Original Manuscript

Nursing Ethics
2021, Vol. 28(5) 766–775

10.1177/0969733020976185
journals.sagepub.com/home/nej

Conscientious objection to medical assistance in dying in rural/remote nursing

Julia Panchuk and Lorraine M Thirsk
Athabasca University, Canada

Abstract

In 2016, the Supreme Court of Canada legalized medical assistance in dying in Canada. Similar to jurisdictions where this has been a more long-standing option for end-of-life care, the Supreme Court's decision in Canada included a caveat that no healthcare provider could be compelled to participate in medical assistance in dying. The Canadian Nurses Association, in alignment with numerous ethical guidelines for healthcare providers around the globe, maintains that nurses may opt out of participation in medical assistance in dying if they conscientiously object to this procedure. The realities of implementing medical assistance in dying are still unfolding. One area that has received little attention in the literature thus far is the ability of nurses who *aid with,* rather than *administer,* medical assistance in dying to conscientiously object. This is particularly significant in rural and remote areas of Canada where geographic dispersion and limited numbers of nursing staff create conditions that limit the ability to transfer care or call on a designated team. Exercising conscientious objection to medical assistance in dying in rural and remote areas, by way of policies developed with an urban focus, is one example of how the needs of rural nurses and patients may not be met, leading to issues of patient access to medical assistance in dying and retention of nursing staff. To illustrate the complexities of nurses' conscientious objection to medical assistance in dying in a rural setting, we apply an ethical decision-making framework to a hypothetical case scenario and discuss the potential consequences and implications for future policy. Realizing that conscientious objection may not be a viable option in a rural or remote context has implications for not only medical assistance in dying, but other ethically sensitive healthcare services as well. These considerations have implications for policy in other jurisdictions allowing or considering medically assisted deaths, as well as other rural and remote areas where nurses may face ethical dilemmas.

Keywords

Conscientious objection, ethical decision-making, ethics, euthanasia, medical assistance in dying, rural and remote nursing

Introduction

Freedom of conscience is a human right addressed in the International Covenant on Civil and Political Rights;[1] however, this freedom is restricted if it impinges on the rights and freedoms of other people. Nurses encounter ethical issues regularly in practice;[2] however, competing personal and professional ethics can

Corresponding author: Lorraine M Thirsk, Athabasca University, 1 University Drive, Athabasca, AB, T9S 3A3, Canada.
Email: lthirsk@athabascau.ca

make some of these challenges more difficult than others. While nurses, as people, have a right to conscientiously object, this right is only upheld in practice to the extent that it does not deny others their rights. A current example of where personal ethics and conscience may result in an ethical dilemma is with the introduction of medical assistance in dying (MAiD) in Canada. The Canadian Charter of Rights and Freedoms allows citizens to live by their conscience[3] and the Canadian Nurses' Association Code of Ethics offers guidance on how to navigate matters of conscience in nursing practice,[4] with specific guidelines developed for MAiD.[5] Despite a Charter of Rights and Freedoms, a national Code of Ethics for nurses, provincial standards of practice, and healthcare laws, there can be ambiguity for nurses. The relative newness of MAiD means the application of the above guidelines and standards has not been fully realized, with gaps in research, policy, and legal precedence surrounding conscientious objection (CO). We believe one of these gaps, which has not yet been addressed, is a need to understand the unique experiences of nurses in rural and remote settings who are navigating issues of conscience related to MAiD. To illustrate the complexities of CO in a rural setting, we apply an ethical decision-making framework to a hypothetical scenario and discuss the potential consequences, including reduced access to MAiD for patients and moral distress for nurses.

Background

In 2016, Bill C-14 was passed in the Supreme Court of Canada (SCC) and MAiD was legalized for adults who meet specific criteria.[6] In Canada, nurse practitioners are prepared at a graduate level of education and are authorized to prescribe and administer MAiD. For the purposes of this paper, we are focused on the role of the generalist nurse (i.e. registered nurses (RN) or licensed practical nurses) who do not prescribe and administer MAiD, but may facilitate access, coordinate self-referrals to MAiD providers, initiate intravenous access, provide pharmacy returns, document nursing care, and support the patient and family before, during, and after the MAiD process.[7] Although nothing in the Canadian legislation suggests that a nurse *must* participate in MAiD,[5] there is an emphasis on the important role nurses have ensuring patients have access to the service.[7,8] The *National Nursing Framework on Medical Assistance in Dying in Canada*[5] states,

> Nurses recognize, respect, and promote a capable person's right to be informed and make decisions about their health and end-of-life care options including MAiD . . . (and) Nurses work to prevent or eliminate discrimination toward all those involved—persons, family members, healthcare staff—in end-of-life care decisions and provisions, including MAiD. (p. 10)

Accessing MAiD is a right of Canadians in all care settings, and nurses have a duty to provide care and must not abandon their patients.[9] Balancing these patient rights and nursing obligations raises questions regarding the freedom of nurses to act in accordance with their conscience—particularly with the constraints of rural and remote nursing where an option such as transfer of care may not be feasible. A CO may occur when a practice violates deeply held, long standing personal ethics or moral beliefs;[10] however, the Code of Ethics for nurses in Canada states that nurses are not necessarily legally protected for actions based on their CO.[4] Furthermore, the Canadian legislation does not detail the responsibilities of nurses who aid with, rather than administer, MAiD instead provincial and territorial regulatory bodies are responsible for detailing the responsibilities of all nurses surrounding MAiD.[5,7] Not only do these roles and responsibilities vary between jurisdictions,[9] they are expanding and changing. For example, one province has recently allowed nurses to return unused MAiD substances to the pharmacy—a role that was, prior to COVID-19, restricted to MAiD administration practitioners.[11]

Nurses often lack ethical support in the workplace regarding participation in MAiD.[8] While there is growing evidence regarding how nurses are involved in supporting MAiD, the guidance from regulatory bodies in Canada is varied and inconsistent.[12] In Belgium, where euthanasia has been legal for more than 15 years, one small study showed that nurses continue to describe participation in euthanasia as emotionally demanding and laden with moral uncertainty.[13] Such moral uncertainty has also been noted in Canadian nurses in the years since the advent of MAiD in Canada.[14] Further to the emotional and psychological burden of MAiD, ethics policies are still lacking in places like Belgium despite the longevity of the practice of euthanasia.[13]

When nurses are in situations where they must participate in activities that do not align with their personal ethics, moral distress is born.[2] The sequalae to the repeated experience of moral distress can include negative physical and psychological effects, burnout, moral disengagement, and potentially attrition from the profession.[15] Furthermore, nurses are promoters of health and well-being for others and are also ethically obligated to ensure their own well-being in order to continue to provide a high standard of care for patients.[4] Well-being includes expressing and acting on what an individual believes to be true,[3] therefore, being able to practice within the limits of one's conscience may be crucial to ensuring fitness to practice as a nurse. Having clear ethical policies in place could support the moral well-being of nurses and reduce the risk of moral distress-related burnout.[2] Avoiding burnout and attrition of nurses is particularly salient in rural and remote areas, which often struggle to recruit and retain healthcare providers. The effects of burnout and attrition could further compromise patient care.

Further concerns regarding CO in the context of MAiD are raised in rural and remote settings where CO, in combination with limited staffing, could compromise patient access to MAiD beyond the practical limitations such as vast geography.[16] Nearly half the global population lives in rural and remote areas and nursing shortages in these areas are well recognized by global, national, and local authorities, with incentives continually being generated to recruit and retain nursing staff.[17] Grappling with ethical issues and experiencing compassion-fatigue are common themes to nurses working in rural and remote areas in countries with widely dispersed populations such as Australia, Canada, and the United States.[18–20]

It is argued by some bioethicists that CO has no place in health care.[21] Currently however, practicing within personal moral principles is permissible for Canadian nurses, supported by the national Code of Ethics and provincial standards of practice. Internationally, CO is supported both directly (such as the Parliamentary Assembly of the Council of Europe) and indirectly by upholding rights of freedom of thought, conscience and religion.[10] Furthermore, concerns have been raised about the unintended consequences of disallowing CO for healthcare providers.[22] Given the current option of CO, and the current practice of MAiD, our focus is on further describing and analyzing the potentially imminent policy and practice implications. Using a hypothetical situation, we explore how a nurse in rural practice, with CO to MAiD, working within the current application of an opt-out approach, is unable to adhere to their personal ethics simultaneously with the professional Code of Ethics and obligation to patient care.

Guiding ethical decision making/introduction

Navigating ethical dilemmas is a crucial element of nursing practice and requires reflection on values and personal ethics, critical thinking, and consideration of alternatives.[2] Application of ethical decision-making frameworks can help support nurses when facing ethically complex situations. Structured frameworks for ethical decision-making are available to assist nurses with making competent, patient-centered, ethical decisions.[2] This is accomplished in part through careful consideration of, and collaboration with, all parties involved.[23] Ethical frameworks can help to examine and consider all aspects of an ethical issue and expose varying perspectives, but do not necessarily result in clear yes/no answers.[24] One scenario where a decision-making framework can help nurses is in the case of CO to MAiD.

Literature has demonstrated that application of relational ethics may help nurse leaders navigate ethical issues surrounding MAiD in the workplace, but there is limited literature addressing the experience of frontline nurses involved in assisting with MAiD,[14] including those with CO. There is also a gap in literature addressing the application of ethical decision-making frameworks to inform and guide nursing decisions related to MAiD.

Furthermore, in rural settings, the intricacies of the environment can make it more challenging for nurses to act in accordance with personal ethics when making decisions due to a variety of restraints. These intricacies include overlap of personal and professional relationships with patients or families, complex power dynamics between nurse and physicians or leaders, and possibly concern of retaliation.[19]

Based on both authors' experiences of rural and remote nursing in Canada, we present a hypothetical scenario and the application of one ethical decision-making framework involving a frontline nurse with a CO to MAiD, drawing attention to the needs of rural practicing nurses. An ethical decision-making framework, adapted from MacDonald,[25] provides step-by-step guidance by way of reflective questioning, and encourages thoughtful and thorough consideration of an ethical issue. This framework was chosen for its brevity and pragmatism. It guides individuals to consider the issues, the participants, the motivations, possible outcomes, and generate options for complex decisions and offers a structure that is easily accessible to nurses facing time-sensitive decisions. Using an ethical decision-making framework does not guarantee a favorable outcome to either patient or nurse but assists in bringing awareness to many aspects of a dilemma.[2] From our experience, the scenario offered in this paper is plausible in rural and remote health care settings, particularly given many MAiD procedures are scheduled during evenings and weekends.[8] For readability purposes, female pronouns will be used for both nurse and resident.

The scenario

A resident of a small long-term care (LTC) facility has requested and been approved for clinician-assisted MAiD via intravenous administration of drugs intended to end her life. She has scheduled her death for Saturday evening—the anniversary of her spouse's death. The resident wishes to die in her home (the LTC facility); her family is supportive of this choice and has arrived from out of town to be with her for her death. There is typically only one RN working in this facility during evening shifts. The RN scheduled for this particular weekend has been working in the facility for over 10 years and has a CO to MAiD that she has reported to her employer as per the standard of accountability in the Code of Ethics.[4] Using this scenario, an adapted ethical decision-making framework[25] will be applied to explore possible outcomes.

Data and moral claims

The main conflicts presented in this scenario are those of personal versus professional ethics. The resident's right to autonomy, choice, and the nurse's responsibility to enable access to MAiD[5] are at odds with the nurse's long-standing moral convictions and subsequent CO to participating in—actively or passively—causing the death of a person.[8] This CO may be based on her value and definition of non-maleficence (do no harm) and moral integrity (commitment to persistent moral truths).[4] Based on these personal ethics, MAiD may be perceived as harmful and immoral. Nurses have a responsibility to honor dignity including to "foster comfort, alleviate suffering . . . and assist people in meeting their goals of culturally and spiritually appropriate care."[4] In this case, the resident's goal is to die a dignified death on a specific day. The resident has a right to have their informed decisions respected,[4] and the nurse cannot allow her CO to obstruct the resident's access to care, nor can the nurse abandon the resident without ensuring transition of care to a provider without CO.[9]

In this case, the important facts are that the resident has the legal right to MAiD, has an emotional investment in the day, the nurse has a duty to provide care, and there are no obvious alternative options for transition of care. The nurse has a responsibility to discuss her CO with those involved,[5] mindful that her communication of this objection must not result in compromised care or in the resident or family members experiencing feelings of judgment.[8] Despite literature supporting dialogue between nurses, patients/residents and families, nurses with CO to MAiD may feel uncomfortable addressing this conversation and thus avoid it all together.[26]

Further to this, nurses asked to work outside their conscience are at risk of burnout and injury through the psychological and negative physical health effects of moral distress.[2] Given the staffing issues in this scenario, consistent with the experience of many rural and remote care settings,[27] risking the health of a nurse through moral injury in an already staffing-challenged unit or area could compromise the care of many other residents.

The emotional aspect of considering ethical dilemmas cannot be understated.[2] In this case, the dying resident may be at risk of abandonment if the nurse does not support her in her end-of-life wishes; the resident may feel guilty if she perceives her request to be judged as immoral and risks feelings of disrespect, hopelessness, frustration, and loss of autonomy. The nurse also risks feelings of guilt, possibly related to being unable to "stay with" the resident due to her personal ethics,[12] despite likely valuing fidelity and justice. The nurse may also feel fear of being judged by her colleagues, punishment from management, and feel confused regarding her professional responsibilities.[25]

Considering the participants

The resident, resident's family, the nurse, the MAiD practitioner, and the facility—governed by provincial regulations and national legislation—are all participants in this dilemma. In this case, the main participants are the providers—registered nurse and medical practitioner—and the resident requesting MAiD;[28] ultimately, the resident has the right to make the decision. The nurse is bound by professional obligations, like the duty to provide care, in the event transfer of care is not possible.[9] The nurse is limited in her choices as, further to the duty to provide care, the Code of Ethics states that the nurse is not necessarily protected from penalty for acting on her CO.[4] In addition, there remains legal and organizational ambiguity around guidelines for dealing with CO in nurses.[3] The nurse may feel that taking a stand based on her CO is futile because of the lack of clarity in legislation and professional protection,[3] and the realization that no alternative nurse is available.

Moral perspectives and development of participants

Nurses are expected to have a high degree of reflective moral development[2] in addition to abiding by Codes of Ethics, Professional Standards, and the law. Therefore, declaring a CO must be carefully considered by the nurse.[14] The patient has been deemed competent through her MAiD assessments, has not likely come to the decision lightly, and has deliberately chosen a meaningful date to die. Common to many nurses both with and without CO to MAiD, is the desire to promote choice, provide a dignified death, and relieve suffering.[26] It could be assumed that these values may be common to the resident also. Both nurse and resident value autonomy and the Canadian right to freedom of conscience and liberty extends to all.[6] The nurse, however, has professional limitations on when she can act on her freedom of conscience due to professional duties.[26]

Factors impacting the nurse's CO may be valuing the sanctity of life to a natural end, as well as nursing experience witnessing death as a process rather than an isolated event.[2] The values of doing the best for the patient (beneficence) and shielding the patient from harm (non-maleficence) are possibly at odds for the

nurse as well.[2] She may see the deliberate act of ending a life as harmful; she may also see prolonging the life of a suffering person as equally harmful.[2]

Outcome options

The resident's desired outcome would be to die a dignified death, in her home, surrounded by family, on the date she has chosen. The nurse's desired outcome would be that the patient dies a dignified death, free of suffering, but that she, the nurse, not be required to participate in actively ending the resident's life. The consequence of the nurse's desired outcome may include the patient suffering longer, requiring transfer to a different facility to obtain MAiD on her desired day and thus the nurse would be implicated in hindering accessibility.[26] A negative consequence of the resident's desired outcome, should it involve the nurse with CO, is the nurse's distress from having to perform in ways that compromise her moral integrity.[3]

An ideal outcome would allow for someone to take over from the objecting nurse and enable the process per the resident's wishes. It is important to note that there is a very real possibility that this cannot be achieved in rural and remote areas with limited nursing staff, particularly on evenings and weekends. With a smaller and limited pool of nursing staff in rural areas, nurses who *do not* CO could be repeatedly asked to participate. This could also lead to burnout or distress.[8] Unacceptable outcomes include the patient being denied her chosen date and place to die, or the nurse having to have an active support role in the MAID procedure (e.g. intravenous initiation and peri-procedure support for the family) despite her CO.

Looking for options

Finding a mutually agreeable solution for both nurse and patient would be the best outcome. The nurse could consider who is following her on the next shift; if the following nurse does not have CO to MAiD, through open dialogue with the resident and family, the objecting nurse could determine whether a time later in the day would be acceptable for the resident. However, this option still risks making the resident and family feel judged and unsupported in their decision.[5] The nurse could then liaise with the MAiD practitioner to discuss the change in schedule. The MAiD practitioner could consider transferring the patient to a different facility, but this solution is not consistent with the resident's desire to die in her home, nor is this a plausible solution in rural and remote areas. In addition, transfer may cause further suffering for the resident and may not be possible due to frequently full facilities and variance of admitting privileges.[26] If the resident and practitioner determine that they wish to go ahead with the plan during the hours the RN with CO was working, the nurse may be required to participate. Though not mandated to participate in MAiD by legislation, the nurse is not protected from penalty[4] and could risk charges of abandonment if she refuses.[26] Planning ahead by the nurse manager could improve this scenario by ensuring nursing staff without CO are available when MAiD is scheduled at the facility. Contingency planning by leadership could include maintaining a roster of nurses willing to be on call for situations such as the one outlined in this paper. Arguably, the nurse in this scenario could have the responsibility of a manager as, with the staffing limitations of rural and remote health care, the only RN at the facility would assume the leadership role on weekends.

One possible solution would be to assume an opt-in versus opt-out approach to MAiD such that those wanting to participate could make themselves known—similarly to how nurses must currently make their objection known—and be part of a consult service. While this type of centralized registry has been set up in some jurisdictions in Canada,[22] it is inconsistent. This option also hosts risks of burnout if the MAiD workload is not shared adequately, especially in rural settings where, despite having 17% of the national population, less than 12% of the nursing population in Canada serves these settings.[29]

Final steps: act and evaluate

The final step in examining an ethical issue with this framework is to act on the decision and evaluate. As this is a hypothetical situation, actual evaluation of an outcome is not possible. The ideal outcome, as discussed above, would be that the resident and nurse are both supported in their liberty and autonomy. This would most likely occur if the resident and MAiD practitioner are able to arrange the death after the nurse with CO is off duty. If we hypothesize that this was the outcome, both the patient and nurse's needs would be met. The relationship between nurse and resident could be strengthened by the nurse's commitment to finding a mutually acceptable outcome; the resident would hopefully feel cared for, supported, respected, and at the very least, not abandoned.[8]

Evaluation of similar situations occurring in practice by the institution might prompt leadership to consider clarifying the roles of nurses within their institution, maintaining up to date policies regarding MAiD[26] as well as possibly building in a contingency plan should a similar situation arise again. The nurse may not feel that the ethical dilemma has been resolved as she passively facilitated the ending of a resident's life[26] despite not being an active participant. Ensuring referral and transfer of care to willing providers is part of the SCC legislation,[30] thus passive involvement may morally affect many nurses with CO but remains an expected professional standard.

Summary

Rural and remote nursing requires well-developed decision-making skills as nurses frequently work with high autonomy, sometimes as sole providers, and without the external support of specialty teams.[31] In Canada, there are not yet established ethical policies and procedures specific to rural and remote nurses and the needs of these diverse communities.[31] In addition, urban-centric policies can worsen moral distress for rural nurses.[32] As shown through this example, acting on a CO may not be possible in the rural care setting due to staffing and/or geographical constraints. Ethical situations are not limited to MAiD but may extend to a variety of ethical issues that conflict with patient autonomy or access to care such as withdrawal of treatment, abortion, staffing shortages, and allocation of resources such as blood for transfusion. Due to the limitations that may exist in rural and remote care settings, nurses with CO in rural and remote areas may be at higher risk for compassion fatigue with extended exposure to ethical dilemmas where, despite applying ethical decision-making frameworks, the ability to act in accordance with their conscience, within the current health care system, may be limited. As the framework chosen for this paper was intended to discuss the options a frontline nurse can generate in time-sensitive situations, it could be that more robust decision-making frameworks need to be applied at leadership levels to explore this evolving topic. Moreover, supporting nurses to work through frameworks such as the one used here *prior to* encountering MAiD, may help to clarify actions that need to be taken in specific rural and remote areas.

It is conceivable that, since rural and remote nursing is often generalist,[31] and MAiD is a right of patients in all care areas, it may not be viable, or even reasonable, for nurses to exercise a CO to MAiD in the rural setting. It is proposed by Schuklenk and Smalling[21] that health care providers with COs seek work in areas that do not violate their conscience. It is important to consider implications of such arguments in the rural and remote setting, and the impact this could have on general patient access to care in already inadequately staffed areas. Without the ability to exercise CO in ethical situations, nurses are limited in liberty and the balance of this right of Canadians with the patients' right to self-determination must be considered.

Within the current legislation in Canada and in accordance with the nursing Code of Ethics, nurses remain able to voice CO, but the ability to act on this objection is clearly limited in rural and remote areas. It

must be considered if the right of the patient to a procedure is greater than the right of the nurse to CO, this may also result in barriers to care through further reduced staffing levels or attrition from the nursing profession, due to burnout. Further research is required to determine the potential impact that limiting nurses with CO to MAiD would have on rural and remote areas.

There are several implications for research, policy and leadership that are made apparent in working through this ethical decision-making framework and examining the current state of the literature on MAiD in Canada. As outlined previously, the roles of nurses aiding rather than administering MAiD should be further documented,[14] including tracking of instances of CO and the impact on patient access to MAiD, as well as legal and moral consequences to the nurses. Rural and remote areas need to be represented at policy tables and for guideline development on MAiD. Although there is a national monitoring and reporting system in Canada for MAiD, there is little known about the different experiences in rural and remote areas. Solutions such as institution-level MAiD teams[33] may not be feasible in smaller centers. Further research is needed to examine the patient, family, and nursing consequences where transferring nursing care for CO is not an option. Finally, as Canada looks to revise MAiD legislation, nurses and nurse leaders can advocate for changes that are not serving them, or their patients, well.

Conclusion

Ethical dilemmas do not always have a right answer but processing the situation through an ethical decision-making framework can help bring to light new perspectives and creative ways to reach a solution that works for all parties involved.[2] With the advent of MAiD as a legal option for patients at end-of-life, a new kind of ethical dilemma has developed for nurses—one where morality, personal and professional ethics, and the law are at odds. MAiD is deemed to be in accordance with the Canadian citizen's right to liberty and to equal protection[6] but how those same rights are extended to nurses with CO is vague. Providing MAiD as an external service whereby willing nurses participate, would avoid situations presented in this paper and would enable patient and resident access to the service without significantly compromising nurses with an objection of conscience. In addition, external services in rural and remote areas may be difficult to develop and is traditionally why healthcare providers need to be generalists who provide a vast breadth of services. With further research and exploration of the ethical dilemma of CO in MAiD, a solution that provides equal protection for nurses, MAiD providers, and Canadian citizens as patients can hopefully be reached.

Acknowledgements

This paper was developed from an assignment submitted to Athabasca University course Nursing 324: Concepts and Theories in Nursing Practice and has been expanded and modified for this manuscript.

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The funding was received from Athabasca University, Academic Research Fund, Publications funding to support open access publication of this article.

ORCID iD


Lorraine M Thirsk https://orcid.org/0000-0001-5459-9491

References

1. OHCHR. International Covenant on Civil and Political Rights. https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (accessed 12 October 2020).
2. Burkhardt MA, Nathaniel AK and Walton NA. *Ethics and issues in contemporary nursing*. 2nd Canadian ed. Toronto, ON, Canada: Nelson, 2014.
3. Lamb C, Evans M, Babenko-Mould Y, et al. Nurses' use of conscientious objection and the implications for conscience. *J Adv Nurs* 2019; 75(3): 594–602.
4. Canadian Nurses Association. Code of ethics for registered nurses, 2017, https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive.pdf
5. Canadian Nurses Association. National nursing framework on medical assistance in dying in Canada, 2017, https://www.cna-aiic.ca/∼/media/cna/page-content/pdf-en/cna-national-nursing-framework-on-maid.pdf
6. Christie T, Sloan J, Dahlgren D, et al. Medical assistance in dying in Canada: an ethical analysis of conscientious and religious objections. *BioethiqueOnline* 2018; 5: 1–9.
7. Pesut B, Thorne S, Stager ML, et al. Medical assistance in dying: a review of Canadian nursing regulatory documents. *Policy Polit Nurs Pract* 2019; 20(3): 113–130.
8. Pesut B, Thorne S and Greig M. Shades of gray: conscientious objection in medical assistance in dying. *Nurs Inq* 2020; 27: e12308.
9. British Columbia College of Nursing Professionals. Duty to provide care, https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Pages/dutytoprovidecare.aspx (accessed 7 August 2020).
10. Dobrowolska B, McGonagle I, Pilewska-Kozak A, et al. Conscientious object in nursing: regulations and practice in two European countries. *Nurs Ethics* 2020; 27(1): 168–183.
11. British Columbia College of Nursing Professionals. Standards, limits and conditions for medical assistance in dying, https://www.bccnp.ca/Standards/RN_NP/RNScopePractice/MAiD/SLC/Pages/Default.aspx (accessed 12 October 2020)
12. Pesut B, Thorne S, Schiller CJ, et al. The rocks and hard places of MAiD: a qualitative study of nursing practice in the context of legislated assisted death. *BMC Nurs* 2020; 19: 12.
13. Bellens M, Debien E, Claessens F, et al. "It is still intense and not unambiguous." Nurses' experiences in the euthanasia care process 15 years after legalisation. *J Clin Nurs* 2020; 29(3–4): 492–502.
14. Pesut B, Greig M, Thorne S, et al. Nursing and euthanasia: a narrative review of the nursing ethics literature. *Nurs Ethics* 2020; 27(1): 152–167.
15. Deschenes S and Kunyk D. Situating moral distress within relational ethics. *Nurs Ethics* 2020; 27(3): 767–777.
16. Schiller CJ. Medical assistance in dying in Canada: focus on rural communities. *J Nurs Pract* 2017; 13: 628–634.
17. Mbemba GIC, Gagnon M-P and Hamelin-Brabant L. Factors influencing recruitment and retention of healthcare workers in rural and remote areas in developed and developing countries: an overview. *J Public Health Africa* 2016; 7: 565.
18. Terry VR, Graham CJ, Rogers C, et al. Building resilience among rural and remote nurses in Queensland, Australia. *Collegian* 2020; 27: 265–270.
19. Alzghoul MM and Jones-Bonofiglio K. Nurses' tension-based ethical decision making in rural acute care settings. *Nurs Ethics* 2020; 27(4): 1032–1043.
20. Dempsey T. *Compassion fatigue among nurses and nursing assistants at a long-term care facility on the Navajo Nation*. Doctoral Dissertation, The University of Arizona, Tucson, AZ, 2020.
21. Schuklenk U and Smalling R. Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *J Med Ethics* 2017; 43: 234–240.
22. Heilman MKD and Trothen TJ. Conscientious objection and moral distress: a relational ethics case study of MAiD in Canada. *J Med Ethics* 2020; 46(2): 123–127.

23. Barlow NA, Hargreaves J and Gillibrand WP. Nurses' contributions to the resolution of ethical dilemmas in practice. *Nurs Ethics* 2018; 25(2): 230–242.
24. College & Association of Registered Nurses of Alberta. Ethical decision-making for registered nurses in Alberta: guidelines and recommendations, 2010, https://nurses.ab.ca/docs/default-source/document-library/guidelines/rn-ethical-decisions-making.pdf?sfvrsn=d714472f_14
25. MacDonald C. A guide to moral decision making, http://www.ethicsweb.ca/guide/ (accessed 7 August 2020)
26. Beuthin R, Bruce A and Scaia M.Medical assistance in dying (MAiD): Canadian nurses' experiences. *Nurs Forum* 2018; 53(4): 511–520.
27. Smith S, Sim J and Halcomb E. Nurses' experiences of working in rural hospitals: an integrative review. *J Nurs Manag* 2019; 27(3): 482–490.
28. Schiller CJ, Pesut B, Roussel J, et al. But it's legal, isn't it? Law and ethics in nursing practice related to medical assistance in dying. *Nurs Philos* 2019; 20: e12277.
29. MacLeod MLP, Stewart NJ, Kulig JC, et al. Nurses who work in rural and remote communities in Canada: a national survey. *Hum Resour Health* 2017; 15: 34.
30. Legislative Summary of Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/LegislativeSummaries/421C14E (accessed 7 July 2020).
31. MacLeod M, Stewart N, Kosteniuk J, et al. Rural and remote registered nurses' perception of working beyond their legislated scope of practice. *Nurs Leadersh* 2019; 32: 20–29.
32. Buckley BJ. *The structure and enactment of agency in the context of rural nursing practice*. Doctoral Dissertation, The University of British Columbia, Vancouver, BC, Canada, 2015.
33. Government of Canada. First annual report on medical assistance in dying in Canada, 2019, https://www.canada.ca/en/health-canada/services/medical-assistance-dying-annual-report-2019.html