

# **An Educator's Reflection on the Exploration of the Ethical Issues of Medical Assistance in Dying with Nursing and Health Care Students**

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## **Abstract**

*In 2016, the Canadian federal government passed Bill C-14, legislation that enables those with irremediable conditions to obtain medical assistance in dying (MAiD). This paper is my reflection on dialogues I continue to have with students in lectures where we explore the various issues that MAiD presents for the health care system and for physicians and nurses who are called upon to assist in dying, with specific reference to the Canadian context from the perspectives of human rights and Kantian and utilitarian ethics. Specific attention is paid to conscientious objection within the Canadian context by those health care practitioners for whom participation in medically assisted dying is ethically objectionable, and the need to protect them from negative consequences. A relational approach is proposed as an option to guide and acknowledge the vulnerability of nurses and those who are suffering and as an ethical consideration that helps avoid Kant's concern about using persons as means to an end.*

**Keywords:** Medical assistance in dying, Kantian ethics, utilitarianism, relational ethics

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## **An Educator's Reflection on the Exploration of the Ethical Issues of Medical Assistance in Dying with Nursing and Health Care Students**

In June 2016, the Canadian federal government passed Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) (S.C. 2016, c. 3). For brevity, we will simply refer to this as Canada's Medical Assistance in Dying (MAiD) legislation. This act enables those who experience a "grievous and irremediable medical condition" for which "natural death is reasonably foreseeable" to request assistance in dying (Nicol & Tiedemann, 2018, p. 10–11). Bill C-14 was a response to earlier Supreme Court of Canada decisions in *Carter v. Canada* (2015 SCC 5, [2015] 1 SCR 331) and *Rodriguez v. British Columbia (Attorney General)* ([1993] 3 SCR 519), which held that laws preventing physician assistance with dying interfered with the life, liberty, and security of persons under the 1981 Canadian Charter of Rights and Freedoms (Attaran, 2015). Once the bill was passed, MAiD legislation enabled health professionals, with legislated safeguards, to freely provide or assist in voluntary assisted death without fear of criminal culpability. It also specified that health professionals were not compelled to participate (Nicol & Tiedemann, 2018). However, it is not as straightforward as simply saying no for those who are conscientious objectors of MAiD. Conscientious objections lead to questions and issues that remain unresolved for many and require further exploration. For instance, can one simply declare a conscience objection and expect a reassignment? Will a conscientious objection affect one's job security? And do conscientious objectors face stigma from colleagues in the workplace?

Medical aid or assistance in dying presents various legal and ethical issues for health care systems and for nurses, physicians, and other health care professionals who might be called upon to assist with the act of dying (Attaran, 2015; CNA, 2022). The legal issues are accompanied by emotional, moral, and professional complexities. Therefore, conversations regarding MAiD are always multilayered, but have for the most part focused on the legal issues. However, among frontline workers, there is a need to explore more deeply how best to address the other complexities of MAiD, including how best to support

those who are conscientious objectors. As educators, we have a responsibility to offer students a safe space to openly discuss the legal as well as the emotional, moral, and professional issues related to MAiD before they enter the workforce. This paper is a reflection of the engaging dialogues I have had in the classroom with practical and baccalaureate nursing students and with graduate students from various health care disciplines since MAiD was legalized. These dialogues have addressed my students' moral agency as health care professionals, specifically with regard to instances in which they may wish to conscientiously object to participating in a MAiD process. The paraphrased and summarized information about student opinion that I include in this reflection come from these informal dialogues. These conversations are valuable because of the way they reveal common concerns among the students in each cohort.

I anchor this discussion in Kantian ethics and utilitarianism. I also use a relational approach to address some of the students concerns. I hope that, in sharing this reflection, I can contribute to the efforts of other educators who are helping preservice health care professionals navigate and position themselves with regard to the contentious issues surrounding MAiD. It is important that students are armed with the accurate information so that they can make informed practice choices. This includes understanding that they, as health care professionals, have rights under MAiD legislation, which they can invoke provided that they do so without harming or influencing patients' rights to choose MAiD.

### **Choosing Dying**

The ability to choose when to end one's own suffering is of increasing interest in various jurisdictions globally. Several countries (Canada, the Netherlands, Belgium, Luxembourg, Colombia, Switzerland, and Germany) and US states (California, Colorado, District of Columbia, Hawaii, Montana, Maine, New Jersey, Oregon, Vermont, and Washington) have established legal and legislative bases for medically assisted dying. Other jurisdictions such as Australia (in 2021) and Austria (in 2022) have recently joined this movement (End of Life Australia, 2021; Mroz et al., 2021; Nicol & Tiedemann, 2015,

2018; Pleschberger, 2022; EPWG Advance Requests, 2018). Still others (for example, the United Kingdom and Scotland) have considered voluntary termination of life related to irreversible disease and suffering, but rejected this as a course of action (Nicol & Tiedemann, 2015, 2018). Countries that have legal medically assisted death shared similar challenges with respect to ongoing debates around ethics, regulation, terminology, and procedural criteria as well as disagreements within practice discourse (Mroz et al., 2021; Roehr, 2021). Another common debate around medically assisted death related to the impact it may have on vulnerable populations such as the elderly and people living with mental health conditions and/or disabilities. Some are concerned that assisted dying, if not carefully evaluated, could become a slippery slope that leads to the practice becoming a business, a kind of passive-suicide, or a procedure done to satisfy the selfish intents of others rather than the needs of the patient (Roehr, 2021).

### **The Scope and Significance of Choice**

As stipulated in the text of Canada's MAiD legislation, eligibility criteria for termination of life with medical assistance include intolerable suffering, an irremediable medical condition, foreseeable death, mental competence, and age of at least 18 years (Nicol & Tiedemann, 2018; CNA, 2022). Of these, foreseeable death, age restrictions, and mental competence continue to be raised as areas of concern (Buote et al., 2022; Charland et al., 2016; Patton & Dobson, 2020; Variath et al., 2022).

Although MAiD is now legal in Canada, debate continues about eligibility criteria, including issues such as the scope of foreseeable death and the availability of MAiD for those with mental illness or deteriorating health (Incardona et al., 2016). These issues were illustrated by the plight of one elderly woman in long-term care who felt she had no meaningful future and expressed a wish to die, but was unable to receive MAiD because she did not have a terminal diagnosis (Fragomeni, 2019). Though she was able to express her wish, her deteriorating health alone was considered to be beyond the scope of MAiD criteria. Others worry that they may become unable to express a future wish for a medically assisted death because of potential future physical or mental limitations. They advocate for the right to

make advance requests that guide future decisions about MAiD, which are not currently allowed (EPWG Advance Request, 2018; EPWG Mental Disorder, 2018).

Some advocates for persons with mental illness argue that suffering experienced by persons with profound mental illness also involves deeply held subjective misery and hopelessness and press for MAiD to be made available to them (Incardona et al., 2016). However, a national survey of Canadian psychiatrists suggested that while most support MAiD, they do not support the use of MAiD in mental illness because of concern about the vulnerability of those with mental illness, personal moral views, and worry that access to MAiD may negatively impact therapeutic rapport and work (Rousseau et al., 2017). Until there are legislative amendments, MAiD remains unavailable to Canadians who suffer exclusively from mental illness, including those with early dementia, who anticipate future deterioration in health and quality of life (EPWG Mental Disorder, 2018).

Despite challenges to age restrictions on the basis of discrimination and a perceived arbitrary prejudgement of the capacity of minors to make life-ending decisions, most countries and states with medical assistance in dying regimes (with the exception of Belgium and the Netherlands) restrict this choice to adults (Nicol & Tiedemann, 2015; EPWG Advance Requests, 2018). Although international and Canadian data indicate that requests by minors for medically assisted dying are limited, Canada's MAiD legislation opens the possibility for mature minors to press for the same consideration as adults. Some Canadian experts suggest that it may be unethical to remain silent or ambivalent on this extension of MAiD until a mature minor who meets all other eligibility criteria requests assistance in dying (EPWG Mature Minors, 2018).

Other considerations in the scope of assisted dying include criteria such as foreseeable death or other variations in the prognosis for survival. In Oregon, for example, the person must have a terminal illness from which, according to medical judgment, death will occur within six months (Nicol & Tiedemann, 2015; Fragomeni, 2019). In Belgium and the Netherlands, there is no requirement that persons requesting assistance in dying have a terminal illness. In fact, prognosis for survival is removed

as a potential decisional barrier (Nicol & Tiedemann, 2018). Terminal illness as an eligibility requirement is also being revisited in Canada through the introduction of Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), which was tabled in the House of Commons in October 2020. This bill proposes to broaden eligibility for medical assistance in dying by repealing requirement that a person's natural death be reasonably foreseeable in order to receive MAiD (Government of Canada, 2021).

The decision to allow medically assisted dying is made federally in Canada, although its delivery remains within the jurisdiction of individual provinces and territories. Thus, while eligibility criteria and decisional processes related to MAiD are laid out in MAiD legislation, implementation is left to the provinces and territories, which are responsible for health laws, regulations, and guidelines. Regulatory colleges are to guide the practice of physicians, nurses, and pharmacists (Nicol & Tiedemann, 2015). This division of governmental responsibility is significant because there are gaps in Canada's MAiD legislation that have yet to be addressed. For instance, more research is required to gain a deeper insight into how and why certain vulnerable populations (e.g., people living with solely mental health illnesses) may consider MAiD. As well, more understanding is needed to evaluate the societal discourses regarding the compatibility of MAiD and palliative care (Dierickx & Cohen, 2019).

Perhaps more importantly for my purposes here, the federal legislation does not address the conscientious objections of health care providers, focusing almost exclusively on the eligibility of patients. It is therefore up to the regulatory professional bodies to issue their policy for the conscientious objectors. For example, the College of Physicians and Surgeons of Ontario (CPSO, 2022) “does not require physicians who have a conscientious or religious objection to MAiD to provide MAiD under any circumstances” (“Conscientious Objection” sec.). On its own, this point sounds supportive. However, the rest of that the section is a list of bullet points that instruct physicians to ensure they fulfill their professional obligations. One such bullet states that the physician must provide their patients with “effective referral”—that is, they must take “positive action to ensure the patient is connected to a non-objecting, available, and accessible physician, other health-care professional, or agency” (CPSO, 2022,

“Definitions” sec.). While the language offers some guidance, many physicians who are conscientious objectors in Ontario do not agree with the process of effective referral because they consider the referral itself to be a form of participation in MAiD. Moreover, some are still confused about the referral process (Ball et al., 2019; Gamble & Gamble, 2022). Gamble and Gamble (2022) also implore us to remember that when an intervention is legal, practitioners are legally required to ensure access to care. This requirement includes MAiD. Depending on one’s interpretation of effective referral and the degree to which one objects to MAiD, this potential for moral and legal conflict may create a bigger ethical conundrum for some conscientious objectors than others. There is an online service that Ontarians can access to find out more information about MAiD and thus bypass objecting physicians all together (Ontario Ministry of Health and Ministry of Long-Term Care, 2022), but the question still remains: Is this sufficient to protect and support health care providers who are conscientious objectors to MAiD?

### **Contemplations with Students Using Kantian Ethics and Utilitarianism**

#### **The Rights-Based Argument for Choice in Dying**

In the numerous ethics lectures I have conducted for various levels of nursing and health care students since the legalization of MAiD, I have offered a few classic ethical philosophies for students to contemplate their own perspectives. Kantian ethics and utilitarianism generate the most engagement from students because they highlight the intellectual tensions between two professional duties: relieving patients’ pain and suffering and respecting patients’ autonomy. A central premise in all medically assisted dying regimes is that suffering can be relieved if the person suffering is able to choose to end their life, and thus their pain. This premise positions medical assistance in dying as similar to that of medical and nursing interventions, which is to relieve pain and suffering. This positioning is, however, far from obvious to many. Considering the ethics at play in the issue of choice in dying in a health care context, it is relevant to further explore Kantian ethics and utilitarianism, which provide contrasting viewpoints.

### ***Kantian Ethics***

It is noteworthy to highlight that while all students believe it is important to respect a patient's autonomy, some also believe their own moral dignity will be compromised through participation in medically assisted dying. This belief, which students of mine have raised in class, is consistent with the influential account of human dignity by Immanuel Kant (1785/1998), for whom inherent dignity arose from the unique capacity of human beings to reason and thus to engage in autonomous self-regulation and freedom of choice. Freedom to choose, however, is for Kant predicated on respect of universal moral law: rationally necessary actions that every human being, insofar as they are a rational actor, must take in response to specific circumstances, without regard for consequences. The human capacities of reason and freedom of choice—essential tenets of Kant's formulation of dignity—are widely reflected in the emergence of the right to have control over one's body and to choose what medical treatment to refuse or accept (Lindberg et al., 2014). Medical assistance in dying has become the new prochoice movement because of the rights-based argument that supports a person's choice to terminate futile treatment and to pursue assisted death. This argument has been inextricably linked with the notion of dignity, even through the naming of enabling legislative acts such as Oregon's Dying with Dignity Act (Nicol & Tiedemann, 2015).

From the perspective of Kantian ethics, full freedom and autonomy arise out of respect of moral law (Andormo, 2014; Kant, 1785/1998). It remains, however, an open question whether the Kantian requirement for universality in moral actions is actually achievable with respect to medically assisted dying, and thus whether health care practitioners can reach the level of moral certainty when it comes to their actions or participation in MAiD. The question of whether autonomy and choice are restricted within MAiD legislation is in fact asking whether dignity is compromised for those who suffer, and is contingent on ethical perspectives about suffering, dignity, the right to die, and what freedom to choose means. From the perspective of dignity and inherent worth, on which international human rights and Kant's account of



dignity and autonomy are based, refusing the right to choose dying does not diminish dignity in dying because dignity is an unconditional quality of being human (Andormo, 2014). Hence, it is understandable that many students are struggling to position themselves when they are asked to apply Kantian ethics to MAiD as a discussion and thought exercise.

Superficially, the ideas of Kant provide the greatest amount of support for choice in dying. For Kant, moral action resides in reason and freedom to choose, which are important underpinnings for the condition of choice in dying (Kant, 1785/1998; Beauchamp et al., 2013). In Kant's theory of moral obligation, Kant argues that action is moral worth when it is congruent with universally valid guidelines, or maxims, and performed with good will (Beauchamp et al., 2013). Good will is the motivation for moral choice and can only be realized when persons act according to duty that is guided by reason rather than by consequences, such as relief of suffering, or by emotion, which can and does accompany suffering (Vong, 2008). Accordingly, goodwill and duty become problematic as ethical foundations for assisted dying.

Assisted dying encounters further challenges within Kantian ethics, in which the notion of suicide is both conflicted and contradictory. Kant (1785/1998) argued that to determine what is right, we must use reason and some considerations for others. Kant's categorical imperative is a way for us to conduct ourselves morally using reason regardless of our desire. There are two popular formulations of Kant's categorical imperative that are relevant to the discussion of MAiD. The first of these I have already mentioned: the maxim of universal moral law, which says that similar circumstances should elicit similar moral actions from the rational actor. For example, if one believes killing people is wrong, then there should never be a time when it is right. We should never make exceptions to this rule unless those exceptions could be universalized—that is, unless the exception could itself be made into a universal law for all rational actors. The second formulation of the categorical imperative is to treat ourselves and others always as an end, and never as a mere means to an end. That is, as rational humans we have autonomy. According to Kant, the rational application of these two categorical imperatives will ensure we are able to respect ours own and others' rational choices.

Kant's second formulation of the categorical imperative, which clearly advocates against the use of self or others as means to an end, gives us a productive lens on the issue of suicide (Vong, 2008). Though Kant does not himself provide a concise conclusion about the morality of suicide, the second categorical imperative would imply that suicide, either as a self-inflicted or an assisted act, is a use of the person as means to an end: the relief of suffering through the elimination of oneself (Andormo, 2014; Hasselaar, 2008). While these arguments would seem to dispute a person's right to choose death over suffering, the exercise of will suggested in Kantian ethics also sets up Kant's conditions under which medical assistance in dying has received social and legal support—specifically, the exercise of the right to autonomy. Thus, although the preservation of life and capacity for reason in Kantian ethics regarding moral action and human dignity is often interpreted as nonnegotiable, Kant's categorical imperative simultaneously insists that the notions of autonomy and reason can also legitimately justify one's actions. In the case of MAiD, they could justify a person's choice to die or a health care professional's decision to respect a patient's choice to die.

### ***Utilitarian Ethics***

Unlike Kantian ethics, the application of utilitarian ethics to questions such as assisted dying rests upon the dynamic evolution of common interests of humanity and human desires (Bird, 2013). In utilitarian ethics, dignity is essentially a contingent, interactional expression of respect for the person rather than an inherent characteristic of being human (Bird, 2013). Traditional utilitarian doctrine holds the view that an action is right when it serves to maximize human desires, happiness, and, by implication, freedom from pain and suffering. According to John Stuart Mill's principle of utility, an action is largely contingent and justified when it produces the greatest amount of good for the greatest number or contributes the greatest benefit, with the fewest bad consequences (Oberle & Bouchal, 2009). While Mill believed that persons will generally make decisions that benefit others, the absence of universal laws in utilitarianism implies that the good is whatever is considered good in the broader society (Burkhardt et al., 2018). The good, then, is socially constructed and potentially temporal, thus enabling varying

interpretation of rights and choices in key issues such as assisted dying that reflect predominant wisdom and reasoning, rather than universal laws that exist irrespective of cultural nuances or other extrinsic factors.

Advocates of assisted dying have worked to achieve legislation and measures to relieve those who are suffering with intolerable, irremediable pain and distress. This work represents a contemporary enactment of Mill's principle of utility. MAiD is intended to eliminate the intolerable suffering of persons, as well as the potential emotional suffering of those persons' loved ones, for whom the pain of loss may be less than that of witnessing their loved one in despair.

Dignity and dying have become conflated in contemporary ethics. Discussions about dying reflect the ideas of Jeremy Bentham and Mill for whom the possibility of suffering was the basis of dignity or our moral worth (Häyry, 2004). Within utilitarian thought, suffering arises out of the sentience of human persons or the ability to experience pain and pleasure (Hasselaar, 2008; Häyry, 2004). From a Millian perspective, medical assistance in dying is morally acceptable because it arises out of socially proclaimed priorities and respect for the suffering of the person and involves interventions that lessen the despair of the hurting person and loved ones, thus honouring the dignity of that person. The denial of access to an autonomous and safe way to die potentially promotes and prolongs suffering and interferes with the security and liberty of the person, which mitigates against dignity (Attaran, 2015). Therefore, medical assistance in dying at the request of a suffering person and justly performed by a physician or nurse who is in moral agreement with the act is morally permissible within the context of utilitarianism insofar as it arises out of a socially constructed obligation of respect for the individual.

Notwithstanding, for some, there are limitations to the application of utilitarian ethics. For example, the renowned Australian philosopher H. J. McCloskey (1963) critically suggested that the "utility" of utilitarianism is never just because the judgment of utility is subjective. For example, utilitarianism can be used to argue for both cases of voluntary and involuntary assistance in dying. Let us picture this: in a utilitarian framework, if enough persons were able to derive happiness and benefit from

the death of another person, then killing this person without their consent would be a moral action according to the principle of utility. Such reasoning is based on the worth of an individual in terms of a person's significance in existence, thus tying dignity to one's legacy and the meaningfulness of one's life to society (Grassian, 1981). This is problematic for vulnerable populations such as the aged, disabled, or those otherwise without a voice or self-advocate, whose contribution to society might be deemed by others to be diminished. The determination of individual worth and the potential to abuse MAiD in these circumstances could become a slippery slope, regardless of how well the process is articulated in MAiD and related legislation (Starkes et al., 2013). While proponents of utilitarianism claim that voluntary assistance in dying could ensure human dignity by maximizing the greatest common good and reducing collective inequality, it could also lead to an unfair distribution of happiness that privileges those with more power to the potential detriment of more vulnerable individuals. This was one of Kant's concerns: such a situation could potentially deny dignity for those unable to exercise freedom of choice (Grassian, 1981). Additionally, the determination of worth of individual life solely through the measurement of the needs of the collective potentially represents utilitarianism in its most selfish form and renders its place in end-of-life discussions questionable.

Extreme care has been taken in Canada's MAiD bills and legislation to indicate that freedom of conscience and religion are to be maintained for everyone (CNA, 2022). Like the Netherlands, Canada's MAiD legislations decriminalizes participation of health care professionals in assisted dying under certain conditions (Kouwehoven et al., 2013). The legalization of MAiD and the conditions of the Canada Health Act essentially mean that MAiD must be accessible to everyone. This makes MAiD a duty of physicians and nurses, which is at odds with conscientious objection (Schiller et al., 2019). This obligation is reflected in the guidance given to physicians by the College of Physicians and Surgeons (CPSO, 2019), which indicates that physicians cannot be compelled to provide aid but must provide timely referral to a nonobjecting, accessible physician, or other professional or agency. The intent of this guideline is to protect freedom of religion and conscience; however, its interpretation of MAiD legislation suggests that

the legislation neither fully protects nor penalizes those who conscientiously object, which is problematic for those who might view even referral itself as participation.

Health care professionals who are conscientious objectors of MAiD are the minority. Not surprisingly, however, there are always several students in my classes who, for religious or other reasons, would consider themselves conscientious objectors of MAiD. They have concerns in terms to how to navigate their practice after graduation or during clinical placements, should they feel the need to express their position on MAiD. To better understand this position, it may well be useful to again turn to Mill. Mill cautioned that doing the greatest good could not violate the rights of the minority. In the case of MAiD, conscientiously objecting health care professionals may wish to remain silent. In remaining silent, however, they risk violating their own right to object (Burkhardt, 2018). Moreover, if pro-MAiD health care professionals do not advocate for the right to conscientiously object, then they also violate the rights of the minority objectors.

### **Nurses and Choice**

All nurses, through their continued and intimate engagement with patients, may potentially be involved in the process of assisted dying, whether being the first person to whom the patient expresses a desire for assisted dying, preparing and/or administering life-ending medication, or providing support to patients and families (Pesut et al., 2019; Lamb et al., 2019). From a nursing perspective, the Canadian Nurses Association's *Code of Ethics for Registered Nurses* defines conscientious objection situationally and instructs nurses to notify employers about and request accommodations for care situations such as medical assistance in dying that conflict with their values or beliefs before such situations arise in their work (CNA, 2022). Many students question whether the CNA's statement of conscientious objection pertaining to MAiD is sufficient to support their request for resignments.

My students understand that moral certainty in utilitarianism resides in the extent to which the good—that is, the greatest good—is clearly defined and agreed upon by the patient, health care

professionals, and even society. Moral certainty is achieved when the aims of the health professional and the patient are united in a common and unquestioned view of the good; however, it is compromised when there is divergence in the good (Romyn, 2003). Hence, the students are grappling with the tensions between their Kantian duty to advocate for patient autonomy and where they position themselves in the utilitarianism spectrum. When differences occur, students on all sides of this issue risk being ostracized or stigmatized by their colleagues, instructors, managers, and others who position themselves differently within the issue. The students are fearful of alienation and stigmatization from colleagues, managers, and the broader professional community should their own moral positioning not align with that of others.

These concerns are not entirely unwarranted. Some students who are pro-MAiD question whether professional regulators should refuse to endorse conscientious objectors because nurses and physicians choose a line of work in which the needs of the patient and the social construction of the good are privileged over individual conscience, thus preemptively revoking their right to object (Hess, 2003). For those who oppose what is potentially the majority view, as encapsulated in current MAiD legislation, efforts to establish their basis of moral certainty can result in moral conflict with ensuing moral distress, loss of self-respect, sadness, and loneliness (Ford & Austin, 2018; Pesut et al., 2019).

### **A Relational Option**

One way around some of these issues is to appeal to a different conception of moral certainty based on a moral good that is neither certain nor explicit. Such a moral truth comes from bringing together expert knowledge with the particularities of individual experience in a shared understanding that emerges out of therapeutic relationship (Gadow, 1996, Hess, 2003). Pollard (2015) and Storch et al. (2013) indicated that relational ethics emphasizes the health care providers' relationships with their colleagues, their patients, and the health care system, all of which include essential relational components of mutual respect and engagement. Therefore, relational ethics could offer a more tangible frame for nurses and health care professionals to navigate their moral agency because it explains ethical decisions

within a relational context (Pollard, 2015; Storch et al., 2013). In the context of relational ethics, the therapeutic relationship assumes that the patient requires the health care professionals to help them comprehend their condition and to make informed decisions for their treatment plan, which could include MAiD (Bishop & Scudder, 2003; Hales et al., 2019). The relational approach recognizes the reciprocity in relationship and therefore acknowledges the vulnerabilities of both the patient and the health care professional. Although Hales et al. (2019) did not specifically apply relational ethics in their qualitative study about family caregivers' perspectives, the themes in their result strongly implied the relational aspects in the therapeutic relationships and rapport between the patients, their families, and the health care professionals. Essentially, a relational approach would avoid Kant's concern in his second categorical imperative; that is, that one could instrumentalized another in the pursuit of desired ends such as, in this case, assisted death (Andormo, 2014). Moreover, the reciprocity of the relationship is respectful of the particularities of each person's moral positioning and acknowledges that morality is socially constructed (Hess, 2003). This potentially enables nurses and other professionals to authentically express their reservations in supporting or enabling the wish of a patient to die, while still enacting their expertise through the proffering of options for comfort and dying and the exploration of the meaning of the experience of dying for the patient (Bergum, 2003; Hales et al., 2019). It is my experience in the classroom that students often breathe a sigh of relief when relational ethics is discussed and explored as a potential middle ground.

### **Conclusion**

MAiD is here, and its new amendments to this legislation are certain and imminent. A relational approach to medical assistance in dying may offer an ethical way forward for the person desiring death and the nurse to whom the desire is made known. More may need to be done to address the rights of nurses and others who are unable to support assisted dying as a choice. It is important that processes and policies at local and national levels provide clear guidance about options such as requests for

reassignment during assisted dying, or even about the absence of certain options. These must be clearly articulated to enable conscientious objectors to navigate their professional moral agency. Although health care organizations such as the London Health Sciences Center in Ontario and the University Health Network in Toronto have well-established algorithms to guide conscience objectors (Ball et al., 2019; K. Azubuike, personal communication, August 24, 2020), many continue to rely on sympathetic colleagues within their interprofessional team for support and dialogue to alleviate the conflict of conscience (Elmore et al., 2018; Lamb et al., 2019). There is urgent need for a more inclusive moral community that acknowledges diversity in conscience and seeks to educate its members on the process of objection to resolve the restrictions on the moral agency of conscientious objectors. Moreover, nursing students need to have a clear understanding of the practice reality they will face before they begin their career. Educators have an obligation to help students explore and navigate the ethical issues pertaining to their potential participation in MAiD.

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