Vol. 5 No. 2 (2026)

Pakistan Journal of Medical & Cardiological Review

https://pakjmcr.com/index.php/1/about

Online ISSN 3007-2387
Print ISSN 3007-2379

Karim et al - 2026

DOI: http://doi.org/10.5281/zenodo.20356647

CONCEPT ANALYSIS MEDICAL ASSISTANCE IN DYING (MAID) PREPARED

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Keywords:
Medical Assistance in Dying, MAiD, concept analysis, nursing ethics, moral distress, end-of-life care, Walker and Avant, palliative care, autonomy, intentionality of finality

Received on 09 May 2026
Accepted on 15 May 2026
Published on 18 May 2026

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Abstract

Medical Assistance in Dying (MAiD) is a complex, ethically sensitive and challenging approach in modern nursing. This paper discusses the concept of MAiD through the lens of structured concept analysis as developed by Walker and Avant (2011) in their eight-step method in a nursing ethical approach. The five key characteristics of MAiD are described using thematic synthesis which are as follows: (1) voluntariness and autonomous patient request where decisional capacity and lack of coercion is a non-negotiable precondition; (2) intolerable and irremediable suffering involving the patient's perception of physical and psychological suffering; (3) documented clinical protocol and legal sanction, where decisional authority over MAiD can be delegated, and MAiD is established as a legally regulated professional activity within its jurisdiction; (4) moral and professional relationality, where MAiD involves a higher degree of relationality than any other form of palliative intervention, encompassing patients, families and nursing staff; and (5) intentionality of finality, where the finality of MAiD is a distinguishing

Vol. 5 No. 2 (2026)

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characteristic; with life put to an end as the explicit, documented, and primary clinical objective. The attributes refer to the four principles of bioethics – autonomy, beneficence, non-maleficence and justice – making clear that these principles are not simply background for MAiD, but play a significant role throughout each stage of patients' care. The consequences of MAiD are recognized within three spheres: for the patient, it is a planned death and a finality that comes in advance of the patient; for the family caregiver, it is a complex and qualitatively different grief process; for nursing staff, it is a continuum of psychological and moral reactions, anxiety and compassion fatigue, moral distress, moral growth, and strengthened professional identity. The analysis includes implications for nursing, concluding that the structured institutional support of nurses who perform MAiD is needed; that there are critical gaps in nursing curricula regarding ethical and legal concerns related to MAiD; and that clear protections against consentious objection,nursing-specific procedures about MAiD and funding are necessary to prevent vulnerable populations from being disproportionately pressured as eligibility for MAiD expands.

INTRODUCTION

The issue of Medical Assistance in Dying (MAiD) may be one of the most complex nursing and healthcare ethics challenges of today. It's a step-by-step procedure with legal requirements and beneficiaries receive medical aid for devitalization when their conditions become intolerable and their life becomes too burdensome to carry. The implementation of MAiD continues to raise a wide range of ethical questions to date, both across and within jurisdictions — in the Canadian context as well as in Belgium, the Netherlands and in several U.S. states — which involve considerations of the roles of health professionals, particularly nurses, and places significant Ethics and Emotion burdens on health professionals (Gerson et al., 2022; Ishihara et al., 2022) . Nurses occupy a central and often underappreciated position in MAiD-related care. Their responsibilities extend from initial patient assessment and eligibility discussions to ongoing emotional support, care coordination, and post-death bereavement care for families. Given this breadth of involvement, a theoretically clear

Online ISSN 3007-2387
Print ISSN 3007-2379
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DOI: http://doi.org/10.5281/zenodo.20356647

and ethically grounded understanding of MAiD is not merely desirable—it is professionally essential (Pesut et al., 2022; Yan et al., 2023). This analysis is grounded in nursing ethics theory, drawing explicitly on the four bioethical principles of autonomy, beneficence, nonmaleficence, and justice. These principles, foundational to professional nursing, are not abstract in the context of MAiD—they are operationalized in every phase of patient interaction. Autonomy underpins the requirement for a voluntary, persistent patient request; beneficence and nonmaleficence exist in tension when suffering is irremediable; and justice demands equitable application of legal safeguards. Importantly, moral distress – defined as distress experienced when unable to act in accordance with one's moral principles – is also woven throughout this analysis, and considered to be a unique occupational challenge to nurses providing MAiD care (Ishihara et al., 2022; Koocher & Keith-Spiegel, 2023). Recent empirical literature confirms that MAiD is a multidimensional phenomenon shaped by legal frameworks, psychiatric evaluation, interdisciplinary collaboration, public trust, and socioeconomic factors (Bastidas-Bilbao et al., 2024; Howard Grubbs et al., 2024; Jamil & Pearce, 2025). Of importance to nursing scholars is the threat that extending MAiD access, without commensurate resources directed to building up palliative care facilities, can further harm vulnerable people, which is a just matter for nursing's professional concern (Jamil & Pearce, 2025).

This paper presents a structured concept analysis of MAiD organized as follows: methodology; definitions and uses of the concept; defining attributes; antecedents and consequences; model, borderline, and contrary cases; and implications for nursing practice, education, and policy. It is hoped that the analysis will provide a clear and specific definition of MAiD that rests firmly on nursing ethics and is supported by the latest empirical evidence, that the concept will be more tangible for nurses, and that a framework for action can be presented to the nursing science literature that can be replicated.

This analysis is an original contribution to the nursing theory analysis, based on the Walker and Avant nurturing approach to the 8-step nursing theory analysis done from a nursing ethics perspective, specifically MAiD. This paper strongly focuses on the moral, and relational and

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professional dimensions that are unique, and more important, of Nursing, as neither the legal nor the biomedical approaches have been the primary focus of previous literature looking at the issue of MAiD. The five characteristics were conceptualized and underpinned by theory and by research, and can help nurses clarify how Maid can be distinguished from other end-of-life interventions, how they themselves can navigate the ethical complexities of working with Maid, and how they can record and communicate with patient and family members. (Walker & Avant, 2011)

Methodology

Conceptual Framework: Walker and Avant's Method

This concept analysis employs the eight-step method developed by Walker and Avant (2011), one of the most widely cited and methodologically rigorous approaches to concept clarification in nursing science. Walker and Avant's framework move from broad contextual exploration to precise clinical operationalization, making it particularly well-suited for a concept as legally, ethically, and relationally complex as MAiD.

Steps of the Method Applied in This Analysis

Step 1: Selection of the Concept

MAiD was selected because it has become a legal reality in multiple countries, carries substantial ethical complexity, and directly shapes nursing practice. Despite this prominence, nurses frequently lack a cohesive, theoretically informed understanding of the concept—a gap this analysis seeks to address.

Step 2: Determination of the Aims or Purposes of Analysis

The primary aim is to identify and articulate the defining attributes of MAiD as a nursing concept, distinguishing it from related interventions such as palliative sedation, withdrawal of life-sustaining treatment, and physician-assisted suicide. The secondary aim is to map the antecedents and consequences of MAiD to inform nursing education, ethics training, and policy development.

Online ISSN 3007-2387
Print ISSN 3007-2379

DOI: http://doi.org/10.5281/zenodo.20356647

Step 3: Identification of All Uses of the Concept

A review of the nursing, medicine, ethnicity, legal and psychologic literature was done in a systematic way to identify all significant uses and definitions of MAiD. Works outside the years 2021-2026 were not considered, unless they are found to be an important theoretical piece. The following databases were utilized: Google Scholar, CINAHL, PubMed and PsycINFO. **Keywords:** *At least one of the following: euthanasia nursing ethics, palliative care ethics, nursing end of life decision making, medical assistance in dying, nursing and euthanasia, nursing and end of life, moral distress nursing are offered in every course.*

Inclusion Criteria: The empirical or theoretical articles published during 2021 – 2026 in the English language focus on MAiD in the clinical context or in ethics related health care contexts and purposes which support nursing related to MAiD (conflict avoidance, moral distress, conscience objecting, professional practice) articles; the foundational theoretical articles before 2021 are cited as such.

Exclusion Criteria: Opinion editorials and commentaries without empirical or theoretical basis; studies not in a nursing perspective (of interest to physicians); grey literature, conference abstracts and news articles (not peer-reviewed articles).

There was a total of 10 primary sources that were in the form of peer-reviewed sources. The following priorities will be some of the methods used to prioritize the sources: 1) relevance of study to issues of ethics and professional practice in nursing; 2) NSFP dates (2021-26); 3) methodological quality (systematic review, meta synthesis for qualitative studies); and 4) intent to provide informational scope related to various issues, ensuring that content is internationally applicable. Legal and professional standards documents were also provided for definitional and/or regulatory context.

Literature Review

The 10 sources cited as proof of this concept utilized four different research types: a systematic review, qualitative research, policy analysis, and practitioners' reflections from Canada, the United States,

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Belgium, the Netherlands and Switzerland. Each source is explored individually, highlighting what it adds to the nursing knowledge of MAiD.

The Canadian provinces, along with Belgium, the Netherlands and Switzerland, were the site of a systematic review and qualitative meta-synthesis carried out by **Gerson et al.** (2022) on the emotional impact of MAiD on health care workers. The authors found a variety of reactions, from compensation fatigue and moral distress to moral growth and greater sense of meaning in their professions, and they found that institutions and opportunities for debriefing and voluntary involvement are risk factors for the results of this experience. This firsthand source of information is related to the concept of moral and professional relationality, and the impact of moral distress on nurses.

Ishihara et al. (2022) conducted a qualitative study, identifying themes from the experiences of British Columbia, Canada, nurses who participated in MAiD. Qualitative in-depth interviews were conducted to be able to capture how the nurses who had been present in the process of reflective practice and peer support, acquired moral self-efficacy and how reflective practice had been experienced as professionally meaningful despite having clear roles and providing debriefing. Of the various sources this is the one that supports the attributes of moral and professional relationality, of instrumentality of finality, and the consequences for nursing education and policy.

Pesut et al. (2022) performed a series of qualitative multi-professional studies in BMC Palliative Care to study nurse, pharmacist and social worker experiences of making meaning of their participation with MAiD in Canada. Relationality with other people (as in 'accompaniment', 'witness' and ‘family support’) was a prominent theme in the nurse’s description of nursing practice and nurses referred to non-explicit suffering elements for a full picture of suffering to be delineated in the family. This paper will include information on the procedural definition of MAiD, the attribute of irremediable suffering and the antecedent 3 (exhaustion of alternatives).

Koocher et al. (2023) conducted a conceptual and ethical study in the context of the role of psychologists in MAiD evaluations, and their obligations toward MLHFAs (Medical Directors of

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Child Death Reviewed) in 2023. The authors talk about the concept of decisional capacity assessment as well as the importance of treatable psychiatric ailments such as major depression in MAiD requests. It speaks to psychological not psychiatric problems, yet relevant to nursing and found myself to have seen patients in distress psychologically before they were known to be suffering from mental illness. It is a measure of voluntariness & antecedent 2 (informed & voluntary decision making).

Yan et al. 2023 did a scoping review in BMJ Supportive and palliative care of the family caregivers' experience of MAiD within different jurisdictions. Many family members reported feeling closer to the person who had died as a result of anticipatory closure and that the patients wish were respected; some families reported feelings of guilt, moral ambiguity and complicated bereavement, particularly where the communities were not culturally supportive of MAiD. This source will give information on consequences 1 and 2, and evidence for the role of the nurse in bereavement (after the MaIeD).

In **2024, Smith and Jones** undertook a systematic review, published in the International Journal of Clinical Medicine (ISCM), that reviewed the attitudes of the public and the legal safeguards afforded to access of MAiD in Canada. There has been high public acceptance of the use of person-centred care, but there are concerns about the quality of the safeguards provided, concerns about the use of person-centred care without psychiatric assessment and concerns about the viability of alternative palliative care options. This source is used as a basis for the structure of regulation for the attribute of legal sanction, for the definitional structure Track 1/Track 2, and for antecedent 4 (legal prerequisites).

Howard Grubbs et al., (2024), published a rapid review article in Journal of Hospice and Palliative Nursing about the current landscape of MAiD in the USA. The review highlighted that there were gaps in understanding by healthcare practitioners in relation to eligibility, documentation and roles related to nursing and that there was a need for intentional documentation of clinical intent which is a legal requirement and safeguards nurses. This source will give information to the attribute of finality as well as the impact on the nursing profession. In the commentary paper "Opening the door

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wider to extending the reach of MAiD into individuals with a primary mental illness—challenges and considerations", **Bastidas-Bilbao et al. (2024)** discuss these difficulties. The authors recommended an interdisciplinary evaluation which is more targeted towards palliative care, a more extended waiting time for reflection about the pall- care of children, and a requirement for a palliative psychiatrist to make a mandatory consultation. This source supports the psychiatric eligibility underlying aspect of antecedent 2 and the policy implications resulting from the extension of MAiD to new populations resulting from this in consequence 4.

Recently, **Jamil and Pearce (2025)** produced a literature review regarding the economic and ethical cost and impacts of extending eligibility for MAiD in Canada. The authors highlighted several concerns, including that "palliative care" is not available or affordable in certain contexts and that, as such, MAiD becomes more about forced than free choice and hence a significant justice concern. The source offers information to the justice dimension of legal sanction and consequence dimension 4 – policy level risks.

In a professional reflection, published in Monitor on Psychology, **Andoh (2025)** titled "Compassion at the forefront of growing acceptance of medical aid in dying in North America," they shared their insight about compassion. The article has integrated the voices of patients, family members and psychologists, and highlighted that, in patient care, a discussion about MAID does not mean an adversarial relationship, but rather the integration of patients' comfort with MAID and the discomfort of healthcare providers is a result of insufficient training at work. This source bolsters one aspect of the definition of MAiD based on the patient-centred approach and compassion, key aspects that underlie the implications for nursing education.

All of these 10 sources present empirical and theoretical supports and antecedents that lead to the concept's defining characteristics, paradigms, antecedents and case examples used throughout this concept analysis.

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Step 4: Determination of Defining Attributes

Defining attributes are the cluster of characteristics most consistently associated with the concept. Thematic synthesis of the reviewed literature yielded five hallmark attributes: (1) voluntariness and autonomous request, (2) presence of intolerable and irremediable suffering, (3) explicit clinical protocol and legal authorization, (4) moral and professional relationality, and (5) intentionality of finality. These are detailed in the Attributes section below.

Step 5: Construction of a Model Case

A model case (Mr. Elias) was constructed to embody all five defining attributes with clarity, providing a clinical benchmark for the concept.

Step 6: Construction of Additional Cases

A borderline case (Mrs. Chen) and a contrary case (Mrs. Gupta) were developed to illustrate what occurs when one or more defining attributes are absent, thereby clarifying the concept's boundaries and helping nurses avoid misclassification of end-of-life interventions.

Step 7: Identification of Antecedents and Consequences

Antecedents (conditions that must precede MAiD) and consequences (outcomes that follow from MAiD) were derived from the reviewed literature and are presented separately in dedicated sections.

Step 8: Definition of Empirical Referents

Empirical referents—observable phenomena that confirm the concept's real-world occurrence—include current eligibility criteria, signed consent documentation, multi-disciplinary assessment records, and structured bereavement support protocols.

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Definitions

1. The Procedural Definition

MAiD is when a medical practitioner or nurse practitioner administers a substance at the patient's explicit request, or prescribes/provides a substance for the patient to self-administer, with the explicit intention of ending the patient's life.

Citation: Pesut et al. (2022). Medical assistance in dying and the meaning of care. BMC Palliative Care, 21(1). https://doi.org/10.1186/s12904-022-00903-y

2. The Patient-Centric (Compassion) Definition

MAiD is a clinical intervention that offers a compassionate end-of-life option for mentally competent adults experiencing intolerable suffering arising from a serious and irreversible medical condition, when all reasonable alternatives to relieve suffering have been considered. *Citation: Andoh, E. (2025). Medical aid in dying brings a compassionate close to life. Monitor on Psychology, 56(5).*

3. The Ethical and Professional Definition

From an ethical standpoint, MAiD involves clinicians ensuring that the patient's request is voluntary, persistent, and free from external coercion or untreated psychiatric illness, in alignment with the bioethical principles of autonomy, beneficence, and nonmaleficence.

Citation: Koocher & Keith-Spiegel (2023). MAiD: Ethical considerations for psychologists. Professional Psychology, 54(2), 101–110. https://doi.org/10.1037/pro0000497

4. The Policy and Regulatory Definition

MAiD is a regulated healthcare service with eligibility classified under Track 1 (natural death reasonably foreseeable) or Track 2 (not reasonably foreseeable), each governed by jurisdiction-specific legal safeguards, waiting periods, and independent assessments.

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Citation: Smith & Jones (2024). Public attitudes toward MAiD and associated safeguards in Canada. International Journal of Clinical Medicine, 15(5), 112–130.

5. The Nursing and Relational Definition

MAiD is a complex care transition in which nurses and the interdisciplinary team integrate the patient's end-of-life preferences with legally mandated clinical protocols, requiring a carefully maintained balance between technical competence and moral-ethical accountability.

Citation: Ishihara et al. (2022). Strengthening moral self-efficacy. Nursing Ethics, 29(3), 642–655. https://doi.org/10.1177/09697330211041725

Defining Attributes

1. Request Voluntariness and Autonomy

The initiating condition for any MAiD process is an autonomous, persistent request originating solely from the patient. Nursing literature consistently identifies 'decisional capacity' and the absence of external coercion as non-negotiable requirements. Decisional capacity is formally assessed using standardized clinical instruments, including psychiatric evaluation when psychological distress is present (Koocher & Keith-Spiegel, 2023). Requirements for multiple requests over a defined waiting period are designed to ensure that the decision reflects stable values rather than a transient crisis or depressive episode. Any evidence of pressure from family, caregivers, or financial circumstances is disqualifying.

Nursing Ethics Focus: It is important for nurses to be able to make a distinction between true autonomy and decisions made when depression is untreated, symptoms are not controlled, or when there is social pressure in the process of engaging in MAiD. It requires the clinical abilities to assess the patient's condition, but also a therapeutic relationship that allows patients to be ambivalent or even change their mind. Moral distress occurs when nurses feel that a patient is being coerced, but

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they do not have a means to address an issue within their institution (Koocher & Keith-Spiegel, 2023; Ishihara et al., 2022)

2. Presence of Intolerable and Irremediable Suffering

A defining characteristic of MAiD is the existence of a grievous and irremediable condition causing suffering that the patient subjectively experiences as unacceptable and incapable of being relieved under conditions they consider tolerable. Suffering may be physical (intractable pain, dyspnea, loss of bodily control), psychological (loss of dignity, existential despair), or a combination of both (Pesut et al., 2022). The irremediability criterion requires that all reasonable treatments have been exhausted or refused by the patient with informed understanding of the alternatives.

Nursing Ethics Focus: This attribute has made the subjective experiences of patients at the center of the process of assessing eligibility, as opposed to clinical parameters. Since nurses have an ethical responsibility to consider ways that the suffering can be reduced through other interventions before considering the option for MAiD, it is their mandate to seek out these options in order to be a voice of the principle of beneficence. Meanwhile, to continue treating a patient who has already made an informed choice not to implies a violation of a patient's autonomy. This ethical dilemma means that a thoughtful and continual interaction with patients and families, as well as with the interdisciplinary team is necessary (Pesut et al., 2022).

3. Explicit Clinical Protocol and Legal Sanction

MAiD is distinguished from all other end-of-life practices by its legally mandated, protocol-driven nature. The deliberate administration or prescription of lethal substances by a licensed provider—within a framework of legal authorization—is the attribute that separates MAiD from palliative sedation, withdrawal of care, or medical error. In Canada, this framework is defined by Bill C-7; in Belgium, by the Euthanasia Act; and in applicable U.S. states, by Death with Dignity Acts (Smith & Jones, 2024). Legal sanction transforms an ethically complex act into a regulated professional

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responsibility, but also generates obligations regarding documentation, reporting, and conscientious objection.

Nursing Ethics Focus: It is a just demand that MAiD is consistently and fairly administered and that it complies with the relevant protections. There is a legal framework for nurses' task to make them understand it in particular. They also should be aware of their rights and protections as a conscientious objector, which must be done in a timely and transparent way, and must not impact the patient's access to care. Whereas institutions do not have clearly written policies dealing with conscience, they foster the potential for conscience to suffer (Gerson et al., 2022; Smith & Jones, 2024).

4. Moral and Professional Relationality

In nursing literature, MAiD is not an isolated clinical act but a profoundly relational one. It marks a fundamental shift in the nurse-patient relationship—from life-preservation to 'witnessing and facilitating a chosen death.' This relational dimension encompasses the nurse's moral self-efficacy: the capacity to act in accordance with one's values while fulfilling professional duties, even when those duties are morally weighted (Ishihara et al., 2022). Research documents a spectrum of outcomes for nurses involved in MAiD, ranging from moral distress and compassion fatigue to moral growth and deepened professional identity (Gerson et al., 2022). **Nursing Ethics Focus:**The lifeguard of the bioethical triad of nonmaleficence is implemented straight and suggests not only towards the patient but towards the nurse. The duty for institutional responsibilities covers aspects of preparing nurses for pre-procedure, inter-professional team communication and debriefing. The absence of such care is a failing of the system; it isn't just a failing of one person. The relationality of MAiD also applies to those in the family, who should receive culturally appropriate death and dying support provided by nurses, who are most equipped to do so (Yan et al., 2023).

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5. Intentionality of Finality

The attribute that most sharply differentiates MAiD from all other palliative measures—including those involving the principle of double effect—is intent. In MAiD, the explicit, documented, primary goal of the clinical intervention is the cessation of the patient's life at a chosen time. There is no clinical ambiguity; the finality of the outcome is intended, consented to, and must be clearly communicated to all members of the care team (Howard Grubbs et al., 2024).

Nursing Ethics Focus: Having a clear understanding of the actions taken is important regarding legal liability, record accuracy and emotional response. Regulatory compliance has failed to adequately remind nurses that they are on the wrong path if they use MAiD when they should be using palliative sedation. This is the point that many new nurses and those charged with the responsibility of documenting consent can be misled, as well as patients and families. Intentionally ending a life is not natural death; there are significant differences in educational preparation needed to address the psychological aspects of intentional, life-ending care, and in nursing programs that reflect this difference (Howard Grubbs et al., 2024).

Summary of Defining Attributes

Attribute	Core Description	Nursing Ethics Relevance
Voluntariness	Patient is sole initiator; decisional capacity and absence of coercion are required	Autonomy principle; nurses monitor for coercion and document persistent, informed requests
Suffering	Subjective, irremediable distress — physical or psychological — judged by the patient	Beneficence/nonmaleficence tension; nurses assess whether palliative alternatives can relieve suffering

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Legality	Adherence to strict jurisdictional protocols and legal safeguards	Justice principle; nurses know local law, fulfill documentation duties, exercise conscientious objection transparently
Relationality	Shared moral and emotional journey of patient, family, and healthcare team	Nonmaleficence toward nurses; requires debrief, ethics consultation, and bereavement support structures
Finality	Explicit intent to end life — not merely to manage symptoms	Informed consent obligation; nurses clearly distinguish MAiD from palliative sedation in documentation and communication

Antecedents

Antecedents are conditions or events that must be present before MAiD can ethically and legally proceed. Four antecedents are identified from the literature.

Antecedent 1: Confirmation of a Grievous and Irremediable Medical Condition

The primary antecedent is clinical and legal confirmation that the patient has a grievous and irremediable medical condition—an advanced illness, disease, or disability that is causing enduring suffering and is in an irreversible state of decline. Smith and Jones (2024) emphasize that this antecedent is not merely diagnostic but constitutes a critical legal threshold. Howard Grubbs et al. (2024) note that nurses are often the first members of the care team to recognize when a patient's condition has reached this stage, given their continuous bedside presence and holistic assessment of quality of life.

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Antecedent 2: Informed and Voluntary Patient Decision-Making

Before consent to MAiD can be valid, the patient must demonstrate full understanding of their diagnosis, prognosis, all available treatment alternatives—including palliative care and hospice—and the nature and irreversible consequences of MAiD itself. Where mental illness is identified as a contributing factor in the patient's request, Koocher and Keith-Spiegel (2023) emphasize that treatable psychiatric conditions such as major depressive disorder must be excluded or adequately treated before the request can be considered autonomous.

Antecedent 3: Exhaustion or Informed Refusal of Alternatives

MAiD cannot proceed while reasonable alternatives that could relieve suffering to an acceptable degree remain unexplored or uncommunicated to the patient. Pesut et al. (2022) underscore the nursing role at this stage: nurses must facilitate transparent, compassionate conversations about the full spectrum of palliative options, ensuring that no patient reaches a MAiD request due to a gap in communicated or accessible care.

Antecedent 4: Satisfaction of Jurisdictional Legal Prerequisites

Every jurisdiction that permits MAiD defines specific eligibility criteria and procedural prerequisites. These typically include: a minimum age of 18 years; a specified number of written requests over a defined reflection period; independent assessments by at least two qualified practitioners; and verified documentation of decisional capacity. In some jurisdictions, additional safeguards apply for patients whose suffering is primarily psychological. Until all mandated prerequisites are documented and satisfied, MAiD cannot legally proceed (Smith & Jones, 2024).

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Consequences

Consequences are the outcomes that follow the occurrence of MAiD. They manifest across three interconnected domains: the patient's death experience, the family's grief trajectory, and the healthcare team's psychological and professional response.

Consequence 1: A Planned, Witnessed Death with Anticipatory Closure

The most direct consequence of MAiD is a scheduled, deliberate death that occurs at a known time and in a manner chosen by the patient. Unlike sudden or prolonged natural deaths, MAiD-related deaths create the conditions for anticipatory closure—a distinctive psychosocial process in which patient and loved ones can exchange final farewells, resolve interpersonal conflicts, complete meaningful rituals, and be present at the moment of death (Yan et al., 2023). Research indicates that this predictability frequently reduces the traumatic component of bereavement for family caregivers.

Consequence 2: A Unique and Complex Grief Response in Families

While anticipatory closure is often reported as a positive consequence, MAiD also generates a grief response qualitatively distinct from grief following natural death. Family members may experience a mixture of relief, guilt, sadness, and moral or religious conflict—particularly in communities where MAiD is not culturally or religiously sanctioned (Yan et al., 2023). The planned nature of the death, while reducing surprise, can also produce a sense of moral complicity that complicates bereavement. Nurses play a critical post-MAiD role in normalizing the range of emotional responses, providing bereavement support, and connecting families to community grief resources.

Consequence 3: Moral Distress and Moral Growth in Nursing Staff

A well-documented consequence of MAiD for healthcare providers is a spectrum of psychological and moral outcomes. Nurses with conscientious objections who are inadequately protected may

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Pakistan Journal of Medical & Cardiological Review

https://pakjmcr.com/index.php/1/about

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Print ISSN 3007-2379

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DOI: http://doi.org/10.5281/zenodo.20356647

experience moral injury. Conversely, nurses who voluntarily participate in MAiD and have access to institutional support, reflective practice, and peer debriefing frequently report moral growth—a deepened understanding of dignity, autonomy, and the meaning of compassionate care (Gerson et al., 2022; Ishihara et al., 2022). Ishihara et al. (2022) documented that such nurses developed stronger moral self-efficacy over time.

Consequence 4: Implications for Institutional Policy and Nursing Education

At the systemic level, MAiD generates institutional obligations: formal MAiD protocols, conscientious objection policies, inter-professional care pathways, and structured bereavement programs must be developed. Nursing curricula must incorporate MAiD-specific content—including ethical frameworks, legal literacy, communication training for end-of-life conversations, and emotional resilience skills (Howard Grubbs et al., 2024; Bastidas-Bilbao et al., 2024). Jamil and Pearce (2025) raise a critical policy-level consequence: without adequate safeguards, MAiD expansion may exert disproportionate pressure on economically and socially vulnerable populations for whom palliative care remains inaccessible.

Case Studies

To operationalize the defining attributes and clarify conceptual boundaries, three cases are constructed: a Model Case that embodies all defining attributes; a Borderline Case illustrating partial attribute expression; and a Contrary Case demonstrating what MAiD is not.

Case 1: The Model Case — "A Peaceful Parting"

Scenario

Mr. Elias is a 68-year-old man with end-stage metastatic lung cancer. Despite comprehensive palliative care, he experiences intractable respiratory distress and bone pain rated as unacceptable to his quality of life. Over three months, he has repeatedly and independently expressed his wish to

Pakistan Journal of Medical & Cardiological Review
https://pakjmcr.com/index.php/1/about
Online ISSN 3007-2387 Print ISSN 3007-2379
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DOI: http://doi.org/10.5281/zenodo.20356647

pursue MAiD. He is assessed by his oncologist and an independent palliative care physician, both of whom confirm he meets all eligibility criteria under applicable legislation. He signs multiple witnessed consent forms following private consultations conducted without family present.

Attribute Analysis

- Voluntariness: Mr. Elias demonstrates decisional capacity and initiates the request without external pressure, signing consent following private, uninfluenced consultation.
- Suffering: He describes his inability to breathe as rendering his life 'unbearable and devoid of dignity'—suffering defined by his own subjective values (Pesut et al., 2022).
- Legal Protocol: Two independent clinicians confirm eligibility; mandatory waiting periods are strictly followed (Smith & Jones, 2024).
- Relationality: His primary nurse coordinates the care team, provides family support before and after the procedure, and participates in a structured team debrief (Ishihara et al., 2022).
- Intentionality of Finality: A specific lethal medication protocol is prepared with the explicit, documented goal of causing death at the patient's chosen time (Howard Grubbs et al., 2024).

Discussion

This case embodies all five defining attributes clearly and without ambiguity. It serves as the conceptual benchmark against which borderline and contrary cases are assessed. The clarity of Mr. Elias's request, the rigor of the clinical process, and the relational support provided to his family align with nursing standards for MAiD provision.

Case 2: The Borderline Case — "The Ambiguous Request"

Scenario

Mrs. Chen has advanced dementia. Years prior, when cognitively intact, she completed an advance directive requesting 'medical help to die' if she ever 'lost her mind.' She is now physically healthy but

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Pakistan Journal of Medical & Cardiological Review

https://pakjmcr.com/index.php/1/about

Online ISSN 3007-2387 Print ISSN 3007-2379

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DOI: http://doi.org/10.5281/zenodo.20356647

lacks the capacity to recognize her children or participate in self-care. She neither contemporaneously requests MAiD nor objects to any care provided.

Attribute Analysis

- Voluntariness (ABSENT): No persistent, contemporaneous, autonomous request exists. Active decisional capacity at the time of the procedure is absent.
- Suffering (PARTIALLY PRESENT): A grievous and progressive condition exists, but Mrs. Chen cannot articulate her subjective experience of suffering at this time.
- Legal Sanction (CONTESTED): Many jurisdictions do not currently permit MAiD for dementia patients on the basis of advance directives alone (Koocher & Keith-Spiegel, 2023).
- Relationality (PRESENT): The family and care team experience significant moral and emotional conflict.
- Intentionality of Finality (UNCLEAR): Without contemporaneous consent, the intentionality of finality cannot be definitively attributed to the patient herself.

Discussion

This is a Borderline Case because it lacks the attribute of active decisional capacity at the time of the procedure. The absence of a contemporaneous, persistent request places this case outside the standard definition of MAiD in most nursing and legal frameworks (Koocher & Keith-Spiegel, 2023). It illustrates the ethical and legal debates surrounding advance directives in dementia—an area of active policy development.

Case 3: The Contrary Case — "Palliative Sedation"

Scenario

Mrs. Gupta is in the final hours of life due to liver failure. She is unconscious and experiencing terminal restlessness—agitation and labored breathing. Her nurse, following a standard comfort care

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protocol, titrates midazolam and morphine to maintain sedation and comfort until her heart naturally stops.

Attribute Analysis

- Voluntariness (ABSENT): Mrs. Gupta is unconscious; no contemporaneous patient request for a life-ending intervention exists.
- Suffering (PRESENT): Terminal suffering is present and is being addressed through symptom management, not a life-ending intervention.
- Legal Sanction for MAiD (ABSENT): The pharmacological intervention follows a palliative sedation protocol, not a MAiD protocol.
- Relationality (PRESENT): The nurse provides compassionate presence to the family.
- Intentionality of Finality (ABSENT): The intent is to relieve agitation. Death is a foreseeable but unintended consequence of comfort care, not the primary goal.

Discussion

This is a Contrary Case because the clinical intent—symptom relief rather than life termination—fundamentally differentiates it from MAiD. This distinction is vital for nursing practice: nurses who understand intentionality of finality as a defining attribute can accurately document their clinical actions and clearly communicate the nature of care to patients and families. Pesut et al. (2022) emphasize that this clarity also protects the integrity of palliative nursing as a profession, preventing standard comfort care from being mischaracterized as MAiD.

Discussion

Theoretical Contributions of This Concept Analysis

There are a multitude of ways the concept analysis further develops the theory of nursing; here are some of the major and novel. First, it applies the eight-step framework of Walker and Avant (2011)

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https://pakjmcr.com/index.php/1/about

Online ISSN 3007-2387

Print ISSN 3007-2379

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DOI: http://doi.org/10.5281/zenodo.20356647

to the concept of MAiD with an explicitly nursing ethics approach, yielding a theoretically-based, attribute-based definition that is not contained within the context of any particular jurisdiction's laws, but can be transferred across nursing to different settings internationally. Previous research on MAiD has focused on the legal or biomedical aspects of the conduct to this study is unique in focusing on the moral, relational and professional aspects unique to nursing.

Second, each of the five defining attributes is assigned to one of the four bioethical principles (autonomy, beneficence, nonmaleficence and justice) thereby showing that the bioethical principles are not simply background concepts in MAiD but are instead saliently active throughout the patient's health journey. This mapping represents an original contribution to the theory of nursing ethics that can be seamlessly incorporated into a clinical ethical consultation, curriculum and policy development.

Third, the use of moral distress throughout the analysis, rather than as a separate study outcome, is an innovation from other studies that used moral distress as an isolated outcome to many others that studied moral distress as an integral part of the moral landscape of the nurse's experience in MAiD contexts (Gerson et al., 2022; Ishihara et al., 2022).

Implications for Nursing Practice

For practicing nurses, the most immediate implication of this analysis is a clinically usable framework for distinguishing MAiD from related end-of-life interventions. The contrary case of palliative sedation resolves a common area of conceptual confusion and equips nurses to document their actions accurately and communicate clearly with patients, families, and legal authorities.

The attribute of moral and professional relationality has direct implications for institutional support structures. Gerson et al.'s (2022) systematic review demonstrates that nurses involved in MAiD—regardless of their personal position on the practice—experience significant emotional impact. Participation in MAiD must therefore be treated as a morally weighty professional experience

requiring structured support: pre-procedure preparation, inter-professional communication, and post-procedure debrief.

Implications for Nursing Education

Nursing curricula have historically underrepresented end-of-life care content, and MAiD-specific education remains even more scarce (Howard Grubbs et al., 2024). The five attributes, antecedents, consequences, and case studies presented here provide faculty with an immediately adaptable framework for case-based learning activities, ethics seminars, simulation scenarios, and clinical placement briefings. Education must include not only legal literacy but also structured preparation for the emotional and moral dimensions of MAiD participation.

Implications for Nursing Policy

Three policy priorities emerge from this analysis. First, conscientious objection policies must be explicit, enforceable, and clearly communicated—nurses who hold moral objections to MAiD must not be coerced into participation, yet must also ensure that patients' access to care is not compromised through their objection. Second, institutional MAiD protocols must incorporate nursing-specific roles and responsibilities, not merely physician-led procedures. Third, as Jamil and Pearce (2025) and Bastidas-Bilbao et al. (2024) demonstrate, policy expansion of MAiD to new populations must be accompanied by rigorous safeguards and adequately funded palliative care alternatives, to protect against the disproportionate pressuring of vulnerable populations.

Limitations

This analysis is limited by its reliance on English-language literature, which may underrepresent nursing perspectives from non-Anglophone countries where MAiD is practiced. The rapid pace of legislative change means that some jurisdiction-specific details may have evolved since the reviewed

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https://pakjmcr.com/index.php/1/about
Online ISSN 3007-2387
Print ISSN 3007-2379
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DOI: http://doi.org/10.5281/zenodo.20356647

sources were published. Future concept analyses should incorporate multi-lingual literature, patient and family narrative data, and updated legal frameworks as they emerge.

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Pakistan Journal of Medical & Cardiological Review

https://pakjmcr.com/index.php/1/about

Online ISSN 3007-2387

Print ISSN 3007-2379

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DOI: http://doi.org/10.5281/zenodo.20356647

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