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Pain Clinic and Sociology of Palliative Care: Request for Medical Assistance in Dying (MAiD) by Chronic Pain Patients

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Abstract

Background: Terminally ill patients require palliative care to mitigate suffering but may request medical assistance in dying (MAiD). Chronic pain patients experience psychosomatic disorders and suffering. The MAiD controversy in chronic pain patients requires continual review. This is a study of MAiD requests in a pain clinic. It examined the characteristics of patients requesting MAiD, their quality of life (QoL), and natural outcomes.

Methods: This is an observational study of 520 chronic pain patients who received treatment in a pain clinic. Data collection included patients' age, gender, diagnoses, and QoL scores. QoL scores were collected using the Medical Outcomes Study Short Form 36 Health Survey (SF-36). QoL scores were recorded across the eight domains of physical functioning (PF), physical role (PR), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), emotional role (ER), and mental health (MH).

Results: Five patients (1%) inquired about or requested MAiD. All of them were men aged 43 to 80 years. All patients have neuropathic paraspinal non-cancer pain. QoL scores were monitored over 3 years. The average change in PF was minimal (-0.2 points). PR score showed an average increase of 0.2 points. BP scores showed an average increase of 1.6 points. GH scores increased by an average of 0.6 points. VT scores showed an average increase of 0.6 points. SF scores showed an average increase of 0.6 points. ER scores increased by an average of 0.8 points. MH scores showed a mean increase of 0.8 points.

Conclusion: Despite chronic pain and suffering, the study shows these patients maintained stable lives with ongoing value-based pain clinic care. Their pain levels are controlled, ensuring stable mental health and general functioning. Therefore, instead of MAiD, it is ethical and logical to continue providing high-quality pain management and compassionate support. These patients can live with dignity and comfort instead of a premature death.

Keywords: Value-based care, Quality of life, Medical assistance in dying, Medical ethics, Multimodal pain management

Introduction

The sociology of palliative care involves social, cultural, and institutional factors affecting end-of-life care. It explores how societies, cultures, healthcare systems, and people handle dying and palliative care. Adult patients with terminal or severe incurable diseases experience existential suffering (1). Patients with existential suffering may request medical assistance in dying (MAiD). The sociology of MAiD involves societal, legal, policy, ethical, and healthcare factors impacting its practice.

Terminally ill patients describe existential suffering as the perception that life has lost meaning or purpose. MAiD is defined as death using prescribed lethal medications or directly causing death through the administration of lethal drugs by physicians. MAiD requires the consent of the patient and involvement of two physicians. MAiD is legal in Australia, Belgium, Canada, Colombia, Luxembourg, New Zealand, the Netherlands, Spain, Switzerland, and eleven states in the United States of America (1). Consequently, MAiD has been provided to terminally ill patients in those jurisdictions. Although societies with MAiD legalization aim to reduce suffering, there are unresolved moral, policy, societal, healthcare, and legal issues. The MAiD controversy necessitates further recognition, debate, and review.

Chronic pain is associated with psychosomatic comorbidities (2,3,4). Chronic pain patients experience insomnia and drug dependence (5,6). Additionally, they experience anxiety, distress, confusion, depression, and suffering (2). In March 2021, the Canadian government amended the criminal code to permit MAiD for patients whose natural mortality is not reasonably foreseeable (1,7). However, there is inadequate information, recommendations, and actions regarding MAiD in chronic pain patients. There is no previous clinical study of MAiD requests in the pain clinic setting. This study analyzed requests for MAiD by chronic pain clinic patients. It evaluated the prevalence of MAiD requests and characteristics of patients requesting MAiD. It evaluated the patient's quality of life (QoL) and natural outcomes.

Methods

This prospective observational study was registered on the Clinical Trials PRS website, with the PRS number NCT06802562. The healthcare organization approved it as a quality assurance study of routine clinical practice and sociology that does not require ethics review. All the patients provided informed consent. The study evaluated documented requests for MAiD and the characteristics of chronic pain patients requesting MAiD. The study evaluated the patient's QoL and natural outcomes.

Data collection included patients' age, gender, diagnoses, and QoL scores. QoL scores were collected using the Medical Outcomes Study Short Form 36 Health Survey (SF-36). The SF-36 is an instrument frequently employed to evaluate the quality of life (QoL) related to health in eight domains (8,9). The domains are physical functioning (PF), physical role (PR), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), emotional role (ER), and mental health (MH). A higher score indicates a superior health status, as each domain is scored on a scale of 0 to 100. The mean scores and standard deviations of normative data are contingent upon the population, gender, and age.

The prospective data collection reduced the risk of information recall and outcome bias. The longitudinal and cohort methodology facilitated data collection on multiple variables and outcomes over a specific duration, potentially discovering new associations between variables and outcomes (10). Data were analyzed with IBM® SPSS® Statistics 28 (IBM Corp, Armonk, NY) using Student's t-test, analysis of variance, regression analysis, Pearson Chi-square test, and Fisher's exact test. The data are compared, analyzed, and interpreted appropriately. Quantitative and qualitative data are presented as figures, tables, categories, and numbers.

Case Presentation

We studied 520 consecutive patients who underwent management of non-cancer pain from April 2021 to March 2025. This study analyzed prospective data collected during routine clinical care. The consecutive sampling approach minimized the risk of patient selection bias. This convenience sample included all patients who received treatment. The patients were provided multimodal value-based pain clinic care, including interventional injection therapy, multimodal analgesics, antidepressants, and clonidine anxiolytic therapy. The patients were provided compassion, but MAiD was not offered to them. The patients were followed up for 3 to 3.5 years. They were provided with multidisciplinary and psychological support.

Results

The study included 520 chronic pain patients, comprising 319 females (61.3%) and 201 males (38.7%). A total of 5 patients (1%) inquired about or requested MAiD. All of them were male. The age distribution showed two patients aged 40-50, two patients aged 50-60, and one patient aged 80. Patient 1 is 48 years old with a history of multiple sclerosis. Patient 2 is 43 years old with a history of stroke and unilateral lower limb paresis. Patient 3 is 55 years old with a history of multiple suicide attempts and substance dependence. Patient 4 is 57 years old with a history of failed spine surgeries and substance dependence. Patient 5 is 80 years old with a history of spinal stenosis and failed spine surgery.

Table 1 shows the patients' characteristics, outcomes, and QoL scores during the initial 12 months of pain clinic care. The patients range in age from 43 to 80 years. All patients have neuropathic paraspinal non-cancer pain. Each patient has different underlying health conditions, such as multiple sclerosis, stroke, substance dependence, failed spine surgeries, or spinal stenosis. Regarding Physical functioning (PF), patient 5 has the lowest scores due to old age. The Physical role (PR) scores vary, with patient five consistently scoring lower. The Bodily pain (BP) scores are similar, with slight variations. Regarding General health (GH), the younger patients have slightly better scores. Regarding Vitality (VT), patient 5 scores the lowest. The Social functioning (SF) scores were mostly stable across patients. The Emotional role (ER) and Mental health (MH) scores were stable across all patients.

Table 1: QoL scores during the initial 12 months of pain clinic care, as mean score (standard deviation).

Patients	Age (years)	Pain Diagnosis	Co-morbidity	SF-36 QoL physical functioning (PF) score: Mean (SD)	SF-36 QoL physical role (PR) score: Mean (SD)	SF-36 QoL bodily pain (BP) score: Mean (SD)	SF-36 QoL general health (GH) score: Mean (SD)	SF-36 QoL vitality (VT) score: Mean (SD)	SF-36 QoL social functioning (SF) score: Mean (SD)	SF-36 QoL emotional role (ER) score: Mean (SD)	SF-36 QoL mental health (MH) score: Mean (SD)	Life outcome at 12 months
Patient-1	48	Paraspinal pain	Relapsing multiple sclerosis	86 (19)	81 (31)	76 (22)	72 (19)	62 (20)	85 (21)	84 (30)	74 (18)	Stable function
Patient-2	43	Paraspinal pain	Stroke, unilateral leg paresis	89 (17)	85 (29)	79 (21)	74 (20)	65 (21)	87 (19)	85 (29)	75 (16)	Stable function
Patient-3	55	Paraspinal pain	Substance dependence, suicide attempts	78 (24)	73 (39)	71 (25)	69 (20)	60 (19)	83 (22)	80 (31)	73 (17)	Stable function
Patient-4	57	Paraspinal pain	Failed spine surgeries, substance dependence	77 (23)	72 (38)	70 (24)	68 (21)	58 (19)	84 (24)	81 (30)	73 (18)	Stable function
Patient-5	80	Paraspinal pain	Spinal stenosis, failed spine surgeries	57 (28)	60 (39)	68 (25)	64 (20)	54 (21)	79 (25)	79 (32)	73 (17)	Stable function
Most other male patients	40-80	Paraspinal or significant joint pain	Depression, insomnia, substance dependence	85 (20)	80 (36)	76 (25)	70 (21)	61 (21)	85 (23)	84 (33)	74 (19)	Stable function

QoL = Quality of Life; SD = Standard Deviation

Table 2 shows the patients' characteristics, QoL scores, and life outcomes after 3 years of pain clinic care. Figure 1 shows QoL scores over time for patient 1. Figure 2 shows QoL scores for patient 2. Figure 3 shows QoL scores for patient 3. Figure 4 shows QoL scores for patient 4. Figure 5 shows QoL scores for patient 5.

The average change in PF was minimal (-0.2 points). PR score showed an average increase of 0.2 points, with a maximum increase of one point in some cases. BP scores showed a noticeable improvement, with an average increase of 1.6 points. GH scores increased by an average of 0.6 points. VT scores showed small fluctuations, with an average increase of 0.6 points. SF scores remained highly stable, with an average increase of 0.6 points. ER scores increased by an average of 0.8 points, with all patients either maintaining or improving their scores. MH scores showed a similar trend, with a mean increase of 0.8 points.

Table 2. QoL scores after 36 months of pain clinic care, as mean score (standard deviation).

Patients	Age (years)	Pain Diagnosis	Co-morbidity	SF-36 QoL physical functioning (PF) score: Mean (SD)	SF-36 QoL physical role (PR) score: Mean (SD)	SF-36 QoL bodily pain (BP) score: Mean (SD)	SF-36 QoL general health (GH) score: Mean (SD)	SF-36 QoL vitality (VT) score: Mean (SD)	SF-36 QoL social functioning (SF) score: Mean (SD)	SF-36 QoL emotional role (ER) score: Mean (SD)	SF-36 QoL mental health (MH) score: Mean (SD)	Life outcome after 3 years
Patient-1	48	Paraspinal pain	Relapsing multiple sclerosis	85 (19)	81 (30)	77 (22)	73 (18)	61 (20)	85 (20)	85 (30)	75 (18)	Stable function
Patient-2	43	Paraspinal pain	Stroke, unilateral leg paresis	89 (18)	85 (27)	80 (20)	75 (20)	65 (20)	88 (19)	85 (28)	76 (16)	Stable function
Patient-3	55	Paraspinal pain	Substance dependence, suicide attempts	78 (22)	74 (39)	73 (25)	70 (19)	62 (19)	84 (22)	81 (30)	75 (17)	Stable function
Patient-4	57	Paraspinal pain	Failed spine surgeries, substance dependence	77 (21)	72 (35)	72 (24)	68 (20)	59 (19)	84 (21)	82 (30)	73 (16)	Stable function
Patient-5	80	Paraspinal pain	Spinal stenosis, failed spine surgeries	57 (25)	60 (34)	70 (25)	64 (20)	55 (21)	80 (25)	80 (31)	73 (17)	Stable function
Most other male patients	40-80	Paraspinal or significant joint pain	Depression, insomnia, substance dependence	85 (20)	80 (36)	76 (25)	70 (21)	61 (21)	85 (23)	84 (33)	74 (19)	Stable function

QoL = Quality of Life; SD = Standard Deviation

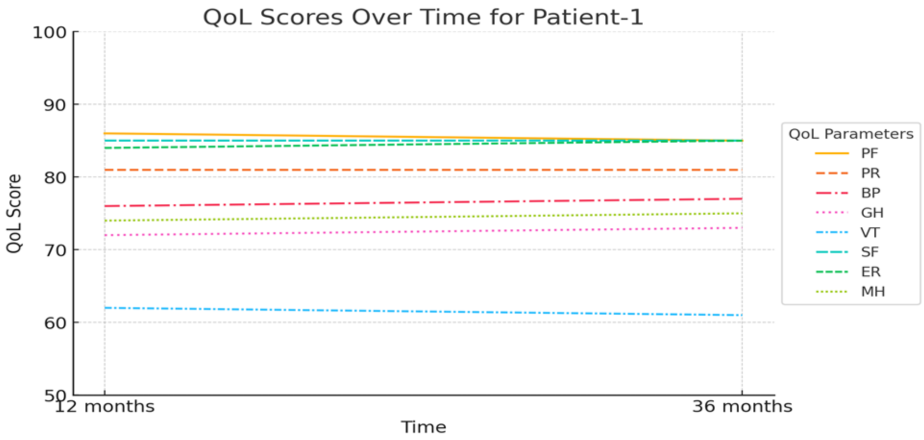

Figure 1

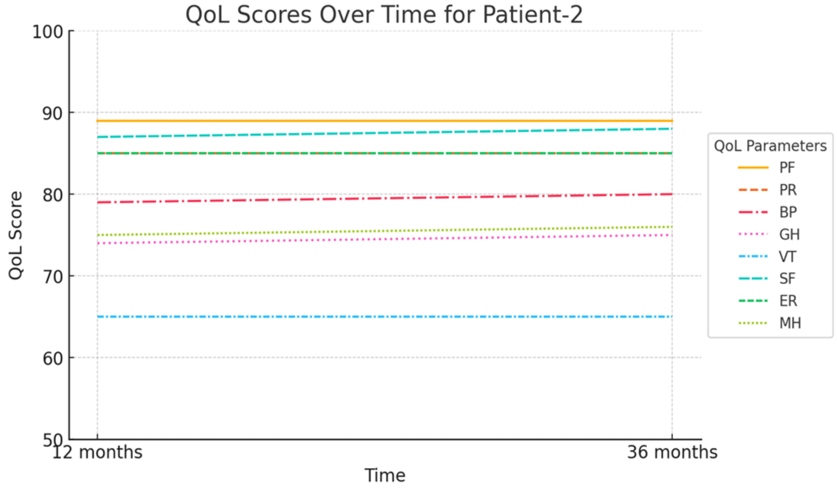

Figure 2

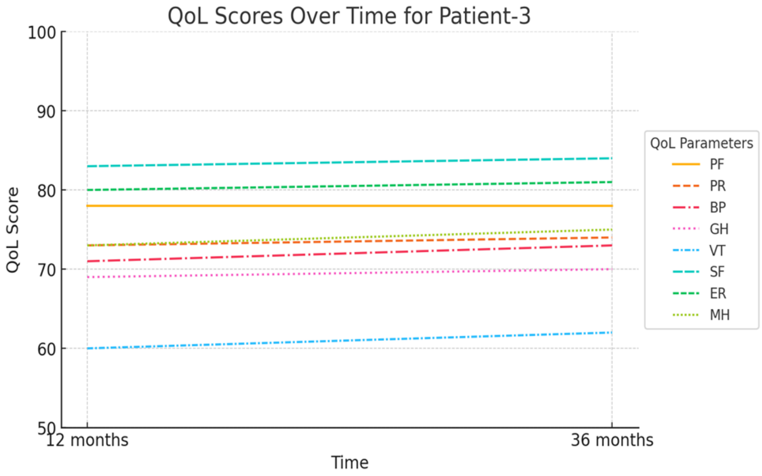

Figure 3

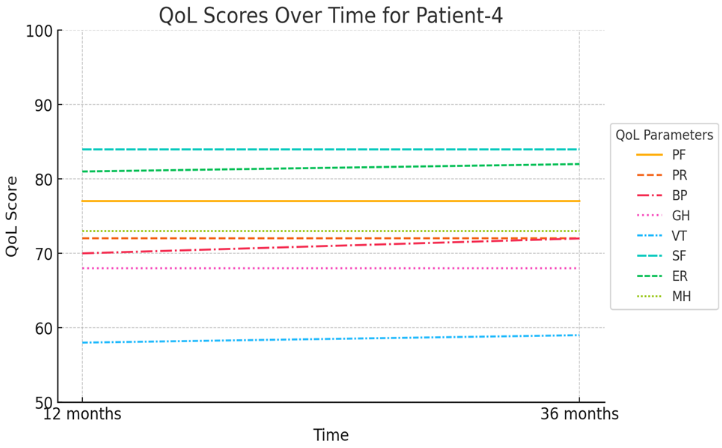

Figure 4

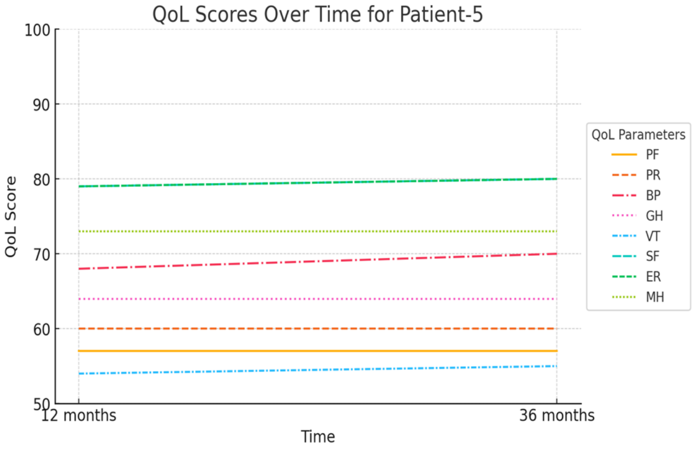

Figure 5

Discussion

Over the 3 years, patients' QoL scores remained largely stable, with only minor fluctuations observed in different categories. While some patients experienced slight improvements in specific QoL dimensions, no significant declines were noted. The average change in PF was minimal (-0.2 points), indicating that most patients maintained their physical capabilities. The most substantial decline observed was a single point, which is negligible over three years. This shows that value-based pain clinic care effectively helped patients maintain their mobility.

The PR score showed an average increase of 0.2 points, with a maximum increase of one point in some cases. This slight positive trend indicates that patients' ability to perform physical tasks improved slightly, though the change is not statistically significant. There was a more noticeable improvement in BP scores, with an average increase of 1.6 points. This indicates that pain levels decreased slightly over time, possibly due to sustained treatment efforts. Some patients experienced a two-point improvement, showing that pain relief strategies were effective for specific individuals.

The GH scores increased by an average of 0.6 points, with some patients reporting no change while others experienced an improvement of one point. This slight increase may indicate that patients perceived their overall health somewhat better after continued care. The VT scores showed small fluctuations, with an average growth of 0.6 points. However, one patient experienced a decline of one point, while another saw an increase of two points. This variation suggests that while some patients may have felt more energetic, others may not have experienced significant benefits in this domain.

The SF scores remained highly stable, with an average increase of 0.6 points. Most patients maintained their ability to engage in social activities, with slight improvements observed in some cases. The ER scores increased by an average of 0.8 points, with all patients either maintaining or improving their scores. This suggests that the psychological support or coping mechanisms provided during treatment may have contributed to better emotional stability. The MH scores showed a similar trend, with an average increase of 0.8 points. While some patients experienced no change, others saw improvements of up to two points. This suggests that long-term care may have positively impacted mental well-being.

The decision between continuing care and MAiD is an ethically complex issue, particularly for patients suffering from chronic pain. However, the provided QoL data evidence strongly supports the argument that these patients should continue receiving care instead of considering MAiD. The patients in this study have demonstrated stability in their functional outcomes over three years. None of the patients experienced a significant decline in their QoL; minor improvements were observed in critical areas such as BP, GH, and MH. These findings suggest that ongoing care successfully maintains their ability to function and engage daily. If patients were experiencing rapid and irreversible deterioration, MAiD might be a consideration. However, the data shows that their pain management and overall QoL are being preserved, making continued value-based care more ethical.

The BP scores showed slight improvements across multiple patients, indicating that treatment strategies provide relief. If pain worsened significantly over time, one might argue that the suffering was intolerable. However, the data suggest that the clinic's value-based pain management strategy is working, making it unjustifiable to abandon treatment in favor of MAiD. Furthermore, advancements in pain management, physical therapy, and psychological support offer hope for continued improvement. Cutting off treatment now would deny these patients the opportunity to benefit from future breakthroughs.

Patients with chronic pain often suffer from depression, anxiety, and emotional distress (2,6). However, this study group's MH and ER scores slightly increased over time. This indicates that patients are not in a state of severe mental distress that would warrant considering MAiD as the only compassionate option. Suicidal ideation is a symptom of treatable depression rather than a rational choice about the future. The fact that patients are maintaining stable emotional and mental health suggests that they are not experiencing an unbearable psychological burden that would justify ending their lives prematurely.

From an ethical standpoint, healthcare professionals must provide value-based care that sustains and improves life whenever possible. Since these patients still benefit from ongoing care, choosing MAiD would contradict the principles of beneficence (doing good) and non-maleficence (avoiding harm). Additionally, allowing MAiD for individuals whose conditions are not terminal but manageable could set a dangerous precedent. It may lead to a broader societal devaluation of lives affected by chronic illness and disability, potentially encouraging premature decisions to end life when alternative treatment options are still available.

Chronic pain patients often face periods of despair, but medical, social, and psychological support systems are in place to help them cope (11,12). Community support, therapy, medication adjustments, and lifestyle interventions can make a significant difference in how a patient experiences pain and disability. These study patients have already demonstrated resilience over three years, and further support can continue to enhance their ability to cope with their condition.

Conclusion

While the suffering caused by chronic pain is real and should never be minimized, the evidence clearly shows that these patients are maintaining stable lives with ongoing value-based care. Their pain levels are being managed, their mental health is stable, and their ability to function in daily life remains intact. Therefore, rather than considering MAiD, the ethical and logical decision is to continue providing high-quality care, pain management, and compassionate support. These patients deserve the opportunity to live with dignity and comfort, not to have their lives ended prematurely when treatment is still effective.

Conflict of Interest

All the authors declare no conflict of interest.

Acknowledgement

All the authors testify that all persons designated as authors qualify for authorship and have checked the article for plagiarism. All the authors were involved in writing initial and final drafts, proofreading, critical review, and approval of the final article draft.

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