as suffering and death. Therefore, including MAID as part of regular advance care planning during times of relative stability helped to prevent the possibility of decisions during vulnerable times that might not be in keeping with abiding patient values.

Beyond the important timing of these discussions, participants also reflected on what these conversations must look like to be effective. These conversations were not about medical treatment directives. Rather, they were about the enduring values and wishes that patients held as their health declined. What is important to you right now? What has been important in your life to-date? And as you think ahead what do you anticipate will be important to you? Questions such as these formed the substance of such conversations. Further, participants emphasized that these needed to be evolving conversations that are revisited on subsequent occasions.

For example, one participant suggested that what people anticipate will be an unacceptable quality of life may be reframed as that anticipated future unfolds.

It’s certainly made me a lot more humble. I can sit here as a healthy person and say, “I don’t want my bum wiped.” But when I get to that point it might be okay because I am still getting joy from something else. [NP 104]

RN participants spoke of the importance of being highly alert to cues about MAID when having these conversations. “I discern from what people say that they would like to be asked about MAID. Some people ask for it with the knowledge of what it is. Others ask for it in a sideways way trying to open conversation” [RN 5]. As another explained,

The idea of MAID never occurs through buzzwords. Nobody says “I would like to talk to the doctor about medically assisted dying.” Do you know what they say? “Take me out behind the barn, I’m done. Give me the needle. Just shoot me.” [RN 62]

However, even amidst statements that seem to imply a desire for MAID, participants warned about making assumptions. This same participant went on to explain that the vast majority of the time patients are just “gassing off this distress of suffering” [RN 62] and have no desire for MAID. But in a small percentage of cases when the legality of MAID is introduced “they’re like ‘holy crap this actually aligns with my values’” [RN 62]. In such instances, the possibility of a MAID death becomes part of the natural flow of clinical conversation rather than being introduced abruptly out of context. This is particularly important in light of the observation that older persons may still have a tendency toward medical paternalism, in which case the introduction of MAID could be perceived as a recommendation. As one nurse cautioned, “When you are dealing with very elderly people lots do say ‘Doctor knows best so I must.’ You know if a doctor says it, it must be right” [RN 29].

Further, nurses agreed that these sensitive conversations benefit greatly from time and trust. Participants described ongoing conversations that could take an hour or more to fully explore the relevant issues. “I have the luxury of time in my job where I can take 15 minutes or 90 minutes depending upon how long it takes to talk to you about end-of-life” [NP 18]. The trust and rapport that must be developed to have these significant conversations also take time.

We get our leads from the residents themselves but that only happens if we give it time. We remember to take the extra time. Rather than sitting at the desk we make sure we sit with people and actually talk. We may hear a story that helps us understand what people are wanting. [RN 5]

Overall, the practice of introducing MAID as part of advance care planning varied widely across the country. Those who advocated for it did so within a communicative

framework that sought to offset potential patient vulnerabilities. However, there were critical system issues that prevented the realization of this ideal, including the fee-for-service practice model and the siloing of communication systems. Participants indicated that models of reimbursement that included fee-for-service simply could not accommodate these best practices. “If you have a fee-for-service model, 99% of the time that (advance care planning) doesn’t get done” [NP 18]. Beyond the reimbursement involved, the shortages in the primary care system meant that spending time on these evolving and in-depth conversations was simply unrealistic. Further, there were few formal systems through which to communicate this vital information. Participants described privacy laws that still prohibit the sharing of a planned MAID death among team members. “We have put in requests over and over again just to be unblinded to the rest of the system so that everybody can see our notes. But there’s still this sense of ‘No it might impact patient care’” [RN 62]. The worry inherent in this statement is that non-MAID providers might change their care approach once they realized this person was seeking MAID. This effectively excluded any information related to MAID from the ongoing team care plan. “The biggest challenge is silos in terms of communication. One agency not being able to speak to another fluidly. The barriers are organizational policy and they are not looking at it from a humanistic lens” [RN 82].

Further, even if these privacy laws did not exist, systems still did not have the mechanisms through which to share the insights derived from these advance care planning conversations. Someone’s wishes related to quality of life are much more difficult to document than their choices around what medical procedures they would or would not want. “How do you write somebody’s values, wishes and beliefs” [RN 82]? And if they couldn’t be documented then they couldn’t be shared among the many healthcare providers who made up that person’s circle of care. These failings led to unintended consequences. One participant shared how a person who lived with chronic illness had been asked multiple times about the possibility of having MAID. “Twelve of her practitioners—in her complex life, she’s got that many—have asked her. And so, she got a little tired of the question” [RN 5]. Siloed communication meant that each provider felt that it was their obligation to present the possibility. Although this particular person happened to be quite confident in their decision-making one can well imagine the effect this could have on a person who believed that the doctor knows best.

Living Beyond Capacity: Waivers of Consent

The waiver of consent made available under the C-7 legislation (in 2021) was perceived as a unique form of advance care planning that provided the opportunity for clients to “drain the last drop of life” [RN113] by not having MAID earlier than they might have wished because of fear of losing capacity to consent to the procedure.

This was an extremely distressing thing for people who are living with illness knowing they might lose that option (MAID) causing them to enact MAID earlier than they would have. Now with the waiver they know they’ve got this in their back pocket. [RN 11]

Under the initial Bill C-14 legislation (2016), clients had been required to give informed consent just prior to the injection of the medication. This put pressure on clients to stay well enough to consent to their procedure and to plan their MAID date carefully in relation to that. Helping clients to live as long as possible could mean that the procedure had to be planned and implemented under enormous time pressure if applicants were deteriorating. “That’s why we had so many saying ‘we need MAID tomorrow’. It was a race to get it done” [RN 113]. Naturally, this time pressure was also difficult for providers who did MAID in addition to their regularly scheduled work. Nurses indicated that this counterproductive sense of urgency was therefore alleviated once the waiver of consent was enacted under Bill C-7.

Implementing the waiver of consent was not without difficulties and did not always go as planned. One participant spoke of how MAID providers originally envisioned signing a waiver of consent with every Track 1 (i.e., facing a reasonably foreseeable death) client, thus alleviating the logistical and emotional difficulties that could arise if a client lost capacity. However, this same participant quickly realized that this was much more difficult than she had envisioned largely because of the complexity of the process. She discovered it was difficult to explain the process of a waiver of consent in a way that clients and family could understand, and in many cases, it was just too much. “The first time I tried to explain it to a patient it didn’t go well. I confused myself and I confused them” [NP 79]. This participant suggested that the level of capacity required for a waiver of consent was much greater than the capacity required for a consent to MAID. “I think what we have recognized is that if somebody has the capacity to give consent to MAID that’s a different level of capacity than understanding the forward thinking and the technicalities around a waiver” [NP 79].

Further, the emotional challenges for healthcare providers were higher with a waiver of consent because now they were responsible for administering the medication in the absence of explicit final consent. And as one participant shared, that final verbal consent provides great moral assurance at the end that this is what the participant truly wanted. “From my own experience of working with clinicians, the consent piece at the end is important because it does provide them with the surety that this was the patient’s wish right up until that last moment” [RN 90].

The moral and legal complexity of administering MAID after a person had lost capacity, largely because there was now no visible suffering, was cited by several participants as another major challenge. Suffering is part of the eligibility criteria under the legislation. However, once a person loses

capacity, participants suggested that the suffering may no longer be apparent.

If you do a waiver and the date is coming up and now the person has lost capacity, and they all [applicant and family] want MAID, but their suffering has been alleviated and they can't sign for another waiver, do we honor those wishes? That can be a hard one for everyone to wrap their brain around. [NP 104]

Some participants pondered whether such a case then no longer met the legal eligibility criteria of irremediable suffering necessary for a MAID death. In effect, they were dealing with an applicant envisioning their future self without knowing whether they really would be suffering after losing capacity. However, this concern was offset by the numbers of patients and families who perceived a natural death as a failure after being approved for MAID. “He’s going to have to die naturally, whatever that means. So back to care planning—and more care planning” [RN 113].

The challenge of having to provide MAID in the absence of explicit applicant consent and suffering led to a more targeted use of waivers of consent by participants in this study. One participant shared what constituted best practice for waivers of consent in their MAID practice. It is important to note that this was a primary care provider who only provided MAID to persons who were already part of their practice. In the context of this ongoing relationship, this provider suggested that the vast majority of trajectories were actually predictable and so a waiver of consent was unnecessary. The status of potential MAID candidates was followed closely and those who were at risk of losing capacity were offered a waiver of consent. This continuity also allowed the provider to know the family well, thus removing the complicating factor of having to provide MAID when the family disagreed and the person was no longer capable of expressing their wishes at the end.

It comes back to why I’ve chosen to only provide MAID for my palliative patients because then I have intimate knowledge of what is going on from day to day and how things are changing. And so, I can’t predict a completely acute event but I’ll be honest with you. In years of doing this job I’ve had less than five patients die suddenly. [NP 79]

For this practitioner, the waiver of consent was best used specifically for those who were declining quickly or who had a medical condition for which a capacity event might become likely (e.g., brain tumors).

Although study participants were broadly in favor of the availability of the waiver of consent, they spoke of the lack of specific guidelines available to enact it. Specifically, they were confused about the length of time that could be allowed under a waiver of consent. “I think myself, I feel like three months is an acceptable time” [RN 11]. They were concerned that a prolonged period for the waiver of consent could

actually become advanced consent, something that is not allowed yet under the legislation. “It’s kind of a grey zone of how much of it is an advanced request versus a waiver” [NP 104]. Such judgments in MAID-related practice often develop across the community of practice over time. Among our participants a common understanding for the appropriate length of a waiver of consent seemed to be about three months although there is no specific guidance upon which to base this decision.

Hastening Death When Death Is Not Foreseeable: Many Shades of Grey

Participants were asked specifically about their experiences with Track 2 patients, that is those for whom natural death was not reasonably foreseeable. A number of participants had little experience with such cases, indicating that they were few and far between in their geographic region. “Track 2s are actually very low in this area—maybe 1%” [RN 112]. However, others suggested they had a number of active applicants. For some participants, these applications were causing significant moral, decisional, and healthcare capacity challenges.

Listening to participants talk about the moral challenges they experienced in the context of Track 2 was reminiscent of listening to the reasoning of conscientious objectors and conscientious participators in the early days of Track 1—except now the reflections came from those persons who agree with MAID in the context of Track 1. One participant indicated that Track 2 cases have a “definite different feel” and that they are “harder” because often applicants “look totally fine” [RN 09]. In this case, the nurse had to remind herself that the goal of MAID was all about choice and quality of life—not about whether someone was dying. “That was difficult for me to get my mind around. Having the new criteria has brought a lot more choice for people which is important when you are looking at quality of life” [RN 09]. Another participant wrestled with the idea of Track 2, wondering whether it was more aptly termed “assisted suicide” [RN 38] because applicants were not dying. She likened the evolving legislation to “trying to pick up sand” [RN38] because just when you thought you had a handle on it, it changed into something new. Though she honored the moral complexity that occurred even under Track 1, she had not yet reconciled herself to Track 2. “This is not what I signed up for. Am I a conscientious objector? I don’t even know anymore” [RN 38]. Another participant’s discomfort with this practice was apparent in this simple statement, “I am pleased to tell you I don’t have much experience with it (Track 2) [RN 24].

Others had become quite reconciled to the evolving legislation even if they had concerns initially. “Early on I thought I might disagree with eligibility decisions but it has never happened” [RN 14]. In part this was because the medical

conditions were clearly serious. “The Track 2 cases I have seen have been extreme. If it’s fibromyalgia [for example]. . . it’s the extreme of what I have seen in my career” [RN 112]. Another participant felt morally reconciled to the Track 2 approach because they had observed the implications for applicants who had been found ineligible for MAID, with some even attempting suicide [RN 113]. One participant reasoned that Track 2 was important because it allowed a more generous application of Track 1. She recalled applicants being turned down because death was not imminent, but with Track 2 being legal this was no longer a significant consideration. “People have a quality of life that is so low that they would like to have MAID but they were not eligible. It opened things up a bit for them” [RN 11].

Overall, the moral wrestling shared by these participants was linked to the very real complexities of the situations of those applying for MAID under Track 2. These complexities required a significant amount of clinical judgment by assessors. As one participant described it:

There is not a one size fits all. MAID according to C-14 and now C-7. If you meet these qualifications this is what happens. As more stories come forward, and we listen to collective voices, it isn’t a binary of you meet criteria or you don’t. You pass go or you don’t. There are a lot more nuances, shades of grey. [RN 38]

Often these MAID applicants had long and complicated healthcare histories and so it really came down to two questions: “can the assessor know enough about the situation to make a good decision and are the applicants engaged enough to have tried alternatives to relieve their suffering” [RN 62]?

Participants provided a number of stories that illustrated this complexity in MAID applicant histories. Many stories were characterized by a common set of challenges: a healthcare seeking background in which they may have received stigmatizing labels (such as drug seeking), care across multiple providers but with no primary care provider to organize and advocate for them, and little understanding on the part of healthcare providers of the personal living situations of applicants, including resources and social support. One participant described an applicant applying for MAID under Track 2 who had received the unfortunate label of being non-compliant with recommended healthcare treatment. After working closely with the applicant for 18 months, and reviewing files from multiple sources, the participant had a much deeper understanding of the barriers encountered by this applicant.

It made me really sad to know that people are treated like that by our system but I felt very very grateful to be able to provide her with what she wanted and had wanted for over 18 months. It was a lot of work, emotional work, but I know definitively that is what she wanted. [NP 79]

Layered onto this social complexity were decisions about what constituted a serious and declining medical condition. For example, did a loss of sight or hearing from an otherwise

stable medical condition qualify someone for Track 2 if it resulted in suffering and a loss of quality of life?

Participants described the time investment and intensity of having to negotiate applicant’s needs to ensure that options available to alleviate their suffering had been considered.

Our Track 2 is certainly more involved. We get as much information as possible about why a patient is seeking a medically assisted death. If there are unmet needs, we walk through with that person. Our social work complement takes the reins and liaisons with community supports. [RN 62]

Another participant described how Track 2 opens the door for applicant decisions that are more related to the choices available to them than to suffering.

I have a person at the moment who is refusing a long-term care bed. He says, “what choices do I have?” He’s too pragmatic. I say “If you had the opportunity for MAID tomorrow would you take it?” He says, “No, I want it in two months.” So, you have to deal with the pragmatics to ensure that the ideal is held to. [RN 24]

Other examples were persons who applied because their family caregiver was no longer able to look after them or they lived in a rural or remote area where there were no home services, and alternative options such as long-term care, were not acceptable. Even though these were pragmatic choices, they did not necessarily disqualify someone from being eligible for MAID.

We can spout all we want about the ideal of what life should look like and what our society should be able to do. But how long do we force people through a system that isn’t ideal in the hope that we get to a place when there is nothing? There’s no wind of change around the corner. [NP 79]

Participants indicated that the requirement to navigate these types of difficult decisions meant there were fewer assessors willing to provide assessments for Track 2 cases and that the burden on those assessors to do a full and defensible assessment could be heavy. “It’s more challenging as a clinician to weave everything through and feel like I am making the right decision” [NP 25]. Further, there was no way to judge how labor-intensive a case would be prior to accepting it. And once the care was accepted, there was a duty of care that followed. Participants suggested that this type of case management for Track 2 MAID is not funded adequately either within salaried or fee-for-service positions.

Beyond adequate time to manage these cases, getting information about applicants was a significant barrier. As one participant explained,

I can spend eight hours just trying to find the information that I need for some patients. Because you’re sending fax after fax and calling and you know they send you to this person and that persons sends you to another person and it can be quite impossible. And we don’t have supports. I don’t have a secretary or a social worker. [NP 30]

Without shared medical records, assessors found themselves tracking down health records from multiple regions, institutions, and providers. The sheer logistical challenges of this were further complicated by those providers who disagreed with MAID and therefore were less forthcoming with the information required by the MAID assessor. Such actions put clinicians in a difficult spot. They wanted to do a thorough job but were unable to get the information necessary to do so.

I don't want to be the clinician going in with the bleeding heart who is intending to euthanize people who are suffering . . . I want to do this to the letter of the law with rigor and to make sure that it's not just my opinion but that there is a medical community who is soundly behind this. [NP 84]

One participant described a strategy that seemed to be working well for their MAID team.

For Track 2 cases only, after initial triage, applicants are required to complete an extensive questionnaire about their medical history and the most responsible providers are also required to complete an assessment form. This is done prior to the first assessment. [RN 62]

Anticipating MAID for Mental Illness: Failures in Care

At the time of this data collection the MAID legislation has not been amended to recognize mental illness (as the sole underlying medical condition) as meeting the eligibility criteria for MAID. This did not mean that participants were not dealing with complex mental illnesses in applicants, but rather that mental illness could not be the primary reason for MAID. One participant described the difficulties in actually separating mental and physical illnesses as described by one of her applicants for MAID when she asked him whether he thought his request was due to mental or physical issues. "It's like when you're making a recipe and you mix the dry ingredients with the wet ingredients and you can never separate them again" [NP 79]. In collecting this data, we felt it was important to get a sense of what participants were anticipating might be the problems once the embargo on mental illness is lifted.

The introduction of MAID for those whose sole underlying disease was mental illness created yet another level of disagreement among nurses about whether this was a morally acceptable option.

I haven't figured it out yet. I haven't reconciled that piece yet. It's the temporal proximity thing. Like if I have a 19-year old with an eating disorder who has suffered for five years that's ugly and I am a compassionate human being I think. I don't like the idea of someone suffering for five years. But is it irremediable? Is there something to be fixed? It's not like cancer. How do you have that same equivalency? Or is it just that the person says, "I have suffered enough." [RN 38]

Overall, however, the reasons participants provided for disagreeing with MAID when mental illness is the sole underlying condition were related to failures within the mental health system in Canada. It is not an exaggeration to say that participants viewed the availability of mental health supports in Canada as abysmal.

I'm working with people who barely have access to psychiatry, much less access to more than two counselling sessions, so I think it puts our society in a very ethical quandary about respecting patients' autonomy on one hand to make decisions about their life. It's super unfortunate and heartbreaking and a failure of the broader society that they don't have unlimited access to resources that might help them. [NP 104]

Participants were aware of the importance under the law of not treating those with psychiatric conditions differently than those with physical conditions. However, they pointed out that, pragmatically, the inequity was already embedded deeply within the health system. "The fact that the medical system separates mental illness from physical illness is already very strange" [NP 62]. The broken nature of the mental healthcare system was seen to have very real implications of whether the ideal of equal rights under the law could be achieved. "What is it? Like 8% of all healthcare funds go to mental health. Like there really should be more resources into peoples' mental health because we all have issues" [RN 62]. This same participant went on to expand.

It's going to create a lot of unnecessary tension and frustration when we have people who are wanting to access MAID because they have been on a waitlist for three years for a psychiatrist who only deals with this particular condition and you can talk to the MAID team in three business days. So, we have to align our expectations appropriately. But how do you work within a system that doesn't value mental health? [RN 62]

Participants described the complete absence of mental health supports in some geographic areas of Canada and the extended wait times even in urban areas for receiving specialized psychiatric services. "It feels so unfair to make something like MAID so accessible but stable housing and substance use disorder programs and things like that are waitlisted with barriers all over the place. That feels wrong" [RN 11].

Participants described the many system issues that were going to make safe and ethical care of this new group of applicants particularly challenging. The first was workload for the mental health system.

There are not a lot of psychiatrists in the public system who are sitting around eating bon bons. It just feels like a numbers game. It was bad before the pandemic and now it is worse. If you are booking people for a preliminary assessment, it is six months which is insane. [NP 104]

Another participant described the impact of the opioid crisis. "Psychiatrists are few and far between. And they are already

stretched thin with the fentanyl crisis and the drug overdoses and the mental health associated with that. And so where do we find people to do that work” [NP 13]? Further, these already existing shortages would be exacerbated by those who disagreed with MAID as an option for their patients. “It’s very difficult to get a psychiatric assessment for a person who is relatively well—in some regions almost impossible. So, you add MAID into that and then you have conscientious objectors” [NP 30].

The second issue was the workload for the MAID system. MAID coordinators described the complexity and time intensive nature of the initial phone calls when mental illness was the sole underlying medical condition for applicants; these potential applicants were already contacting coordinators in anticipation of the legislative changes. Coordinators were anticipating being inundated with such calls and they were unsure about how they were going to manage.

Our health region already has high MAID rates and they will skyrocket even more. We have a large population of very vulnerable people who don’t have their needs met in a meaningful way and our numbers will increase and accessibility will increase, and I think provider distress will increase if more people are electing this kind of end-of-life, particularly if they can’t access support they need for even a baseline quality of life. [RN 11]

Those acting as assessors described difficulties they anticipated in getting adequate information about applicants.

People who are assessors take their job very seriously. But a lot of people with mental health illnesses don’t necessarily have a practitioner they have been seeing for 20 years. They move around and access walk-in clinics or specific places and so it’s very hard to get documentation of what they have tried and to assess properly. [NP 13]

A number of participants spoke of best practices for assessment being a case management system in which a dedicated healthcare provider worked carefully with applicants over time to ensure the integrity of the choice. This was seen as particularly important in light of the complicated relationships that can develop between healthcare providers and those who have been in the mental health system for years.

Those patients use a lot of resources and time, something that physicians don’t usually have and they frown upon people taking more of their time. So, my worry is that this will complicate assessments by their primary care provider. It’s not going to be an objective assessment. [RN 82]

However, they recognized that case management could be intensely difficult in a siloed system, particularly when the mental health system was already overburdened. The need to work proactively with the mental health system was described by a number of participants.

We really need to start working with mental health teams now before this comes into law and make sure there are pathways for both MAID assessors and providers and mental health providers to follow and easily available to guide practice. [NP 36]

They recognized that this was unlikely to happen prior to the lifting of the embargo, which is anticipated to take place in March 2024.

Overall, it did not matter whether participants agreed that MAID should be available to this population on legal and human rights grounds. Many felt it was unethical to provide access to MAID when access to mental health treatment was unavailable. Some were anticipating further legislation or regulation to clarify additional eligibility criteria and safeguards—even though this was unlikely to be the case. “I think people are waiting for leadership from the government of what the guidelines will be” [RN 112]. The perceived lack of guidance in caring for this population caused a great deal of anxiety. As one participant predicted the pending change was going to be a “real nightmare” [NP 13]. In her opinion, the conscientious way in which assessors currently went about their work was going to be deeply challenged by changing the eligibility criteria to include mental illness as the sole underlying medical condition. Another participant described her perceived sense of gravity of the situation.

This is the biggest decision that someone can make in their life, ending it, so I want to make sure that I’m doing right by my patients and the law and our principles and you know it’s complicated. I’m not against it but it’s complicated and I have reservations. [NP 36]

Discussion

The purpose of this study was to explore the implications of the evolving MAID legislation in Canada from the perspectives of nurses. Changes in legislation require changes in practice on the ground, and it is important that those affected by those changes have a voice. Findings from this study point to three important consequences of legislative developments for nurses and nursing practice: taking a risk-centered versus a person-centered planning approach; moving the goalposts on conscientious participation; and ensuring adequate systems.

A Risk-Centered Versus Person-Centered Planning Approach

Since the early days of the legislation, nurses were discouraged, and under some provincial policies forbidden, to introduce the idea of assisted dying to their patients (Pesut, Thorne, Greig, et al., 2019). Instead, they were required to listen for cues that might indicate that someone was inquiring about assisted death and to respond to those cues cautiously so that they would never risk being seen to encourage, solicit or

incite MAID, which might mean the illegal act of counseling to commit suicide. This resulted in nurses adopting a risk-centered approach to care in which they focused on not breaking the law rather than a person-centered approach in which they focused on communicating what was most relevant for this person at this time of their illness trajectory. It is not surprising that a study exploring nurses' experiences with MAID in the Quebec context indicated that some nurses felt they lacked the tools to communicate well in this unique situation (Hébert & Asri, 2022).

There are several assumptions inherent in policies that prohibit nurses from introducing the topic of MAID. First, that nurses are incapable of recognizing when information about MAID, outside of an explicit request, might be appropriate. Second, that nurses cannot conduct those conversations in a way that patients would not feel coerced. And third, that nurses are unlikely to have to respond to implicit or veiled requests, or ones in which patients did not use the precise phrasing perceived as being needed to open a MAID discussion. Such assumptions placed nurses in a difficult bind in the early days of the MAID legislation—they were torn between responding to patient cues in situations in which the patient might have viewed MAID as a good option and the legal risks of doing so if they were found to be counseling to commit suicide (Canadian Nurses Protective Society, 2021). However, over time the practice of introducing MAID as part of regular and acceptable advance care planning has become more common (Canadian Association of MAID Assessors and Providers, n.d.). Nurses in this study further explained that it was important to introduce MAID in a proactive manner in a context that was not itself a transitional decision point so that persons who would potentially be eligible would be informed of all the legal end of life options available to them; to not do so would be to violate two core principles of Canadian healthcare—that of equity and accessibility (Tiedemann, 2019).

NPs in this study had clearly gained greater comfort over time with introducing the topic of MAID with persons who were part of their primary care practice. What was particularly revealing in these findings was that nurses felt that by doing so they were preventing coercion rather than risking it. They recognized that within a person-centered approach the potential for coercion is far more likely when the topic of MAID is introduced during times of transitions such as entry into long term care or significant health declines. Such precarious times of transition or crisis were recognized as precisely the wrong time to be having a conversation about MAID. By introducing the topic during times of stability, nurses were best able to discern whether this option might or might not be in keeping with long-held patient values. Further, nurses had learned how to introduce the topic in a neutral way alongside other options so that patients could immediately identify whether such an option was acceptable to them or in alignment with their values; the nurses would then know if it would be approach to broach the topic again

at a future time. This approach is a radical departure from the sensationalized accounts in which raising the topic of MAID has allegedly led to patient harms and fear of accessing healthcare (Coelho et al., 2023) and supports other empirical findings in which knowing about end-of-life options empowers patients (Variath et al., 2022).

It was also apparent from descriptions provided by participants in this study that nurses were doing a different type of advance care planning than what might be considered medical advance care planning. They were focused on quality of life rather than medical scope of treatment. In Canada, medical orders for scope of treatment are part of current goals of care conversations; whereas advance care planning focuses on future events (Mallidou et al., 2022). Even though in this study MAID was introduced as a medical treatment option as part of advance care planning, it was done within an ongoing conversation about what patients valued most and how that was being influenced by their declining health. Yet, nurses also acknowledged the time-intensive nature of these conversations and how difficult it was to conduct them within busy healthcare environments and to document such patient-centered conversations for other healthcare providers to see. Physicians in Canada similarly cite lack of time and difficulty sharing advance care plans as two of the most significant barriers to advance care planning (Howard et al., 2018). The siloed nature of communication in Canadian healthcare clearly has serious implications for MAID conversations. The startling example in this data of the person who had been asked about MAID multiple times by different healthcare providers alerts us to the serious impact such an experience could have if that information-sharing was interpreted as being recommendations of those healthcare providers. So even though nurses in this study were clearly comfortable with integrating considerations of MAID into their role of advance care planning, they also perceived serious limitations to that practice from a system perspective. Other Canadian studies of nurses' experiences indicate that workload, team support, and effective communication determines whether a MAID death is perceived as satisfying or stressful (Hébert & Asri, 2022).

Moving the Goal Posts on Conscientious Participation

The legalization of MAID created divisive and emotionally charged nursing environments, particularly in the early days after the legislation first passed (Pesut, Thorne, Schiller, Greig, & Roussel, 2020). In one Canadian study, nurses perceived MAID as more divisive than their pharmacist or social work colleagues (Mills et al., 2020). Under the law, nurses could declare conscientious objection, but doing so had the potential to negatively impact patient care and their colleagues, and so this was a difficult stance for nurses to take (Pesut, Thorne, Schiller, Greig, & Roussel, 2020). An interesting counterpoint to those who declared themselves to

be conscientious objectors were those who declared themselves to be conscientious participators, those who participate in MAID on the basis of conscience. In using the term conscientious, participators too were naming their moral stance in relation to MAID (Allyson & Andrea Nadine, 2021). However, in addition to those who clearly positioned themselves in the realm of conscientious there were many nurses who were still trying to make sense of their position in relation to MAID. The evidence on why healthcare providers choose to participate in MAID, or not, indicates that many factors such as professional identity and experiences, personal values and identity, social relationships, and organizational context could influence this decision (Brown et al., 2021a, 2021b; Oliphant & Frolic, 2021; Pesut, Thorne, Storch, et al., 2020).

Findings from this study, and others, suggest that this work of moral sense-making is an important part of participating in MAID (Beuthin et al., 2018) and that it continues with each evolution of the MAID eligibility criteria (Pesut et al., 2021). Participants in this study indicated that the extension of MAID to those whose natural death is not reasonably foreseeable, and the anticipated extension to those for whom mental illness is the sole underlying medical condition, have challenged their beliefs about whether MAID is still a morally acceptable option in those extensions. However, this moral tension is not about whether one should hasten death or not; it is now about the social and structural factors that have the potential to exacerbate suffering beyond that directly caused by the serious illness, disease, or disability directly. Participants were concerned about healthcare harms that could be done to those who were particularly vulnerable, such as frequent users of this system, those for whom there were no clear diagnoses or failed treatments, and those who used substances. These were the patients who were stigmatized and labeled as problematic within the system and hence were felt to be more likely to believe they had no viable choices remaining other than MAID. Participants were further concerned about the system's longstanding failure to effectively serve those with particular needs, specifically the lack of health and social care services for those living with chronic medical conditions and disabilities, and most notably the serious gaps in available mental health services.

Here is where the tension between MAID as a legal option and an ethical option becomes most apparent. The evolving MAID legislation has occurred as a result of a series of legal challenges in which human rights, as defined by the Canadian Charter of Rights and Freedoms, have been negotiated in Canadian courts of law. The ethical tensions nurses struggled with in this study were not related to individual freedoms but rather to systemic and structural barriers that limited or constrained those individual freedoms. In other words, they felt that there were healthcare equity issues at play that needed deep consideration in relationship to a legal framework that highlights rights and freedoms. The Canadian Nurses' Association Code of Ethics for Nurses emphasizes nursing

responsibilities for advocating against health inequities and so it was not surprising to see this reflected in the data (Canadian Nurses Association, 2017). Although nurses in this study did not always name this legal/ethical tension as such, each time they highlighted personal constraints (e.g., stigma, problem patients) and structural barriers (e.g., time, services, resources) and their subsequent implications for a decision regarding MAID, they confirmed that those concerns challenged their ideas about whether MAID was a morally acceptable option. We can anticipate that these ethical challenges will become more prominent when the anticipated amendments regarding mental illness as the sole underlying medical condition take effect in March 2024. In preparation for this change, model practice guidelines, launched after this study was conducted, have been created by Health Canada (Health Canada, 2023b). Although structural and systemic barriers are addressed within these guidelines, such barriers do not necessarily have to be removed prior to a person being found eligible for MAID. For example, there is no legal obligation to ensure that applicants have received evidence-based treatment if that treatment is unavailable or inaccessible. In such an environment, nurses will increasingly be placed in tension between their legal and ethical obligations.

Ensuring Adequate Systems: The Most Important Safeguard of All

The acceptability of MAID as a treatment option is typically debated within a legal and ethical framework with little consideration of the robustness of the system within which it is being implemented (Pesut, Thorne, Schiller, Greg & Roussel, 2020). Yet, that system determines to large extent whether the legal and ethical considerations can be fulfilled properly, and system-level challenges have the potential to exacerbate the potential vulnerabilities of those who might be eligible for MAID. In the early days of the MAID legislation Canadian healthcare professionals became increasingly concerned with the robustness of the palliative care system (Canadian Society of Palliative Care Physicians, 2019). A recent review indicated that in the context of MAID and mental illness concerns arise around the adequacy of the societal context, healthcare system, and continuums of care (Favron-Godbout & Racine, 2023). In 2020, about one in five Canadians reported needing mental healthcare and 50% of those individuals felt their needs were unmet (Canadian Institute for Health Information, 2023b). However, participants in this study also acknowledged other pressing and influential challenges: physician shortages and lack of a robust primary care system that leads to orphaned patients; siloed communication between providers that make it difficult to access and share key patient information; a fee-for-service model that disincentivizes important patient/provider communication; and complicated or missing care systems that require extensive navigation (Canadian Medical Association, 2022; House of Commons Standing Committee on Health, 2023). Layered on to this is Canada's

vast geography where rural and remote citizens routinely suffer from lack of health and social care services (Canadian Medical Association, 2022). The question of course is whether such system-level barriers will disproportionately influence patients' decisions to choose MAID.

When MAID was legalized in 2016, the approach taken to who would provide services was different from that of other countries. In Canada, MAID is frequently provided by teams who do not know the patient and family until they are called in to perform a MAID assessment. This differs from the approach used in countries such as Belgium where euthanasia is typically provided within the primary physician/patient relationship. Such a team-based approach was necessary in Canada because so many primary care providers chose not to be involved and hence accessibility for patients was a predictable problem (Frolic & Oliphant, 2022). For example, as the growth in MAID provisions increased by about 33% annually, the number of unique MAID providers only increased by about 18% annually (Health Canada, 2023a). While this team approach has worked reasonably well for those whose natural death is reasonably foreseeable, participants in this study indicated that it may be far more challenging for those whose death is not reasonably foreseeable, those referred to as the Track 2 applicants. Getting access to good information about, and navigating services for, these complex clients may be difficult to do well within the limitations of current MAID delivery systems. In a recent book written by an experienced Canadian MAID provider, the challenges that MAID providers encounter when they are placed in the difficult role of having to assume primary care responsibilities for applicants are clearly highlighted (Marmoreo & Schneller, 2022).

However, even as participants described such challenges, they described a model of primary care that worked well. Within a primary care relationship, nurses were able to sensitively and diplomatically conduct ongoing advance care planning discussions, discern when a waiver of consent might be appropriate, work alongside families with whom they had pre-existing relationships in the event of enacting a waiver of consent, and advocate for resources and services for their clients over time. In doing so, they were able to apply the eligibility criteria and safeguards in a careful and reasoned way that is far more difficult to accomplish outside of a primary care relationship. Findings from the current study, and from other empirical work, indicate that one of the most important safeguards, particularly for Track 2 clients, may indeed be a robust primary care relationship that provides holistic care and sufficient time to provide such care (Brown et al., 2022). There are innovative and creative ways to ensure that those applying for MAID under Track 2 have access to care providers, including nurses, who can work alongside them to ensure that their choice of MAID is for the right person, at the right time, and for the right reasons.

Conclusion

This paper provided an interpretive account of registered nurses' and nurse practitioners' experiences with the evolving MAID legislation. Participants described how they negotiated sensitive conversations about MAID as part of advance care planning while avoiding critical patient transition times. They described the moral complexities inherent in waivers of consent when patient suffering was no longer visible. Although many nurses had reconciled themselves to the different nature of Track 2 MAID applicants, assessing those clients required significant clinical judgment that depended upon access to good information and treatment options. The perceived inadequacies of the health and social care system for those living with mental illness generated significant moral tension as participants anticipated caring for these clients. The most significant finding related to the importance of robust systems in meeting the legislative requirements. Seamless communication among healthcare providers, primary care providers that could do case management outside of a fee for service system, and mental health practitioners willing to be involved were factors that were perceived to be essential for nurses to meet their legal and ethical obligations in the context of MAID.

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Supplemental Material

Supplemental material for this article is available online.

Notes

1. *Criminal Code*, R.S.C. 1985 c. C-46, ss. 241.1-241.4
2. *Criminal Code*, s. 241.2(3.2).
3. *Criminal Code*, s. 241.2(3.2).
4. *Criminal Code*, s. 241.2(2) and (2.1)

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