

# MAID's evolving ethical tensions: Does it make dying with dignity easier than living with dignity?

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Medical assistance in dying (MAID) has [received lots of media attention over the past few years](#). This is especially true as the Canadian government considers expanding eligibility for people whose sole

underlying condition is a mental illness. This has led to increased concerns about the ethics of MAID.

Even in its present form, MAID is fraught with ethical tensions. As scholars [engaged in research on MAID](#), we have heard about these tensions firsthand through interviews with physicians and nurses who provide MAID-related care, clinical ethicists who perform MAID-related consults, family members of patients who have received MAID and patients who have requested MAID.

From these conversations, we highlight three emerging tensions:

1. Palliative care versus MAID provision;
2. Transparency versus privacy; and
3. Providing a dignified death versus a dignified life.

These tensions can contribute to unpredictability in health service provision, strained relationships, moral distress, harm for prospective patients and the erosion of public trust.

## **Palliative care vs. MAID provision**

There is debate about whether a health-care worker can participate in both [palliative care](#) and the MAID program.

Palliative care involves efforts to improve the [quality of life of patients facing serious or life-threatening illness by preventing or relieving suffering through early identification, assessment and treatment of pain, including physical, psychosocial and spiritual pain](#). MAID, on the other hand, provides patients experiencing intolerable suffering the option to end their lives with the assistance of a doctor or nurse practitioner.

Some people see the two services as [co-existing within end-of-life care](#).

Others view them as having [incompatible intentions and goals](#), and may see the two services as being in conflict.

For instance, as one [medical professional](#) informed us, pharmaceuticals that might be provided to relieve pain during palliative care could undermine cognitive capacity and limit a patient's ability to provide consent to MAID:

"It was brutal. I knew at that time we wouldn't be able to do the provision because we would have to medicate her so much... then we'd have to reverse it to get consent, and that was really hard."

Examples like this reveal the tensions that medical professionals might face if they seek to provide both palliative care and MAID. We also heard that some palliative care professionals perceive MAID requests as a failure of their efforts to provide quality palliative care.

This can potentially place strain on professional relationships between MAID providers and palliative care teams, or cause moral distress for palliative care providers.

## **Transparency vs. privacy**

The [federal government](#) notes the importance of [transparency for the improvement of MAID and maintenance of public trust](#). However, patients and care providers sometimes have strict privacy concerns, wanting their participation in MAID kept confidential because of disapproving family, colleagues or [community members](#).

This is particularly true in smaller communities where privacy may be more limited, health-care professionals are [highly visible](#) and people may be concerned about [MAID-related stigma](#).

One patient in our study had family members insist on keeping their cause of death a secret. Another participant spoke about a patient's request for the MAID team to do the provision at a long-term care home without letting the staff, family or other residents know.

When medical providers are asked to assist patients in such secrecy, transparency may become compromised.

"Staff had to really balance transparency with confidentiality... One of those transparency pieces, very clearly from the government, was accurate recording, so that there was nothing secret... (But) we've had patients who have said, 'I don't want my family to know.' But they're going to find out what the cause of death was; the death certificate is very clear."

In cases like this, [medical professionals](#) are placed in the difficult position of not being able to accommodate privacy requests of patients or family members, as doing so could undermine ethical obligations of transparency and professional accountability.

## **A dignified death vs. a dignified life**

MAID is often celebrated for supporting [suffering patients to exercise control and die with dignity](#).

With the passage of [Bill C-7](#), which removed the requirement of a reasonably foreseeable death, Canadians are now applying for MAID when suffering is impacted by socioeconomic factors such as inadequate housing, medical care, food security or income supports.

As a result, there has been growing concern about offering this service in a limited social welfare state [that does not provide the conditions for people with an illness or disability to live with dignity](#).

There have been news reports of people being offered MAID when they just needed assistance to live. This has included a [veteran who merely required a wheelchair ramp](#), individuals who did not have access to food or [adequate housing](#) and [patients who needed home care](#).

We have also recently seen [reports of prisoners who may be requesting MAID to escape the harsh conditions of prison life](#).

In our research, a participant told us about an individual who had received MAID and might have otherwise benefited from existing programs:

"There was a (patient) in our community who went through MAID... and his diagnosis was heart failure... (But) he never came to our program and I felt there were a lot of things that we can actually do with these heart failure patients to give them good quality of life."

Canadian legal scholar Trudo Lemmens has similarly noted [that MAID may be quicker to access than certain medical and financial supports](#), including, for instance, access to specialized long-term care, specialized pain clinics and the [Canada Pension Plan Disability Benefits](#).

"It is crucial that individuals are not placed in a position [where MAID will be seen as the only alternative to suffering](#).

Unfortunately, we heard from study participants that this issue may be further exacerbated in rural areas with limited access to palliative care.

"I think some of those patients don't get the same palliative care that somebody in town would and so maybe they're opting to do MAID sooner than somebody else would... maybe they didn't really want to do it but they kind of felt that it was their only option."

Another study has already corroborated this concern, noting there is an [inadequate provision of palliative care for those requesting MAID](#). This is alarming as it signals the reality that MAID requests are sometimes made not out of necessity, but rather due to unmet needs.

## Moving forward

These tensions surrounding MAID place staff in complex ethical predicaments and are deserving of greater attention. Current policy and legislation do not adequately address how they ought to navigate potential conflicts between palliative care and MAID, between transparency and privacy, or how to best handle MAID requests being made due to unmet socioeconomic or medical needs.

This situation is made worse by the fact that some of our participants felt ill-prepared to step into a MAID-related role due to limited training or support.

We encourage the federal government to reconsider its role in improving the quality of life of its citizens. In many situations, Bill C-7 has made "dying with dignity" easier than "living with dignity." It is ethically problematic if a state is more willing to facilitate death than to provide the necessities of life.

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