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The moral web of accessibility to medical assistance in dying: Reflections from the Canadian context

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Abstract

In this paper, we reflect on factors that seem to have influenced the accessibility of medical assistance in dying (MAID) in the Canadian context. Since legalization in 2016, the uptake of MAID has increased rapidly to equal or exceed rates in other countries. In that MAID implementation involves numerous ethical/moral complexities, we consider four factors that appear to have influenced this growth. First, we reflect on the vague language contained within the legislation that has been interpreted by a community of practice in which making MAID accessible is an important priority. Second, we consider policies of effective referral and self-referral that have been strategies for enhancing accessibility in relation to a wider context that contains conscientious objection. Third, we examine the apparent impact of centralized clinical teams and coordination services that have enhanced accessibility for persons residing in rural and remote areas. Fourth, we reflect on ways in which public awareness of MAID has been enhanced through policies that enable healthcare providers to introduce the topic of MAID as an option within advance care planning. We conclude with a consideration of how these intersecting factors may be shaping the moral complexity inherent in the idea of making MAID accessible.

Keywords

Euthanasia, medical assistance in dying, Canada, accessibility, healthcare

Introduction

Assisted death, or medical assistance in dying (MAID) as it is called in Canada, has experienced significant developments since legalization first made provision for it in 2016. Uptake has increased rapidly to represent 4.1% of all deaths in Canada with some Canadian provinces reaching as high as 6.6% of all deaths (as of the

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most recent national report).[1] Expanding the eligibility criteria since first legislation has resulted in some of the most liberal MAID laws in the world.[2] In this essay, we explore some of the factors that have influenced the accessibility of MAID in the Canadian context. To set the stage, we begin with a brief description of how healthcare is organized and governed in Canada. We then reflect upon the implications of four key accessibility factors related to Canada's unique context: the legislation, conscientious objection, Canada's rural and remote geography, and public and healthcare provider knowledge of MAID. We will conclude with reflections on how work on reducing these barriers to access is exposing further layers of moral complexity that may also have implications for nursing work in relation to legalized assisted dying in other national contexts.

The observations and reflections we make in this essay have been informed by our position as researchers on what can be learned about MAID from the perspective of nurses who engage with patients contemplating or seeking it. We began this work shortly after the legislation and have continued it throughout in a series of studies involving interviews with nurses that have been published elsewhere (and will be referenced throughout this discussion). Some of the registered nurses and nurse practitioners we have interviewed over these years incorporate MAID-related care into their everyday practice, others work in MAID coordination positions, and yet others act as independent MAID assessors and providers. Yet others have been conscientious objectors whose focus has been on maintaining professional standards in contexts in which they provide care for patients who may be on a path toward MAID. Because nurses often have access into the operations of whole systems that are simply not available to those healthcare providers whose interaction with patients is limited to specific points within the system, these nursing perspectives have often included insights about accessibility.

We have learned over this time that no writing in this area is entirely amoral or apolitical. Much of the published work on MAID in Canada or comparable practices elsewhere reveals clear standpoints on the inherent morality of the practice itself or on its various manifestations. We have tried in our own work to be mindful of the various moral stances we encounter without judgement on their rightness or wrongness. And we fully appreciate that all who work directly or indirectly in MAID practice come from a particular moral stance that influences what they see as necessary and acceptable. That in turn shapes their understandings of concepts, even those that are relatively morally uncontested such as accessibility. In Canadian healthcare, accessibility to care is generally accepted as an unquestioned moral good. But, when that accessibility is applied to MAID, the debate tends to change. If one is in favor of MAID, then rising MAID rates are viewed as a moral good because it means it is increasingly accessible to those who need it.[3] If one is opposed to MAID, then rising rates of MAID are indicative of a slippery slope of moral decline.[4] Therefore, we recognize that all observations about accessibility, or lack thereof, will be a product of how we perceive and interpret data.

Through listening to nurses over these years, we have deepened our own awareness of why MAID has become important to so many Canadians. Such insights have shifted our own understandings of what it means to suffer intolerably and for healthcare providers to witness suffering that cannot be relieved. Within this context, we have inevitably found ourselves reflecting on MAID within the Canadian context, and the manner in which MAID accessibility influences the health and well-being of those seeking it as well as those who care for them.

Background to MAID within Canadian healthcare

Canada is a country of 10 provinces and three territories. Although MAID is legislated at the Federal level, responsibility for enacting healthcare lies with the provinces and territories. The Federal government contributes to provincial and territorial healthcare funding based upon guiding principles for the delivery of healthcare outlined in the Canada Health Act.[5] This Act establishes the legislation for publicly funded healthcare insurance; MAID is an insured healthcare service in Canada. The Act also establishes conditions and criteria which must be met for the provinces and territories to receive their full federal cash contributions. A key criterion under the Act is that of accessibility which is meant to "ensure that insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances)." [p.4] However, it is important to note that accessibility in the Act is interpreted according to a *where and as available rule*. Canadian residents are "entitled to have access on uniform terms and conditions to insured health services at the setting 'where' the services are provided and 'as' the services are available in that setting." [p.4] This then does not imply that insured services must be accessible in every setting.

When MAID was legalized in 2016, accessibility was influenced by the degree to which provinces and territories were proactively prepared with policies, procedures, and practice supports. Such preparedness varied widely across the country.[6–8] Our research is full of accounts of policies and procedures being created in response to the earliest patient requests for assessment of eligibility for MAID.[9] Nurses, physicians, social workers, and pharmacists were often seconded to play a role in MAID delivery with little educational or emotional preparation for this specialized practice.[9] Recognizing that many healthcare providers would refuse to participate in MAID, either for reasons of conscience or competence (such as in determining eligibility), some health regions took the step of creating centralized services and/or teams to ensure that MAID was accessible throughout their jurisdiction.[10] Typically, keen supporters of MAID provided leadership for these teams and one of their primary goals was to ensure timely and accessible MAID assessments and provisions. As these systems evolved, one of the first barriers to accessibility was ensuring standardized clinical interpretation of what was remarkably unclear legislative language about what constituted eligibility.

Accessibility and eligibility criteria clarity

Under the original 2016 legislation, MAID applicants were required to have a grievous and irremediable medical condition for which *natural death has become reasonably foreseeable* and to be *in a state of decline causes enduring physical or psychological suffering that is intolerable and cannot be relieved under conditions that the persons considers acceptable* (among other criteria).[11] It was remarkable how such carefully crafted legal language could be so unclear from a clinical standpoint.[12] For example, whereas in other countries eligibility criteria include a designated time until death (e.g., 6 months to live), in Canada the determination of reasonably foreseeable natural death was left to the judgement of the clinician doing the assessment.[11] For example, one assessor might interpret this as final weeks until death while another might interpret this to mean years until death as long as the trajectory was clear (e.g., in the case of progressive neurological diseases).[13] This variability in clinical interpretation influenced the accessibility of MAID for applicants and led in some cases to "assessor shopping" in which some applicants continued to seek assessments from different assessors until the requisite two assessors found them eligible for MAID.[14] Despite acknowledging this possibility, in recognition that many conditions progress over time or are interpreted differently by different health specialties, some health region policies specify that there are no restrictions on the number of assessments an applicant can have.[15] It is important to note that health regions may be reluctant to impose barriers to access that are not specified in the MAID legislation because these barriers may then be subject to legal challenges.

Clinical clarity about what constituted a reasonably foreseeable natural death and the subsequent problems of inaccessibility by virtue of that definition were resolved in three ways. First, MAID coordinators became astute at recognizing who the assessors were that would apply more generous clinical decision-making and made referrals to those assessors when cases were more complex.[14] Second, experienced MAID assessors across the country formed a community of practice in which they could discuss and mentor one another into a common clinical interpretation.[13,16] Ultimately, the legislation was modified in 2021 to exclude reasonably foreseeable natural death as an eligibility criterion, although assessors are still required to indicate whether the person applying has a reasonably foreseeable natural death (referred to as Track 1) or not (referred to as Track 2) because the safeguards vary depending upon the Track to which the applicant is assigned. For example, Track 2 cases require special expertise in the patient's condition as a part of the assessment and a significantly extended assessment and waiting period until MAID provision.[17]

Another eligibility criterion that has been difficult to interpret is that of enduring physical or psychological suffering that is intolerable and cannot be relieved under conditions that the person considers acceptable. Again, clinicians were required to determine a standard of what constituted suffering intolerably and that in turn would determine whether or not they thought persons were eligible for MAID. For example, in some cases, a clinician might determine that their patient was not suffering sufficiently to quality for MAID while another might believe that intolerable suffering was whatever the patient said it was. Some of this interpretation was shaped by various healthcare providers' experiences of witnessing suffering.[18] We know that being in close relational contact over time while patients are suffering with no means available to relieve that suffering leaves indelible memories on healthcare providers. Nurses we interviewed could recount those experiences in great detail even though they may have occurred years prior and said that witnessing such suffering was one of their major reasons for being morally comfortable with assisted death.[19] However, some of these nurses also observed that MAID applicants were not necessarily presenting with the intractable suffering that was characteristic of their past clinical experiences. Some of the most difficult stories we heard were from nurses attending to support home deaths completely unprepared to have the person scheduled to receive MAID appearing relatively free of any visible manifestations of suffering and even cheerfully welcoming them at the door.[18] Such experiences challenged them to reframe their conceptualization of what intolerable suffering ought to be in the context of MAID eligibility.

This need to reframe the criterion of intolerable suffering was an unintended effect of the legislative safeguards. Under the original 2016 legislation, MAID applicants were required to have a 10-day waiting period between the final assessment and the provision (except in specific urgent circumstances).[11] Further they had been required to give final verbal consent just prior to the administration of the medications that would cause death.[11] This meant that patients had to maintain cognitive capacity for at least 10 days after the required assessments had been completed. This effectively disqualified those from MAID who reached the point of the intractable suffering that clinicians had seen in their previous practice as, if it had reached that point, persons were typically incapable of giving final consent. Too often MAID applicants and family would prepare themselves for a MAID death only to have the patient lose capacity. For those opposed to MAID, this might seem like a preferable outcome, but it is important to recognize that for those who choose MAID as an expression of their dignity and autonomy at end of life, losing that option can be deeply disappointing.[21] Understandably, this conundrum led many healthcare providers to further ponder the irony of requiring persons to experience the very suffering they were hoping to avoid.[13] Ultimately, MAID coordinators, assessors, and providers sought ways to schedule assessments and provisions in a rapid and timely manner so that the MAID for which they were deemed eligible would remain accessible for patients.[20] Challenges related to the definition of intolerable suffering have also been resolved in several ways. In the 2021 legislation, the 10-day waiting period was removed for those whose natural death is reasonably foreseeable and there is now allowance for a waiver of final consent when specific conditions have been met.[17] This means that assessors and providers no longer have to worry about patients coming to the point that suffering, and the treatment required to manage that suffering, results in applicants no longer being eligible for a MAID death. Additionally, over the years since legislation, the community of MAID practitioners has forged considerable agreement on what intolerable suffering constitutes in the context of MAID, recognizing that it includes some of the psychosocial and existential suffering that can accompany physical disease and disability.[13] This standard is evident in the federal reports. Fully, 86.3% of patients seeking MAID acknowledge these emotional and existential sufferings as their primary reason for their request.[1] This is not, therefore, the kind of intractable suffering on a more physical basis that so many healthcare providers had witnessed over the course of their careers but rather reflective of a series of losses that attend declining health that at some point becomes intolerable to the person experiencing them. In a practical sense, this means that MAID assessors, although interested in witnessing and recording the suffering story, are not there to judge that story as part of their eligibility assessments. This in turn makes MAID accessible to a broader population of persons in that applicants are not required to "prove" their suffering but rather to provide a credible narrative account of it and demonstrate a convincing case that their efforts to resolve it have not been successful.

Accessibility and conscientious objection

Accessibility to MAID has been influenced by the right of healthcare providers to not participate in MAID, and the presumed rights of faith-based institutions to not allow MAID assessments and/or provisions within their institutional walls. The MAID legislation provides allowance for conscientious objection for the protection of healthcare providers for whom MAID is an unacceptable moral option. Section 241.2 of the Criminal Code states, "For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying." Subsequent policies provided by professional associations and health regions typically provided further explanation of what it means to conscientiously object to MAID[8] although some would argue that such policies are inconsistent and vague.[22] Policies generally emphasize that this moral position must be both enduring and well thought out.[8] In Canada, those who have conscientiously objected often did so for reasons of faith or philosophy. For example, some palliative care providers have objected on the grounds that assisted death contravenes the established palliative care philosophy of neither delaying nor hastening death.[23]

Laws and policies that protect conscientious objection do so on the grounds that to participate in MAID against one's moral principles would constitute harm.[24] As such, they were meant to protect the well-being of healthcare providers. The practical impact on accessibility was predictable; those who conscientiously objected had to determine the degree of participation in MAID that they could morally tolerate. This could include, for example, refusing to acknowledge a patient's request for MAID or refusing to initiate an intravenous line that could in future be used for MAID administration. In the early days of the legislation, there were even instances where conscientiously objecting nurses were granted time off if a patient was receiving MAID on their nursing unit that day.[9] However, sometimes conscientious objection on the part of healthcare providers became a more active form of gatekeeping to prevent patients from accessing MAID assessments. Examples we heard about from nurses included physicians suggesting to patients that they would not yet qualify when potentially they would have, threatening to remove care if patients pursued the option of MAID, or advocating for palliative sedation so that patients would be less inclined to choose MAID.[9]

Such accessibility barriers related to conscientious objection have been addressed in several ways. First, health regions and regulatory bodies have created effective referral policies in which even conscientiously objecting healthcare providers and institutions are required to ensure that patients requesting MAID have access to someone who will evaluate their request.[7,25,26] Second, nursing policies were created that required conscientiously objecting nurses to continue with regular care except during the moments of MAID provision.[8] Third, the widespread implementation of MAID coordination services and the ability of patients to self-refer to these services helped to address, in part, the gatekeeping barriers set up by individual healthcare providers.[10] Although it would be unrealistic to think that all of these gatekeeping barriers have been resolved, our most recent interviews with nurses suggest that healthcare providers have become more accepting over time of the rights patients have to choose this option even if they don't agree with that option.[27]

Despite these steps forward, the challenge of accessibility if one is receiving care within a faith-based institution that limits assessments and/or provisions (not all do) remains to be solved. A significant portion of healthcare in Canada is delivered through faith-based organizations who receive public funds for that care.

These faith-based organizations are often major providers of palliative and end of life care, including long-term care where older persons with complex needs are cared for. In some communities, faith-based institutions may be the only providers of palliative or long-term care. These are, of course, the same institutions where a high number of persons requesting MAID are likely to reside. In many cases, there are long-standing agreements between these faith-based organizations and provincial and territorial governments that specify the rights of these organizations to their faith-keeping principles. Solving the challenge of accessibility for patients residing within these institutions has therefore been complex.[28,29] Because these institutional providers play a critical role within the overall health service delivery system, it would be challenging for publicly funded entities to assume responsibility for the totality of those services. On the other hand, it is unrealistic to change long-standing theological commitments that may be determined at a global level (e.g., in the case of Catholicism), and to try to do so would undermine the very purposes for why these organizations exist.

Accessibility to MAID for persons residing in these institutions has been advanced in several ways. Institutions are required to make visible their MAID policies so that patients are well informed prior to selecting that institution as their place of care.[7] This may do little to help those for whom there are no other care options. Another conciliation on the part of a number of these faith-based providers has been to allow arrangements for the conduct of MAID assessments and/or provisions for their patients off site. There are examples of institutions who have created spaces that, while nearby or co-located with the faith-based institution, are nevertheless considered separate (and secular). Such forced transfers, however, can put undue burdens on patients and families during an intensely vulnerable time.[30] A court challenge of such practices is now underway,[31] allowing for a critical consideration of whether conscientious objection, which is a right of individuals, can be rightly claimed on behalf of institutions.[28]

Finally, it is important to note a key limitation of policies related to conscientious objection. An underlying assumption of these policies is that the healthcare providers would be able to identify themselves as conscientious objectors or not. Evidence from the last 7 years in Canada indicates that this all or nothing approach is not characteristic of a significant percentage of healthcare providers' decision-making.[32,33] Rather, learning ones' moral positioning in relation to MAID often evolves and is refined over time, with experience, and within a collegial community of practice.[19,34] Further, the legislation that expands MAID to more populations results in healthcare providers having to rethink their involvement in MAID, questioning whether MAID is a moral good within the new contexts in which it is becoming theoretically possible.[14] This means that healthcare providers are continually weighing the moral good of MAID within the particulars of a case. Practically, healthcare providers must be able to step away from particular cases of MAID that cause them moral distress. While some persons requesting MAID may indeed meet eligibility criteria under the law, individual healthcare providers may recognize circumstances with respect to the case that they cannot reconcile morally. A classic example would be where healthcare services to relieve patient suffering are simply not available.[35] If healthcare providers are unable to withdraw from cases they cannot reconcile morally, then they become reluctant to be involved in MAID at all. This has led to speculation about whether accessibility to MAID will become increasingly difficult as the eligibility criteria expand.[27,36]

Accessibility and geographic location

Canada has a vast rural and remote geography; roughly 30% of the population lives in rural and remote areas. One of Canada's greatest challenges has been ensuring access to healthcare services for these populations. However, given the distinctive legislative context in Canada in which MAID became legal as a response to a challenge to Canada's Charter of Rights and Freedoms, ensuring access to MAID if one is eligible has taken on a quite different urgency than has been the case for the slowly evolving process of expanding rural and remote access to other services.[37]

Rural healthcare providers in general face the perennial challenge of trying to be competent generalists in an increasingly specialized world. Much of that competence is determined by whether they do a particular procedure often enough with enough support and mentorship to feel competent, and performing MAID assessments and provisions is no exception. One of the strategies used by provinces has been to establish centralized MAID coordination services and to provide funding for assessors and providers to travel for care. This model has advantages. Potential MAID applicants have accessibility even if they live remotely, and health providers working within such services have a sufficient case load that enables them to gain expertise and competence in MAID assessment and provision.

However, using a centralized service for the assessment and delivery of MAID has been less than ideal in other ways. Assessors and providers must do their work without prior knowledge of the patient and family. They are essentially assessing strangers and must do so in a relatively brief period of time. Determining eligibility, particularly for those who do not fall within Track 1 of having a reasonably foreseeable natural death, becomes far more challenging without the benefit of direct knowledge of the patient's long-term trajectory. Further, there may be only brief intervals within which to establish therapeutic relationships with patients and family amidst what is an emotionally intense, and for some families, a traumatic experience. Thus, providing MAID-related care outside of the context of an established primary care relationship poses unique challenges.

Despite these limitations, the centralized service has been an important strategy for ensuring accessibility when primary care providers in a particular rural area will not be involved in MAID either for reasons of conscience or because of the dual relationships of professional and friend that can occur in smaller communities. Because rural areas are typically served by small numbers of primary care providers, an individual provider's decision not to be involved in MAID may create a disproportionate effect on patients.[38,39] Outside of a centralized service, there may be no access to MAID unless patients travel outside of their community, which in many instances is neither feasible nor reasonable.

For rural practitioners, however, the reasons for not providing MAID-related care may be more pragmatic and related to their reputation in the communities within which they practice.[38] In an urban center, it is quite feasible to perform the roles of MAID assessor and provider without your immediate community knowing that you do so. However, this anonymity is simply not possible within the socially connected relationships characteristic of a rural community. In such instances, members of the community who believe that MAID is a moral wrong may also question the integrity of those rural healthcare providers who participate in it, thereby becoming reluctant to receive any form of care from them. We have also learned that the stigma of being a rural healthcare provider who participates in MAID can extend beyond the realm of healthcare into social relationships, in some instances negatively impacting healthcare providers' relationships with their own family members, friends, or faith communities.[38] Therefore, the decision to take on the role of MAID assessor and provider in a rural community can be highly complex on many levels.

Despite these complexities, some healthcare providers do commit to taking on this work because they believe that rural and remote patients should have accessibility to MAID. However, these assessors and providers are more likely than their urban counterparts to perform this role independently and/or with limited support. From the poignant stories of nurses we have interviewed, we have come to understand the enormous personal cost that this commitment to accessibility entails for some of these providers.[9,19]

Accessibility and publicly available knowledge

Perhaps one of the greatest accessibility barriers in the Canadian context has been a lack of public knowledge of MAID as a legal option and a lack of healthcare provider knowledge about MAID eligibility criteria. Surveys of the Canadian public have revealed significant knowledge gaps in relation to MAID.[40] These gaps have been exacerbated by some healthcare providers' reluctance to discuss MAID as an option for fear of running afoul of subsection 241(a) of the Criminal Code that makes it a criminal offense to “counsel” a person to commit suicide. Healthcare regulatory organizations have outlined what they believe this phrase means. For example, the Canadian Nurses’ Protective Society cautions nurses “must be mindful not to encourage or incite a patient to seek MAID” and to refrain from participating in written requests.[41]

One can easily imagine the effect that this counseling to commit suicide language has had on patient accessibility to MAID. In the early days after the legislation, much of the public was uninformed about this option. Healthcare providers therefore engaged in a delicate dance of providing information that would be sufficiently informative but would also fall within the legal parameters. We heard from nurses how challenging navigating such conversations could be. Patients would ask about MAID in veiled language (e.g., making reference to treating dying pets with more dignity) or express a wish to die (e.g., wondering how long they must endure) without any explicit intent of accessing MAID as a way to relieve their suffering. As a result, nurses had to become skilled in using their own veiled language to determine whether someone was indeed asking about MAID or simply expressing the suffering of dying. Such strategies were important to ensuring that the information nurses provided to patients about MAID could not be construed as “counseling to commit suicide.”[42,43] These perceived prohibitions on introducing a conversation about MAID were compounded by the fact that in the early days after the legislation those who were opposed to MAID had no obligation to respond to explicit MAID requests. However, families could become quite distressed if and when they realized that MAID would have been a desirable and legitimate option for their loved one only after he or she lost the capacity to consider and give consent to the procedure.[20]

General public knowledge of MAID has evolved in two significant ways. First, with the numbers of persons who have received MAID in Canada since 2016, a significant proportion of the public now knows or knows of someone who has received a MAID death.[44] Awareness has been raised simply because the experience is now much more common. Second, there has been substantial discussion around the importance of introducing MAID as part of advance care planning for all who are experiencing serious chronic and/or life-limiting conditions and a developing consensus that this constitutes a best practice. The Canadian Association of MAID Assessors and Providers has articulated a defense of why this is the case,[45] and nurses in our studies have provided compelling ethical reasons for why the possibility of MAID should be introduced early on as a regular part of advance care planning rather than reserved for what may be a more emotionally fraught later period when decisions become imminent.[27] They have observed that patients are much more likely to be able to reflect on how MAID may or may not align with their own life-long values during times of illness stability. By including the option of MAID during advance care planning discussions, healthcare providers are seeking to reduce the likelihood that patients will feel pressure to make a choice that may not be consistent with their values. Further, by expanding these conversations into their more general practice, nurses feel that they are addressing the inherent inequity associated with it being functionally accessible only to those with the knowledge and confidence to openly inquire. Thus, while a lack of public knowledge about MAID and a prohibition on healthcare providers introducing the topic of MAID significantly influenced accessibility in the early days after the legislation, these challenges are seemingly becoming largely resolved in the practice context.

Reflections on moral complexities within the accessibility challenge

Navigating access barriers

Equitable accessibility is a core value inherent in how Canadians, including Canadian nurses, think about their healthcare. Canada’s legislative, social, and geographic context has meant that making MAID as equitably accessible as possible has required somewhat different approaches than might be necessary in other countries. In this essay, we have reflected on how the lack of clarity in legislative language initially left accessibility resting on the clinical decision-making and interpretation of the law by the provider, leading to variations in who was deemed eligible. The combination of protecting conscience under the law and delegating end of life care to faith-based institutional providers has at times created apparently insurmountable barriers before some persons seeking MAID. Canada's vast rural and remote geography has required centralized coordination services to effectively serve these populations; however, that model requires the use of MAID assessors and providers who have no direct knowledge of that patient's history and may not have access to it through consultation with those who do. Because of this, the Canadian approach has evolved quite differently from models used in other countries where euthanasia is primarily negotiated within the primary physician/patient relationship. This creates a special challenge for cases where the patient represents with a complex clinical picture such that eligibility for MAID is not clear. We are also beginning to understand that healthcare providers who do act as assessors and providers in rural areas run the risk of becoming socially ostracized or alienating some of their patients from feeling safe in their care. Thus, the emotional cost for rural care providers may be much higher than that of those who practice in supportive urban team contexts. And although many nurses and others within the healthcare team have developed comfort with clinical conversations around options for care within a palliative approach to care, the specter that they could be caught up in legal challenges should a family member or faith community feel they have "counseled to commit suicide" can have a chilling effect. This too will be especially the case for patients in complex populations for whom eligibility remains more contentious.

Although we recognize that experiences of nurses in the Canadian context may be somewhat different from that of their colleagues in other legislative, social and legislative contexts, we believe that these Canadian complexities may offer insight into what we have come to see as a moral web of complexity that depicts the understanding of many nurses. Although in early days, the moral question seemed limited to whether they did or did not agree with this practice, over time MAID has been normalized into a relatively accepted practice within which nurses see many layers of complexity within which the rights of patients must be protected, the safeguards within the law must be carefully navigated, and the moral sensibilities of patients, families, caregivers, healthcare providers, and even communities must be thoughtfully attended to. Excessive or inequitable barriers to an intervention to which Canadians are eligible by law does not sit comfortably with nurses, and many find themselves in a position of actively supporting patients and families in a manner designed to overcome them. On the other hand, where MAID seems overly accessible, especially in contexts in which they cannot know with certainty that all reasonable means by which to remediate suffering have been made available to their patients, nurses may feel pressure to participate in care in a manner that can heighten their own moral distress. And these tensions in finding confidence about right action may well be exacerbated when the care nurses are providing to their patients takes place within a dynamic or even highly contentious family or community morality debate.

Navigating dialogue and debate

In the ongoing dichotomized debate culture around MAID in Canada, raising critique can be interpreted as opposition to MAID. Although the public press has focused considerable attention on the sustained voice of opposition, either to MAID in principle or to MAID under various circumstances (chronic conditions, conditions involving psychosocial or emotional suffering, cognitive decline, mature minors, and advance directives),[4] many nurses encounter complex intersecting accessibility dimensions within the care contexts in which they practice and require a supportive professional space within which to think them through, wrestle with the moral implications, and come to a sense of peace with respect to the appropriate direction for practice in the everyday moments of relational care. Although nursing practice standards around MAID continue to evolve to address some of these evolving complexities, it seems to us that no structures and systems will be able to anticipate all possible variations and circumstances with which nurses will be confronted over time.

Fundamentally, nurses will need to return to the core ethics that have always guided their practice—ethics of service, patient-centeredness, respect for autonomy and dignity, and social justice—for normative direction. And enacting these will require an open professional community of practice within which nurses can raise matters with complex ethical and moral nuances without that being misunderstood as an oppositional voice.

Nurses are often positioned in more close and intimate contact with patients and families in the circumstances that may lead to a request for MAID than are those health team members who hold legislative responsibility for eligibility assessment and direct provision. They are often best placed to have knowledge of the illness trajectory, to witness the impact of assessment decisions, and to interpret the implications of such decisions in supporting forward progress toward or away from MAID provision. Therefore, their importance within the system of care in relation to MAID is widely acknowledged. Within a few short years since its legislation, many Canadian nurses have come to terms with the moral acceptability of MAID being sought for the purposes of hastening a reasonably foreseeable death in order to remediate suffering (Track 1). They have demonstrated considerable advocacy and leadership in initiating “goals of care” conversations with their patients, facilitating access to MAID coordinating centers for patients who seek eligibility assessment information, and supporting eligible patients and families toward orchestrating the final days and moments of life. Even in contexts in which there are established geographic, social, institutional, and informational barriers to access, they have demonstrated the capacity for creative leadership in helping patients and families explore alternatives, such as transfers, that bridge the access gaps.

This relatively smooth transition to the acceptability of facilitating access as right action, however, becomes considerably more complex in the context of patients for whom death is not reasonably foreseeable (Track 2).[37] In this context, nurses face a disturbing tension between, on the one hand, facilitating MAID access for those who are deemed eligible and, on the other hand, recognizing that a significant component of the eligibility determination may be directly associated with the lack of availability of alternative means by which to have relieved that suffering. Canadian nurses recognize that chronic illness and disability have not represented the highest priority emphasis of their healthcare system, and that many individuals with chronic and debilitating conditions will also have experienced social disadvantage in various forms, concurrent with or because of their illness, that itself becomes a form of suffering. Despite (or perhaps because of) their widely shared ethical commitment to social justice, Canadian nurses on the one hand want to ensure that these individuals who have suffered by virtue of gaps in Canada’s health service delivery and social safety net are not further prejudiced by being deprived access to the dignified death that they may desire as their ending. On the other hand, in seeking to support their access to MAID care, they are painfully aware that they, as a part of Canada’s health and social system, have not sufficiently protected these vulnerable persons to the point where death now seems a more viable option. Thus, in the Track 2 context in particular, it seems apparent that nursing must strategically avoid the dichotomized debate, play an active role in bringing their informed nursing perspectives into the wider public policy discussion, and open up space within which the complexities of MAID accessibility can be seriously thought through.

Final reflections

As we close this essay, we want to reiterate the morally laden nature of the concept of accessibility within the Canadian MAID context and how that plays out in the debate about eligibility criteria and safeguards. For those who are opposed to assisted death, the focus is on ensuring strict interpretations of eligibility criteria and safeguards and about alleviating suffering so that patients are less likely to choose an assisted death. In this case, rising rates of MAID are viewed as a failure of the care system.[46] In contrast, for those who believe in a right to an assisted death, the focus is upon ensuring that those who choose an assisted death can have it in a timely manner and with as few barriers as possible.[37] They recognize that there are complex reasons underlying a patient’s decision to seek assisted death, and that being deprived of that option can be devastating and an added source of suffering. Thus, their ethical judgments may be shaped by the desire to make MAID accessible. What we see then is that debates about eligibility and safeguards become proxies for accessibility debates, which in turn reveal deep divides in philosophical assumptions about the right to choose one's means of death. It is only at this level of unpacking and working through the philosophical assumptions that debates about what constitutes acceptable accessibility can ultimately be resolved. However, as the rates of MAID in Canada rapidly met and exceeded those of other countries where MAID has been legal for decades, the access imperative must become a focus of serious critical reflection. And such shared critical reflection is difficult in a world that seems to prioritize dichotomized positioning and contentious debate.

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