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Navigating the Growing Challenges of Medical Assistance in Dying: Insights from Nursing Practice

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Abstract

Medical Assistance in Dying (MAiD) becomes one of the most ethically, legally and emotionally complicated questions of modern health care in Canada. Nursing-wise, MAiD comes with a series of challenges that go beyond clinical practice into issues of morality decision and professional accountability and patient-oriented care. The role of nurses is critical to achieving this balance between compassion and advocacy and compliance with rapidly changing legal environments by acting as the first point of contact with patients having MAiD on their minds. This paper examines the multidimensional issues associated with nurses giving MAiD such as the issues of ethics, emotional strain, communication issues, and professional responsibility. It also points to a constant justification to teach, implement, and enforce thoughtful policies and interdisciplinary partnership to promote quality care without infringing upon autonomy of patients. By focusing on the nursing voice, the present study highlights an imperative role of nurses in the development of both compassionate and ethically acceptable with legal compliance MAiD practices in Canada.

Keywords: ***Medical Assistance in Dying (MAiD), Canada, nursing perspective, ethical dilemmas, patient-centered care, end-of-life care, autonomy, professional responsibility, emotional burden, health policy.***

1.Introduction

The last ten years have seen a radical shift in the Canadian health care environment with the legalization and expansion of Medical Assistance in Dying (MAiD). Through the appointed Commissioners in 2016, what was once a cautiously policed practice of people whose natural death was reasonably predictable has progressed into more intricate procedural and moral landscape. Nurses have a unique role that puts them at the crossroad between patient care, end-of-life decision-making and health system delivery. As such, the impact of these changes has been profound on the role of the nurses. In contrast with other medical innovations that slowly become part of established practice, the legalization of MAiD gave rise to a sudden overhaul of conventions of professional responsibility, patient-provider relationships, and societal expectations around what it is to care about dying patients. This rapidly changing environment has presented new possible directions and dilemmas to the discipline of nursing, on which nurses have found themselves on unfamiliar territory navigating through both work-related career opportunities and moral ambiguity(1).

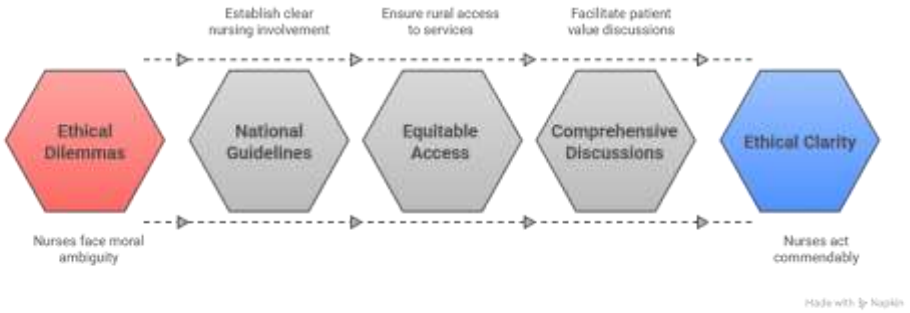

FIGURE 1 Navigating MAiD's Ethical Landscape

The main substance of this change is the Canadian Criminal Code which a certain number of acts of deliberately accelerating death became crimes and, in certain cases, valid medical procedures. Notably, the Canadian paradigm went against the international patterns in that it specifically empowered nurse practitioners (NPs) in addition to physicians to assess the patient status, as well as administer MAiD. This acknowledgment of the nursing expertise made NPs equal decision-makers with inherent rights of administering life-ending procedures or prescribing medications that the patients administer to themselves. Aside from being forbidden to administer MAiD, registered nurses (RNs) evidently fulfill important and irreplaceable functions as coordinators, clinical leaders, intravenous initiators, and emotional and informational support providers in patients/families. Collectively, RNs and NPs comprise the workforce that brings MAiD to the front line, making it accessible, safe and meaningful in practice, despite uncertain, ambiguous regulations and professional jeopardy(2).

The experience of the rapid increase of MAiD has further raised the concerns on its effect on nursing practice. The adoption of the law has led to a significant increase in the number of Canadians opting to MAiD; in 2022 alone, over 13,000 deaths of this nature were reported by Health Canada- more than 4 percent of all deaths in the country. This gradual rise each year indicates not only the desires of the population but also the extent to which MAiD has been normalised in health services. Nurses have become thoroughly integrated in these practices as they are uniformly present in almost all settings to observe and care for the terminally ill including hospitals, long-term care homes, hospices, and even the individual home. However, with the growing normalization of MAiD, the nature of the situation is becoming more and more complicated. Issues of consent, patient vulnerability, equal access and the desirable scope of professional responsibility all raise questions with nurses at the epicentre of some of the most disputed ethical issues in Canadian health care today.

A notable characteristic of the MAiD environment is that both eligibility requirements have been widened with each amendment to the MAiD legislation. In the original Bill C-14 (2016), the eligibility was restricted to those whose natural death is called foreseeable. A lot of Canadians however argued that this restriction was unjust since the conditions of intolerable suffering was not always accompanied by imminent death. In 2021, Parliament enacted Bill C-7 that provided a two-track framework: Track 1 and Track 2 patients. This change substantially expanded the group of potential applicants and came in with new protections, including the extension of assessment of Track 2 applications. To the nurses, this enlargement implied meeting patients with conditions that could not fit in traditional notions of terminal illness, including chronic pain, neurodegenerable disorders, and profound disabilities. The cases produced have usually required more subtle evaluation, greater moral reasoning, and longer engagement in supporting patients through their complicated medical and social backgroundS.

The other key change in law came in the form of the introduction of waivers of final consent. Individuals were required by Bill C-14 to give informed consent just before the administration of MAiD, and this forced individuals, who were at risk of becoming incapacitated, under untenable pressure. Even high-profile Canadian patient advocates like Audrey Parker felt forced to access MAiD before they hoped to in the fear that their eligibility would be lost. The 2021 reforms, therefore, attempted to eliminate this by allowing suitable patients on Track 1 to make written agreements with providers to enable MAiD to take place, even in the event they had lost capacity by the planned date. This shift helped to reduce the anxiety of being biased on decision-making tasks prematurely and thus, offered new ethical and legal challenges to nurses. Administering subjects to life-ending procedures without their simultaneous consent undercut traditional guarantees of moral exactitude that nurses could depend on to ensure they act commendably(3).

The most controversial of these developments yet to hit the horizon is the expected change giving eligibility also to persons whose single underlying condition is mental illness. Though Parliament had intended this to go into effect in March 2023, it has been deferred so that additional consultation and preparation of the system could go ahead, and the expected date of commencement has now been moved to 2024. On the part of the nurses, the incorporation of mental illness poses great ethical, clinical, and structural dilemmas. It is doubted whether sufficient protection measures are in place in a country where mental health support is already under pressure, where people can wait years to receive a psychiatric appointment, and where a stigma is still leading to the suffering of people who receive treatment. Nurses worry that they will be put on the untenable position of aiding assisted death when the reason that people perceive suffering may be more related to the existence of systemic failures- such as poverty, housing insecurity, or inadequate treatment- than to an untreatable mental condition.

More than legislation, the realities of health system organization add to the challenges. The Canadian fee-for-service model tends to curtail the amount of time during which comprehensive discussions about patient values are possible, and overcoming the barriers of siloed channels of communication can pose a challenge when it comes to ensuring that essential information about advance care planning is accessible. Rural and remote children are disadvantaged because they are more likely to lack access to all health services, especially when the services are faraway. Consequently, the nurses will find it hard to offer equitable services. In the meantime, the lack of ample national guidelines with respect to nursing involvement in MAiD has subjected RNs especially to the regulatory gray zone. As another example, they may be called upon to establish intravenous lines to administer MAiD but are not in a position to have documentation of the fact that eligibility has been confirmed, which begs the question of professional responsibility.

2.Methods

Research Design

The qualitative research approach used in this study sought to place special emphasis on what nurses who deal with Medical Assistance in Dying (MAiD) in Canada have to say about it. Instead of the survey or extremely quantitative approaches, the research team used an interpretive descriptive framework, which is most appropriate regarding health research aiming to cover a very hands-on element of practice-oriented messages. This design enabled a comprehensive examination of the ways nurses understand, perform and contest their roles and duties in the dynamic landscape of MAiD as well as pointing to the implications that can be inferred to other fields within health care systems and policy.

Sampling and Recruitment of Participants

The participants were targeted using a purposive and snowball sampling approach to have a maximum dispersion of geographical, institutional and cultural backgrounds of various expertise. Nurses who provided their first-hand, direct experience with MAiD as RNs or NPs were welcome to participate. Recruitment was supported by professional networks including the Canadian Association Of MAiD Assessors and Providers (CAMAP), direct approaches to professional networks, and personal referral. This plan made sure that it embraced the different scenarios: urban, rural and remote practices, representing the diversity of nursing practice in Canada(4).

Thirty five nurses participated at the end of which 25 were RNs and 10 NPs. The years of their professional experience varied between newcomers into the field of work and nurses, who had dozens of years of work experience. The research participants also represent diverse cultures, religious, and spiritual backgrounds, which ensured that the study would grasp how personal values can be at the crossroads with professional expectations when it comes to MAiD.

TABLE 1 Methods

Component	Description
Research Design	Qualitative study using Interpretive Description to explore nursing perspectives on MAiD.
Participants	35 nurses (25 Registered Nurses, 10 Nurse Practitioners) from diverse regions of Canada.
Sampling Strategy	Purposive and snowball sampling; recruitment via CAMAP networks and referrals.
Data Collection	Semi-structured interviews (average 60 minutes) conducted via secure videoconferencing.
Interview Focus Areas	Roles in MAiD practice, advance care planning, waivers of consent, Track 2 cases, mental illness eligibility, systemic challenges.
Data Management	Audio-recorded, transcribed verbatim, anonymized, and coded using NVivo software.
Data Analysis	Iterative thematic coding guided by Interpretive Description; constant comparative analysis.
Ethical Considerations	Approval from University of British Columbia BREB; informed consent; confidentiality maintained.
Researcher Reflexivity	Field notes, team discussions, and interdisciplinary perspectives to enhance credibility.

Data Collection

Semi-structured interviews were conducted predominantly on the basis of secure video conferencing networks in order to reach as broad an audience as possible, this communication method was selected due to the high accessibility and versatile geographic reach. Interviews were in the range of 60 minutes with an average of 60 minutes and the interviews were related by the research team members who have been trained in qualitative interviewing. Interview guide was modelled in a manner that sought deeper and descriptive experiences of the participants.

Major areas to investigate were:

The role of nurses in practice of MAiD practice ? How did nurses interpret their scope of practice/professional roles and responsibilities.

- Advance care planning - the introduction of MAiD within the discussions with patients.
- Consent and capacity- experiences with obtaining the waivers and the hard work of balance ability of patients in decision making.
- Track 2 cases - thoughts about administering MAiD to patients where it was not reasonably foreseeable that death would come.
- Anticipated changes - views on potential inclusion of mental illness as a condition in sole category.
- Challenges of change – challenges on the road to change such as communication silos, regulatory uncertainty and workloads.

All interviews were audio-recorded on the assent of the participants, professionally transcribed and accuracy checked. To ensure confidentiality we removed identifying information and participants were only referred to by role (RN or NP) and an anonymized participant number.

Data Analysis

The results are comparable to the interpretive descriptions method that prioritizes both the theory and practical implications of the findings to the nursing practice (Thorne, 2016). The research team sat down to read transcripts line by line and initiated a rough algorithm of coding. Anergic coding and comparison involved steps to refine the themes so as to capture the nuanced moral, professional and systemic dilemmas that the nurses described(5).

NVivo qualitative analysis software was used to facilitate coding process, and helped to organise and retrieve data in a systematic way. In order to enhance credibility and trustworthiness a sub-set of transcripts was coded independently by multiple members of the team, and interpretations compared and categories refined through discussion. Previous themes were refined and new themes were identified with the full dataset to ascertain that they were representative of a large part.

Ethical Considerations

The research was conducted in accordance with the principles stipulated in the Declaration of Helsinki and was ethically approved by the Behavioural Research Ethics Board of the university of British Columbia. The consent of all subjects was made on an informed ground as the subjects were made to understand that their participation was voluntary and that they may withdraw any time. The confidentiality was received a lot of attention and transcripts were anonymized and stored safely.

Researcher Reflexivity

At the value-laden and sensitive nature of the topic of MAiD, the research team applied a recurrent process of reflexivity in the conducting of the study. Field notes were taken after interview to capture observations, possible biases and emerging questions. The discussions in the research team helped to ensure that interpretations were rooted in accounts of the participants rather than only blaced on the assumptions of the researchers. Significantly, the use of both interdisciplinary and nursing researchers contributed to the interpretation process as they gave a variety of professional perspectives to look at the data.

Overview of the Methodology Approach

This study used an integrated approach in the trio of interpretive description, diversified sampling, and robust thematic analysis to develop a layered picture of how nurses negotiate the shifting dynamics of MAiD in Canada. The selected design helped to make the findings not distilled away but very much brought back to the realities of nurses and their ethical stresses, systemic obstacles, and care situations. The approach places the nursing voice in the national discussion, which tends to focus on legal or physician-centered discussion, and keeps the experiences of those who are providing constant, compassionate care as a central part of the debates about assisted dying.

3.Results

1. Within the discussions of end-of-life planning, AiD fits

Among the most powerful themes, which were generated, was how MAiD fits into the bigger picture of end-of-life care. Nurses reported conflict between professional rules-many of which had originally banned introducing MAiD even on request- and their ethical imperative to be as transparent as possible with patients about all the available options. In the case of nurse practitioners MAiD was justified as a postulate of the healing discourse and included, along with palliative treatment and hospice, other options. In comparison, several registered nurses believed that the regulatory statements limiting them to introduce MAiD were unnecessarily restrictive to patients using non-explicit terminology to express their intentions.

This kind of variation yielded an array in practice. On the one hand, omitting MAiD in the field of advance care planning could be viewed by the nurses as a flaw of informed decision-making because some patients could be unaware of its existence. The alternative, to prematurely raise the issue, especially at vulnerable times (during hospital discharge or when entering long-term care), was feared by nurses, in case it might serve as a signal of abandonment or pressure. The best practice was reported by the participants as a discussion about MAiD in days of relative stability when patients were able to reflect on their long-term wishes and values best (6). These discussions involved less medical treatment and more of meaning and identity and quality of life: What is it that makes your life worth living? What to you would constitute intolerable suffering?

One of the issues encountered repeatedly was communication silo in the health system One of the reported negative changes that happened to the patients is that they are sometimes asked many times about the concept of MAiD by various doctors which left them confused or tired. The others pointed out to privacy regulations and dualistic electronic records that reduced the ability to share advance care planning discussions between teams, and further mentioned that it would hinder the continuity of care. In brief, nurses acknowledged the necessity to view MAiD as part of comprehensive planning, but there were many barriers to this ideal, both on a systems and regulatory level.

TABLE 2 Results

Theme	Focus	Key Insights from Nurses
1. MAiD in End-of-Life Planning	Integration of MAiD into advance care planning	Nurses debated when and how to introduce MAiD; best timing was during stability, not crisis. Communication silos and repeated questioning created confusion.
2. Waivers of Consent	Use of written waivers for patients at risk of losing capacity	Reduced anxiety of premature MAiD, but created moral tension for providers acting without final consent. Best used selectively in predictable decline cases.
3. Track 2 Cases	MAiD for patients whose death is not reasonably foreseeable	Ethically complex; suffering often linked to systemic inequities (caregiver loss, lack of supports). Assessments were labor-intensive and required nuanced judgment.
4. Anticipating Mental Illness Eligibility	Possible expansion to applicants with mental illness as the sole condition	Nurses feared system inadequacies (long wait times, lack of mental health supports) would make MAiD unsafe. Concern that patients might seek MAiD due to social failures rather than irremediable illness.

2. The waivers of consent and how capacity challenges are approached

The second theme was the waiver of final consent, which was introduced in 2021 to solve the dilemma of patients who feared losing decision-making ability prior to the preferred choice of MAiD date. However, this shift was welcomed by nurses since it gave the patient the opportunity to have every last drop of life before making hasty decisions. They however also outlined new practical and moral dilemmas.

On the one hand, the waiver decreased the degree of urgency that previously compelled families and providers to coordinate MAiD in a situation of severe time pressure. On the one hand, it put providers in the morally heavy, but not necessarily life-saving, place of providing life-ending drugs without explicit, concurrent patient consent. Some of the nurses voiced their uneasiness in asserting that last minute consent had given them the satisfaction that the wishes of the patient were understandable up to the point of death.

Laws were also highlighted as being complex to explain to patients and families as to the waiver process. The waiver involved a different level of perception as compared to simple consent (concerning hypothetical future-oriented decisions). In case of some patients, the technicalities overwhelmed them. There was also a doubt on the tenure of waiver validity and informally, the duration ranged between a few weeks to up to three months, but no formal guidance on this.

The cases which were most difficult to present to a jury was the situation where a patient had lost capacity but there was no longer a visible vincible suffering. It was tough on the nurses, who underwent the debate of whether intolerable suffering still was the case. In the minds of many, the waiver was either a manifestation of a faith in the previously established values of a patient- even when visible evidence of distress had diminished. It became apparent that nurses tended to be more supportive of a selective, individual approach to waivers, or tended to restrict waivers to predictable cases of declines (brain tumors) rather than a blanket application(7).

3. Multi-Dimensional Challenges of Track 2 MAiD Requestors

The other dominant theme was the experience of giving MAiD to those whose natural death was not reasonably predictable (Track 2). Some nurses reported minimal exposure to such cases but others reported that they were one of the most ethically challenging parts of their job. The patients in this category had injuries, diseases or conditions that were really a constant illness or disability and the effects were a very bad suffering but they were not considered terminal.

Nurses expressed being in conflict between respecting patient autonomy and doubting whether such cases are an example of malfunctions in the health and social care system. One applicant, for example, sought MAiD due to poor home care service or the removal of loved ones to provide care; the applicant also needed appropriate housing, which according to the nurses should never be a factor in an ideal system. Some would be considered as non-compliant by the system, but when the nurses interacted with them it turned out the patients had significant barriers to accessing appropriate care.

A common theme was the time and labor-intensity of Track 2 evaluations. Nurses used hours to fill in the gaps in fragmented medical histories, coordinate with more than one provider, and defend patients who suffered stigmatization or underrepresentation. Whereas in Track 1 the medical prognosis could be simple, in Track 2 the sympathetic construal of the medical prognosis needed to be complex, and not only that, they had to reach decisions about whether the sufferings were serious and incurable as well as whether the sufferings were intolerable without using alternatives.

The reconciliation that some nurses experienced towards Track 2 went up to the reframing of it as a further extension of choice and quality of life, whereas some nurses still experienced a closer relation of Track 2 to assisted suicide. The respondents were in agreement that Track 2 could use more systemic supports, dedicated assessors, and sustainable funding without which the provider burden would be unsustainable.

4. The anticipatory MAiD in Mental Illness

Last, the participants speculated on the possible expansion of MAiD to persons whose only underlying impediment is mental illness. Despite not being in existence during the data collection period, its impact on the nurses is already being felt as they are receiving questions from patients and foresee significant difficulties.

The major issue that participants were concerned with was the situation with the state of the mental health system in Canada: they called it poor, disjointed, and inadequately funded. There were claims that it was unethically to provide MAiD in a system where patients did not have regular access to psychiatric services, counseling, housing, or substance use programs. Nurses feared that some people would take MAiD as a result of the failure of the system at that point rather than because their condition was adjustmentless.

Concomitantly, nurses also conceded the legal maxim of parity: that neither Mental illness can be automatically discounted when the suffering is really intolerable and unresponsive to treatment. This conflict--between not interfering with self-determination and not denying injustice as a system--was among the most morally conflicted situations reported.

Scarcity in practice also was foreseen Nurses were afraid of being overstretched, with such a large number of possible applicants and there was doubt as to whether an optimal level of psychiatric knowledge lay to complete high quality and defensible assessments. In addition, they were concerned with disjointed records, as many mentally ill people lacked both a set of stable providers and consistent records.

Others add interdisciplinary case management models would ensure MAiD applications were treated with both sensitivity and rigor. Others said there would be more provider distress, especially when nurses would be asked to assist suicide in a case where social supports, rather than medical futility, were the motivating factor.

Results Summary

Within these four domains, nurses articulated a practice that exists at the intersection of patient autonomy, professional ethics and system failures. They explained how time, communication, and trust intervene in the introduction of MAiD in the process of advance care planning. They emphasized the pros and cons of the waivers of consent, the autonomy of the patient versus the guarantee of the provider. They exposed the grey areas of the Track 2 cases, where the suffering tended to be excruciatingly real but not usually cut off of social injustices. They brought up critical concerns of how it can be practically and ethically possible to expand MAiD to mental illnesses when mental health treatment is in a dire state of insufficiency.

4.Discussion

The results of this study show the depth and in many cases unsettled nature of the complexities that Canadian nurses are faced with as MAiD legislation takes its current form. Although the legal model creates requirements and protection, it is mostly the task of nurses to translate the laws into clinical practice, whose responsibilities go far beyond technical skills. Nurses are among the most likely to be in continuous relationships with patients and their families, and who must not only understand the law, but also the human realities of suffering, autonomy and dignity. The implications of these findings can be reduced to three overarching considerations: the transformation of risk-based approaches to planning into person-based approaches; changing boundaries of conscientious involvement; and the essential role of effective health and social systems as a safety net.

From Risk Based to Person Based Planning

Among the most apparent tensions, which appear, is how nurses explore the topic of MAiD during advance care planning. Emerging under the legislation, the threat of legal reproach and professional sanction meant that nurses took up a position of risk avoidance: they only reacted to requests by patients that used precise language to talk about MAiD. This strategy kept nurses out of the line of fire of those accusing them of counseling suicide, but it also failed to clue some patients into an avenue of legal action which would be focused on their values.

The notions of autonomy and equality of information has over the years shifted the focus of many nurses to that approach. By approaching MAiD as but one among many available to patients in their end-of-life planning, they strove to make sure patients felt empowered to make informed, value-driven choices as opposed to being influenced by the silence of the system or physician bias. Critically, nurses explained that discussion of MAiD should occur when the patient is stable and not at the moment of crisis. When talked about at the wrong time, as in the middle of a transition between hospital and home or into long-term care: MAiD may be perceived as abandonment or coercion. In contrast, in patients whose relationship was not built on trust, when the MAiD topic was raised sensitively in the context of the relationships, which had existed over a long time, patients became better prepared to locate MAiD in their existing thoughts about the quality of life.

This transformation shows that there is a paradigmatic shift: the initial, defensive, risk-based position to patient-centered communicative paradigm. nonetheless, systemic blocks still exist The value differently based conversation is avoided due to the fee-for-service systems, fragmented records, and the communication silos. Such results indicate that system change is urgently required to uphold the nurses in carrying out the type of holistic advance care planning that embraces both patient agency and professional integrity.

The Good-Consciled Fluidity of Participation

The other significant implication of this study concerns the path that nurses take to find their own position regarding MAiD. At the time of first legalizing MAiD, the common arguments were predominantly along the axis of whether or not providers could in good conscience engage in the process of accelerating the deaths of other people. Nurses, along with other health professionals, separated into conscientious objectors and conscientious participators: the moral values demanded them to provide assistance in the implementation of MAiD.

As legislation broadened, the moral tension fault lines shifted, though. The debate has now moved beyond a declaration as to whether MAiD can be accepted in principle to one as to whether its extrapolation to Track 2 cases and its likely extension to mental illness makes sense academically. Nurses in this study told of the struggle against cases where suffering was tangible and at the same time so bound up with system U.269 inequities poverty, stigma, disability, or poor facilities. To others this made the distinction between legal qualification and moral rightfulness hazy (8).

This is part and parcel of a wider redefinition of being a conscientious participant: this is no longer a case of being either in favor of or opposed to MAiD, but a sliding scale of moral bargaining as legislation changes. The testimonies of nurses provide the justification of powerful professional bodies and health institutions to facilitate ethical dialogue spaces and other forms of support that will enable the practitioners to process the dilemmas without fear of stigma. The importance of advocating justice under the code of ethics of the Canadian Nurses Association implies that the moral distress of nurses should be less about objecting to MAiD altogether but more about wondering whether there has been a systematic problem with the system that applies to patients because of insufficient alternatives.

Having certified democracies as the most supreme protection

A significant theme evident in this paper is that what underpins ethical MAiD practice most is not merely the force of law, but the nature and robustness of health and social care systems in which MAiD is performed. Several times, nurses also cited system failures- palliative care unavailability, poor mental health supports, obstacles to communication, physician shortages, and ineffective primary care- as barriers to patient choice fairness and integrity(9).

Such is the case of a Track 2 carrier where the nurses would waste hours following down a record or representing a patient whom they had categorized as a non-compliant patient. These cases provoke the concern that the suffering of patients might be even exacerbated due to the systemic neglect at the expense of their medical conditions as such. Expanding MAiD to include persons with mental illness was also deemed highly inappropriate in a context in which psychiatric services have consistently experienced low levels of funding and inaccessibility. To many nurses, the provision of MAiD in this situation was not so much respecting autonomy as it was an abdication of responsibility to the society to provide care.

These results parallel the broader issues raised by palliative care experts and ethicists that MAiD debates have prioritized legal safeguards and discounted an emphasis on system-level inequalities. This indicates the best guard of all can be a strong, accessible care system-the one that would give patients meaningful alternatives to MAiD, as opposed to being directed toward it by scarcity.

Implications

Considered collectively, the results point to some important directions. The health systems need to establish clear standards of practice regarding nurses, especially registered nurses whose functions are crucial in the introduction in IV lines, coordination of their care and family support but are not well-acknowledged by policy. Second, there is an imperative to introduce changes in communication infrastructure to avoid disjointed dialog and redundant inquiries that can lead to poor patient trust. Third, palliative care and mental health should be invested to make the choice of MAiD the free one, rather than the only available rescue option. Lastly, nurse education and professional development should focus on providing practitioners with the skills that it requires to communicate values-based, make decisions through moral reflection, and figure out systems and operations, as these are equally essential to the MAiD practice, as is technical expertise.

5.Conclusion

The Canadian example of Medical Assistance in Dying (MAiD) is one of the most prominent changes in present-day health care that transformed the ways the population views the limit of medical responsibility, self-determination, and the path to death. This change has been especially radical in the case of the nurses. Nurses are usually the professionals who are closest with patients and families due to the fact that they are on the front lines of patient care, and it is they who see patients the most during the process of end-of-life discussions and the moment of assisted death itself. Their sentiments indicate that the issues surrounding MAiD on an institutional level go well beyond ensuring a technical deserving of the legislation; they also involve the levels of human suffering including communication, ethics, trust, and infection of the system.

This paper reveals that the wider the legislation is, the more the moral, and practical dilemma confronting nurses. The discussion at the MAiD during advance care planning has changed to be in the sphere of legal uncertainty more than a probable approach but is still dependent on the choppy communication systems and professional incoherence. The introduction of waivers of consent has allayed fear on the part of patients to lose the opportunity but has placed additional burdens on providers who must now act without having a confirmation. The expansion of eligibility to Track 2 cases, in which death is not necessarily foreseeable, has resulted in nurses having to operate in grey areas where pain and suffering exist without clear boundaries or lines. With the expected addition of mental illness to the list of qualifying conditions, the preparedness of the Canadian system of care that supports mental health needs, and of the ethical mandate of nurses expected to practice within it takes on a special urgency.

Throughout these areas, there is one key question to which the answer is made obvious; the future and ethical soundness of MAiD in Canada is inevitably bound to the health and social care systems within which it exists. Nurses repeatedly stressed that failures of systems play as much a role as individual patients in decisions over things like poor palliative care, under-invested mental health services, and disconnected primary care. Providing

MAiD without providing accessible alternatives is dangerous and will work against the spirit of autonomy and equity the legislation aims to achieve.

Simultaneously, the study sheds further light to the strength, flexibility and moral gravity with which nurses approach to MAiD. The interpretation of the law and the negotiations by the nurses are not passive, but they reflect the patient dignity and their values. Their aptitude towards the conversation when there is a stable situation, their capacity to trade off compassion with professional responsibility and their ability to support patients against the systemic problems are all confirmation to the fact that nursing plays an important role in shaping a humanistic practice of assisted dying. However, such contributions tend to be done in an environment of ambiguity, work pressure, and little institutional sensitivity. The assistance of nurses in this time-consuming work will require clear standards of practice, forums on ethical issues, and systematic changes that are consistent with the facts of end-of-life care.

The sui generis case of MAiD in Canada will continue to evolve and be informed primarily not by the question of eligibility and safeguards in the law, but by how care is, in fact, practiced. Nurses make clear to us that laws alone are not enough to produce ethically acceptable consequences; it is the combination of law with clinical judgment, the values of the patients, and system supports that can bring about the desired results of the reduction of suffering and respecting autonomy. To ensure that the Canada continues to expand the availability of MAiD, equal emphasis should be placed on enhancing both palliative care and mental health services as well as communication infrastructures to ensure that any chosen theatread option is fully informed and voluntary.

To sum it up, MAiD is a unique opportunity and humongous challenge posed to the Canadian nursing. It provides a system to follow through with patient agency in end of life, but it also reveals disturbances between law, ethics and systems imbalances in equity. Navigating the ever-changing landscape of the legislation, it is important to remember that nurses - people who administer care at the bedside, coordinate the care provided across the different systems, and face moral aspect of assisted dying, should undoubtedly remain the voice of the legislation. Their testimonies highlight that the best safeguard of all, however, is not that the procedures are followed, but rather that a good health system is established, which ensures that patients will be able to live and die with dignity.

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Conflicts of interest

The authors have no conflicts of interest to declare

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