

# Medical assistance in dying (MAiD): Canadian nurses' experiences

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## Abstract

Medical assistance in dying (MAiD) represents a historic change in Canadian society and the provision of end-of-life care. In this descriptive narrative inquiry, 17 nurses were interviewed during the first 6 months of assisted dying becoming a legal option for patients in Canada. Nurses' experiences of either providing care for a patient who had chosen MAiD, or declining to participate in MAiD, were explored. Findings describe three themes and eight storylines of the impact of MAiD on nurses' view of the profession, clinical practice, and personally. While most nurses perceived MAiD as an extension of the profession and their nursing practice, a small number also expressed moral distress as they grappled with assisted dying. Narratives illustrated an ongoing sensemaking process and spectrum of emotions. These findings offer insight and provide direction for nurses and managers in this new clinical and legal reality. Further research is needed to understand more fully the moral distress of some nurses, as well as the importance of communicating openly and nonjudgmentally with patients, families, and the health-care team.

## KEYWORDS

end of life, euthanasia, medical assistance in dying (MAiD), narrative inquiry, nursing, nursing care, quality of life

## 1 | INTRODUCTION

*(A Nurse's Story) In this particular situation there were 20 people attending the medically assisted death and so as a nurse I'm reading the room. Being genuine with yourself and learning to appreciate what's going on is really important. For me, I focus on the patient who is my priority and then include the family and friends. In this case the patient was an elderly woman who was quite relaxed. The physician had already gone in and completed the consent process and all the paperwork. I had met the patient already during routine care for vascular access about 5 days earlier, and I didn't realize that she was choosing medically assisted dying. They don't share and I don't ask. Later when I learned about her choice, I volunteered to be the attending nurse.*

*In the room, there was the physician who was also teaching another physician the roles and protocol. There appeared*

*to be some friends and family and some congregational support, I think, some sort of church group. The minister read some scriptures and they prayed. The physician asked the patient "are you ready, are you still good with this?" Even though all the paperwork had been done, the patient looked at him and smiled, and said "yes." Then he picked up the first of the syringes and administered the medication and within probably two and a half minutes, the patient began to snore and then stopped breathing. Then the rest of the medications were administered and the physician listened to her heart. He acknowledged the family and said "she's gone now" and then I exited the room and left them to be with their family member. So it's pretty quick actually ... and then outside the room, we reviewed with the physician being mentored some of the details about the process: when the iv can be initiated, when the drugs are administered, and when a pronouncement of death happens. Usually the physicians are engaged in the process of dealing with the family and paying attention to the*

*patient, they are not recording. They could, but we (nurses) take that off their plate as a supportive role. And basically in this situation I stood back and let the family gather around; her daughters were present holding her hand. It was actually very peaceful, very relaxing. I mean obviously the family was emotional but the patient seemed to be the most relaxed.*  
(Nurse William)

Nurses across Canada are directly impacted by changes to the Criminal Code that now allow medical assistance in dying (MAiD) under clearly defined legal and regulatory circumstances. As William's story shows (almost verbatim with minor editorial changes for clarity), MAiD heralds an unprecedented change for nurses who have been educated and trained toward supporting life. Even nurses with expertise in providing end-of-life care are being called to rethink their practice by reorienting toward directly assisting and hastening dying for patients who make this choice. While the public welcomes assisted dying as a care option, there remain many uncertainties, misconceptions, and polarized views.<sup>1</sup> A 2014 poll indicated that while 79% of the Canadian public favors having an option of assisted suicide, health-care personnel who are expected to deliver this end-of-life care are less supportive.<sup>1</sup> This is perhaps foreseeable given that conflicting values and the sacredness of human life are at the heart of tensions related to this legislation. There are many ethical, legal, regulatory, clinical, and individual implications that all come together in this unique option of assisted dying. How nurses access information is multifaceted and variable across care settings especially during the first 6 months of MAiD becoming available. In June, 2016 provincial nursing regulatory colleges, provincial and national nursing associations, Ministries of Health, the Canadian Nurse Protective Society,<sup>2</sup> and employers were working quickly to develop and disseminate guidelines and procedures. Currently, there are workshops, support tools, educational modules, and information sessions available to support nurses. Specific MAiD education is currently not mandatory in most provinces, except for a nurse practitioner (NP).<sup>3</sup>

As with any social change as significant as this, there have been early adopters<sup>4</sup> and those who have actively resisted the change based on a range of justifiable reasons. The same holds true for nurses who find themselves at this critical juncture of having to implement assisted dying into their daily work. In one Health Authority where the study was conducted, MAiD is carried out approximately twice per week.<sup>5</sup> While provisions are available for nurses to decline direct participation or to "aide" based on a conscientious objection, this is not always straightforward. The element of choice is complex as nurses are bound by a duty to care such that a nurse cannot object to providing routine nursing care before or after this care option (eg. CRNBC, 2016).<sup>3</sup> It is vital we understand what happens for nurses faced with providing care when professionally or personally they may not be sure of how they yet understand this new practice responsibility.

Due to the sensitive nature and critical newness of assisted dying in Canada, understanding nurses' experience of participating or opting out of MAiD is vital to ensuring a smooth transition of assisted dying into health-care settings. There is limited research available about how nurses are engaging in assisted dying in the Canadian context, and what

they perceive their clinical role and responsibilities to be. This study provides insight into these questions and knowledge of how MAiD is being enacted and understood from nurses' perspectives and contributes to the literature concerning assisted dying, which has been largely physician-focused.<sup>6</sup>

## 2 | OVERVIEW OF MAiD IN CANADA

In Canada the law changed in June 2016 when an act to amend the Criminal Code prohibiting physician-assisted suicide was passed. A Supreme Court of Canada decision in February 2015<sup>7</sup> ruled that parts of the Criminal Code would need to change to satisfy the Canadian Charter of Rights and Freedoms. Subsequently, as of June 17, 2016, a person who is facing foreseeable death and meets all eligibility criteria (Bill C-14) can pursue an assisted death.<sup>8</sup> The term MAiD includes both assisted suicide and euthanasia. The changes stipulate that physicians and NPs may provide MAiD and are bound by the laws of the land, professional standards of practice, and codes of ethics. Criteria for eligibility continues to be debated and currently require patients to be: (a) eligible for health-care services in Canada, (b) at least 18 years of age, (c) have a grievous and irremediable medical condition (incurable illness, disease, disability or state of decline), (d) make a voluntary request, and (e) provide informed consent to MAiD (s. 241.2 of the Criminal Code as implemented through Bill C-14<sup>8</sup>). Safeguards have also been established including the following requirements: meeting all eligibility criteria, providing a signed and dated request form, valid witnesses, fully informed consent, two assessments by independent practitioners, a clear 10-day waiting period from the time of request, consent prior to administration, and reliable communication.

Health Canada<sup>9</sup> outlines two forms of MAiD currently available. First is a clinician-assisted MAiD (previously known as voluntary euthanasia) where providers directly administer medication that causes death or second, a self-administered MAiD (previously known as medically assisted suicide) where a prescribed drug provided by an eligible physician or NP is taken by a patient with the intent of causing death. According to available reporting to date, patients in Canada are opting for the intravenous injection over the oral route and choosing to die in the home.<sup>10</sup> The dominance of intravenous route may change with the reintroduction into Canada of the oral drug Secobarbital (self-administered), which is commonly used in physician-assisted dying in the United States.<sup>11</sup>

## 3 | LITERATURE REVIEW

The number of jurisdictions across the world where some type of legislation related to assisted dying and euthanasia is in place continues to grow since first introduced in Switzerland in 1942. Amendments made to the Criminal Code on June 17, 2016, by the federal government mean that Canadians now can access MAiD. The spirit of the law is that this new service is to be provided compassionately and ethically, that all involved are supported and harm is not caused to

staff or patients. Yet, we have heard anecdotally from nurses that they struggle to make sense of this major practice change, practically and ethically. This aligns with 2015 polling data indicating that while 79% of the public favor having an option of assisted suicide, health-care personnel who are expected to deliver this end-of-life care are less supportive.<sup>1,12</sup> A 2014 survey of Canadian doctors found that only 45% of respondents favored legalizing MAiD.<sup>13</sup> The palliative care community also has raised concerns, wanting to ensure that MAiD is not the only alternative, that government addresses current gaps and inconsistencies in the availability of palliative care, and that there is an understanding of how palliative care is philosophically distinct.<sup>14</sup> It is vital to understand how MAiD is influencing nurses in the Canadian context to ensure a smooth transition of this end-of-life care option across settings and communities.

## 4 | STUDY PURPOSE AND DESIGN

The aim of our inquiry is to understand the range of nurses' experience in providing care for someone choosing MAiD, whether directly aiding, providing supportive care, or declining to participate. The joint University and Health Authority ethical review board granted ethics approval.

### 4.1 | Methodology

We used a qualitative design of narrative inquiry and thematic analysis.<sup>15</sup> Recruitment of participants occurred via a poster distributed across the Health Authority. A local contact at three local hospitals and a hospice were approached and informed of the study. Balancing respect for high demands on clinicians' time with the importance of research, we asked each contact person to make an announcement about the study at an appropriate staff meeting.

Participants included 17 nurses (NPs, RNs, and LPNs,) from urban and rural areas across Vancouver Island, British Columbia, working across settings including acute care, residential care, primary care clinics, and community and palliative care. Nurses were experienced clinicians with a range of 10 to 38 years of nursing (mean = 23.6 years). Length of education varied, with 6 years for an NP, 4 years for an RN, and 2 years for an LPN. We did not ask about religious affiliation. Of the 17 participants, 15 had experience with MAiD: eight nurses directly aided with an assisted death on one occasion or more, and seven were involved in some aspect along a patient's journey (e.g., providing information, acting as witness to the medical assessment, providing care before or after, etc.). Two participants had no patient involvement and claimed a conscientious objection.

#### 4.1.1 | Data collection

We collected data through audiotaped semi-structured interviews conducted in-person or by phone to foster accessibility for participants across a broad geographical area. Interviews lasted approximately 40 to 90 min. Sample interview questions included: (a) Please tell me about your first experience of being asked to participate in a medically assisted death and how you came to the decision to participate or

not participate. (b) What was the decision-making process like for you? (c) Tell me about the MAiD experience itself. What was the most challenging for you? Or, in declining to participate. (d) What concerns did you have, if any? (e) How has this experience influenced your sense of nursing? How do you see your professional responsibilities in MAiD? (f) What do you consider your normal nursing practice and how does this intersect with your care for patients undergoing MAiD?

#### 4.1.2 | Rigor and reflexivity

Interviewers used established qualitative standards to ensure trustworthiness and rigor.<sup>16</sup> Credibility was enhanced by asking participants to review preliminary findings. Feedback was provided to co-investigators and integrated into the final manuscript.

#### 4.1.3 | Analysis

We followed a narrative approach informed by Riessman<sup>17</sup> and thematic analysis by Braun and Clarke.<sup>15</sup> Researchers read each interview as it was transcribed verbatim from audio recordings. Once the data set was complete, we divided transcripts among the team to ensure a close reading of assigned transcripts. We presented a summary narrative of participants and their stories during analysis days. As each participant was presented, we identified storylines and recurring themes. Drawing on Braun and Clarke's semantic approach, we identified preliminary descriptive themes and coded transcripts accordingly. Eventually, key concepts were collapsed into themes and storylines. Data management was facilitated using Atlas-ti software package, a program designed for qualitative data.

## 5 | RESULTS

Results are organized around three themes and seven storylines. The three themes describe how participating in, or declining to participate in MAiD is shaping the participants' perceptions of nursing as a profession, their clinical nursing practice, and the personal impact. Each theme has three corresponding storylines that are described below (Table 1).

### 5.1 | Theme 1: Profession of nursing

Fifteen nurses reported how participating in MAiD positively reinforced their view of the profession as providing *holistic care without judgment, advocating patients' choice, and supporting a good death* as defined by the patient. Overall, for nurses who participated directly in assisted dying, this was not a significant departure from their professional goals.

#### 5.1.1 | Holistic care without judgment

Participants described the profession as providing holistic nursing care and MAiD as an expression of this care. One nurse questioned, "So why does holistic care not include a controlled death? There's still care in death." Nurses who conscientiously objected expressed a differing view, "for me euthanizing a patient is not a part of nursing... it's the

**TABLE 1** Key themes and storylines

Themes	Storylines
Profession of nursing	<ul style="list-style-type: none"> <li>● Providing holistic care without judgment</li> <li>● Advocating choice</li> <li>● Supporting a good death</li> </ul>
Personal impact	<ul style="list-style-type: none"> <li>● Being pioneers</li> <li>● Sensemaking—taking a stand               <ul style="list-style-type: none"> <li>○ Strongly oppose</li> <li>○ In-Between</li> <li>○ Strongly support</li> </ul> </li> <li>● Experiencing emotional spectrum</li> </ul>
Practice of nursing	<ul style="list-style-type: none"> <li>● Technical skills (intravenous &amp; physical care)</li> <li>● Communication and relational care</li> </ul>

opposite of everything that I've been doing or wanting to do." Consistently however, all participants believed that to be a nurse is to not judge patients or their choices. A patient's right to choose came first: "if someone makes the choice, it's not whether they should or they shouldn't...if it's a personal decision and is best for them, then I think I should support it because it's not about me." Similarly another nurse, who was unable to support in principle the option of assisted dying, nevertheless was clear that this did not mean judging the person who made this choice.

### 5.1.2 | Advocating choice

Providing nursing care without judging patients and their choices overlapped with what some nurses saw as their professional responsibility to advocate more broadly for patient choice and specifically for an individual's right to choose assisted dying. As one nurses stated, there is "a little window ...for nursing to be a stronger advocate for patients who don't want to suffer any more." While some nurses were also still determining whether they were personally aligned with assisted dying, their questioning did not impede a commitment to patient advocacy. Most participants saw their role as promoting a patient's right to choose, rather than supporting assisted dying per se, "I don't think it's a better option, I think it's another option." Many believed offering a range of end-of-life options was more humane. Despite the ethical debates and politics, one nurse shared, "I'm not in charge of that patient's life, I'm there to help that patient with their life decisions." Others spoke to ongoing public discussions and suggested nurses should speak out more openly as advocates of choice.

### 5.1.3 | Supporting a good death

Nurses shared how participating in MAiD reinforced a sense of their role in providing comfort care, mitigating suffering, and it also broadened their understanding of what a so-called good death could be. Nurses spoke tentatively and at times apologetically when describing death using affirmative terms:

*Sometimes when people pass and they've been palliative ... it's hard to watch people die, especially when they're strugg-*

*ling. This might sound a little funny but it was actually a very positive experience... So I found it interesting that people asked me after, do you need to debrief, do you need to talk about it? And I was like "no"; I mean this death was everything this person wanted it to be. Like he was so ready and so, I mean it was almost, not happy, he wasn't obviously, happy, but he was sure and he got the death he wanted. That's good. His wife held him in her arms and it was so peaceful. There was no struggling for breath, there was no phlegm to suction, like all the ugly parts of death, went away. And so it was different ... it did get to be what the patient wanted. And his family, to see the benefit to the family.*

This good death was contrasted with more negative language when describing witnessing patients and families suffering, as Maria shares a difficult death experience prior to MAiD,

*We messed up. We didn't have orders in place and they're suffering. It's just horrible. There's nothing worse than a bad death where we didn't manage it well and that's why people want to be killed right? They don't want that.*

Participants were experienced nurses who collectively had watched hundreds of people die and as one nurse shared, "... 95% of them have been good deaths but that 5% [when] we weren't able to give them a good death ... we could see that train coming down the tracks--that was hard." Similarly, William says "I spent 20 years in trauma services. So yea, I've just seen a lot, and the accumulation of long term suffering I think [MAiD] is an opportunity [to do things differently]..." An overriding perception of those who participated was that assisted dying is an approach to individualized care that helps minimize real and projected suffering

## 5.2 | Theme 2: Personal impact

Many nurses in this study are considered early adopters because of their receptivity to this change.<sup>4</sup> Their stories reflect a pioneering spirit as they volunteered to participate in MAiD despite the many unanswered questions. Three storylines are identified: *being pioneers*, *sensemaking—taking a stand*, and *emotional impact*.

### 5.2.1 | Being pioneers

Many nurses were aware of the historic role they were playing. Some described it as "unchartered territory," where "there was almost no foundation" for providing this option, and "this is a whole new role for all of us." Their pioneering spirit was conveyed as "jumping into it with both feet" and "I helped blaze that trail." The courage required stepping forward and volunteering is illustrated in Joan's story working in an urban center:

*So the experience started right from the get-go when it was brought into law on June 17. We provided the first MAiD on June 19. Our first case happened in a home. I met the provider [physician] for the first time ever on the doorstep and hoped that it was the provider because neither one of us was wearing a name tag. We both had parked about a half*

*a block away and tried to go in as inconspicuously as possible. So it was unique because I didn't know the patient—all I knew about the patient was that he was terminal. And when I walked up to the door, the family greeted me with such enthusiasm, and the gentleman got up off the couch with his walker, made his way to me, gave me a hug and told me I was the bravest person he'd ever met. So, even from the get go it has been a bit of a roller coaster...*

In Canada, an NP's scope of practice may include serving as an assessor and prescriber (provider of MAiD). However, one NP we spoke with worked in teams with physicians and shared stories of intense and rewarding work—entering into unexplored professional spaces. Joan shares a story of the first MAiD experience with a physician colleague,

*The physician's hands were shaking, and by all means, mine were too when I went to put in the intravenous. So as he went to connect ...he couldn't connect the syringe to the cap on the end of the intravenous. So without even thinking twice, I put my hand on his shoulder, "take a deep breath." And he did—in, out, and then he was ok.*

As pioneers in this first 6 months, nurses recounted stories of stepping forward, helping to create and write protocols, encouraging conversations about MAiD in their nursing communities, and also facing resistance from nurses. As one nurse shared, "no other nurse would make it known that they would help." They had concerns about stigma (their participation in MAiD), about patient privacy, confidentiality, and professional risks if they transgressed any laws. Sandra, a clinical nurse leader in palliative care shared:

*There's still... like a shroud around it right? Do we talk about it? Are we allowed to say it? Can we put that they've requested MAiD on the kardex? "Cause you know, if you go in to talk to the patient and they say, 'when's this doctor coming so I can get on with this?'"... You need to know.*

Nurses reported uncertainty as they were figuring out the procedures and deciding whether they would directly participate. Janice, an RN in a small community shared:

*Our big struggle here at this hospital is who can provide it, how do you get ahold of them, where do you find their name? So if a patient says to me "I would like to be involved or start the conversation about MAiD," well now I'm like, "oh ok," well what do [we do], who do I contact? It's not something that we have got a lot of experience with. I had a patient walk through the door ...and I've had to say, well I'm not sure if there's a doctor [in our community]. I know that there's this one doctor in [the next town] but where's the paper work? What do I print off?*

While not all participants were pioneers in this way, two nurses were also entering new territory of resistance as conscientious objectors. Tamara, with years of experience, would not participate in MAiD for religious reasons. She described a lack of clarity around legal and

professional requirements for nurses and the absence of support for those with a conscientious objection in her hospital:

*I think that in some units [the] "duty to provide care" is being touted as "you don't have a choice" and the information isn't there [about] how to object if you don't agree with it. And that's one thing through the whole process—there is not one thing that came from [the administration] that said, "you have the right to file a contentious objection on this." There wasn't one thing that came through the pipe.*

Some nurses shared that by participating in this study, they hoped to better understand through reflecting on how they are being impacted, what they think and feel about assisted dying, and where they stand.

## 5.2.2 | Sensemaking: Taking a stand

Nurses were personally impacted as they worked through a process of sensemaking trying to determine where they personally stood in relation to the underlying values and practice of MAiD. The intersection of personal and professional values about life, death, suffering, and nursing came to the fore when confronted by patients and families asking for information or preparing and waiting for an assisted death. We described this sensemaking as a dynamic continuum with only a few nurses who strongly opposed on one end and a few who were strongly in favor on the other. The majority of nurses shared stories of being in process, holding an in-between space of uncertainty, reflection, and active sensemaking.

### Strongly opposed

As noted earlier, only two participants expressed clear opposition based on religious beliefs. Tamara shared, "I am an Evangelical Christian, I support life on all levels. And to me this is very personal, that life is a God-given gift and we do not have the right to take that." She described the personal cost of participating in assisting a death as too high, "I don't think I'd be able to live well with myself if I was forced to participate. It would wreck me." Maria, also made a clear decision and explained how religious beliefs shape how much she is willing to participate,

*We have doctors coming up and asking us to co-sign things, I need someone to witness somebody's request [for MAiD] with me, and... we're kind of put on the spot—oh I'm a catholic, I can't do it. No I can't do it either, I'm a catholic also.*

Fears of being judged for their oppositional stance were shared, "What if your team thinks that you are a fanatic or if your team thinks you don't care about suffering?" Other reported impacts included feeling pressured at times, recognizing they are in the minority, and concerns of future bullying. Maria explained:

*If I had a different manager, then I would be very worried that I could be bullied. I certainly have been bullied as an LPN to take on, to do things that I don't feel comfortable. I have been expected to take an unstable cardiac patient and nobody would listen to me and was forcing me to take a patient that was completely out of my scope of practice. And I think the*



experience of nurses having to take on acute patients way out of their scope, and nobody is listening to you--the RN manager, nobody's listening. I think when you've had that experience before, I think it's easy to feel that you could be forced to participate in something that you don't want... or don't feel comfortable doing. Or be charged with abandonment. And the [nursing regulatory College] on "duty to provide care" has written that you have the right to be a contentious objector, however, if another nurse--if you cannot be accommodated, then you have to act as if it doesn't bother you, or you could be charged with abandonment. And so according to the College, I could risk losing my license if I choose--there's a contradiction between my rights, the charter of rights and freedoms doesn't apply to me in that case because I have the duty to provide care. I do find that problematic.

While these two nurses expressed clear opposition to MAiD, they were less certain about where the line of participation should fall. Although they disagreed in principle with assisted dying, their primary concern remained patient care and therefore what they would or would not do seemed less definite. Tamara shared how she is still making sense of starting an intravenous for a patient who has requested MAiD, "if they're getting antibiotics or pain medication through an intravenous, that's different, that's providing care, it's not part of the termination of life. So it's different for me, that's ok" and another nurse recounts:

*So initially I had the feeling that I just couldn't care for a person who had requested MAiD, that I didn't want to have anything to do with it, ... I didn't want to be associated with it in any way. And after some reflection I think I've come to the place where I feel like I can be there for that person, I can keep that person as a patient, as long as I'm not participating in any way with the end of life, with the euthanizing of that patient. So I can do care and support and all that sort of thing but at the same time I'm not sure because I still think there's a part of me that's really maybe not be okay, maybe it's still too difficult... I think there's a lot of people... are frightened to talk about it because it's their job.*

### In-Between

Similarly, nurses were also in flux, in an in-between place of active sensemaking about participating directly, indirectly, or not at all. This uncertainty was not linked to religious, spiritual, or ideological reasons but arose from fear and confusion around the legal, ethical, and professional messaging they were receiving. Donna, an RN in a primary care clinic explains:

*I had been asked to see a patient with a head and neck cancer who was starting to have some problems eating and dealing with some pain issues. So the patient came in, we sat down and talked, we were talking about nutrition and he said to me, "I'm ready to die and I heard on the news that you can help me with that now," and that was the lead in. I didn't know what to say in that moment. I think it would have been*

*really helpful for me to have more guidance on that because it's scary, and I think we've been fed a lot of fear from the college [nursing regulatory organization]... It was scary in that moment having to make a decision about what I would do, what I would say, and being in check about what I would say just because I had this strange fear. I think [regulatory College] planted in my head that depending on what I said, I could put myself in some sort of legal or professional problem. ... So I don't know, I don't think it's something that I would be ready to do unless I felt that I was part of a team, [where] I felt there was good communication and good support.*

This in-between place for other nurses was sometimes based in an existential questioning,<sup>18</sup> "I need to do this personal soul searching." Jean, an ER nurse in a large urban hospital shared: "I've rolled it around in my brain. Could I do that? I don't know if I could. So you know, I feel quite compassionate about people with end-of-life issues and I believe in it but I think it might be difficult in the heat of the moment." For many nurses, it seemed too early to tell what they felt about it all; their sensemaking was taking shape. A reflective process was described by Donna:

*It was something really big for me when I saw the death certificate, it was this overwhelming feeling like, oh my gosh, I killed him. Because I think I truly believed that knowing his situation, and his... sort of isolation, that had I not been open to the conversation, had I not helped him access the information, that he probably would have never been able to access the MAiD services. So that was a really weird feeling. And I've really thought of it since. And I no longer... carry that burden because I think obviously many people he had contact with later led to MAiD for him. And also that really as a professional nurse I did the right thing of helping connect a client with the care that he sought.*

Others expressed uncertainty or hesitancy to engage in MAiD for other reasons, including a lack of confidence--they just did not know what they could say or do, and the lack of time for them to take the required education.

### Strongly supportive

Participants, especially those who identified as pioneers, spoke openly, confidently, and welcomed MAiD as an option. These nurses talked about being positively impacted and expressed relief in now having more tools and options for patients. Many explained how their values underpin their decision to actively participate:

*I was driven by the fact that I personally believe in it so I made my best effort to do everything possible, because that was my personal belief even though I was a little bit unsure about my professional scope. I'm glad to be involved because I think it's important, really important.*

These nurses described how witnessing patients receiving MAiD has been affirming and left them "feeling happy and pleased for the patient" who is "so grateful" and "really, really, ready." This was in contrast with experiences of distress when witnessing painful and lin-

gering dying. Their MAiD experiences were described as “profound,” “amazing,” and “this is how I'd like to die.” Nurses shared a range of stories about the uniqueness of each death and how often there was a celebratory nature to dying that they had never witnessed before MAiD. One nurse shared:

*...And one family had a penthouse suite (in a hotel), and there was a full party going on. And we walked in and at the end there were about 45 people who stayed to watch the event. And they all had, they were all standing around one area, they were all holding hands, and there was a big slide show of the person behind us all during their life and all special moments to them. So different trips and friends and sitting in cafes and I would love for them to be able to experience, even along those lines, to truly grasp ..... the difference that we're making... I haven't had a person yet not tell me how brave we were to do this. And when I turn around and say I'm very honored to have helped you and they're just, they always say thank you. And that is it. Families are always like, “thank you for coming out. Thank you.”*

### 5.2.3 | Experiencing emotional spectrum

In addition to the stories of being positively impacted, nurses also described a range of emotions--some anticipated, and others not. Stories of “being emotional” included feeling choked up or shedding a tear. “I don't really know the person, but I can feel the tears and sadness.” William described experiencing the emotion of the environment.

*I think anybody would feel the emotion of the room, no question. I'm just quiet, you know, I'm not there to be centre stage...and yet at the same time, we have to find ways to be supportive. But, I'd feel a little tear come to me when I see the family crying because this is the final moment on this side of life.*

Although some feared witnessing the death might be overwhelming, many found patients' readiness and clarity had an uplifted quality to the experience. Other nurses spoke to the unanticipated humor and heart-opening moments, “in one instance the patient cried and I found that really hard, when I put his intravenous in he said to me, ‘I'm such a baby.’ I found that hard.” Participants were surprised by the emotional impact: “honored or somehow privileged to be able to participate when someone is so sure that this is what they want.” Overall, feeling emotional and expressing emotions of sadness were interpreted as “very natural,” “a genuine place to be,” and “something I'm not afraid of.” Feeling positive emotions of peace and amazement were more surprising and often shared cautiously in public.

### 5.3 | Theme 3: Nursing practice

Diverse levels of comfort and competence of nurses are reflected in their varying levels of engagement with persons seeking MAiD. What was foregrounded with MAiD was nurses' emphasis on the importance of communication and technical intravenous insertion skills. Nurses described degrees of involvement in MAiD from listening to conversa-

tions at a distance, to being fully present at the death. Chronologically, nurses may engage in some or all of the following aspects:

- Responding to a request for information,
- Engaging in a deeper conversation with patient and family,
- Objecting to involvement but provide basic care,
- Providing nursing care (up to the time of MAiD),
- Starting intravenous,
- Aiding directly (support through a palliative care approach),
- Debriefing with family and doctor,
- Providing afterlife care, and
- Debriefing with team, supporting one another.

Nurses were drawing on existing competencies related to end-of-life, palliative, chronic illness, and patient-centered care approaches, as well as complex clinical skills and relational skills that foster trust and engagement.<sup>19</sup>

### 5.4 | Technical skills

While initiating a reliable intravenous access is not considered the most vital nursing responsibility in MAiD, many nurses considered this skill as paramount. In Canada, patients may choose intravenous-administered medication or oral medication for MAiD, in this study, only intravenous medications were referenced by the nurses.

*So we bring full syringes, two sets, we bring needles to draw up with, we bring labels, we bring four iv start kits of varying gauges, we bring syringes for flushes, we bring extra saline for flushes between the meds if pharmacy didn't provide that, tourniquets. I've bought my own special little reusable hot packs because you can wipe them off and all you need to do is just dip them in hot water for seven minutes post and then they go back to normal. Otherwise where are you going to find a hot pack if you need one? I have a flashlight to do transillumination to find a vein if need be. (Joan)*

Establishing and maintaining a patent intravenous is integral to MAiD, and nurses from the vascular access team were often asked to start the intravenous both in hospital settings and in the community. One nurse shared, “I actually gave the family my private line in case there were any problems with the intravenous by the time I got home and I took extra supplies home so I could go back to his home and start it if need be.” Nurses shared concerns about community health nurses who knew their patients well and wanted to assist, however they often did not have the intravenous skills required. This resulted in some nurses performing this singular function of inserting an intravenous in the outpatient clinic the day before, or immediately before MAiD. However, most of the nurses aiding with MAiD participated in all aspects including inserting the intravenous beforehand and removing afterwards, assisting the physician, writing down medications, providing afterdeath care, completing documentation, supporting the family, and transferring the body to the morgue or designated funeral home.

## 5.5 | Communication

The combination of having excellent technical capacity with requisite communication skills was described as essential. Nurses identified compassionate listening, engaging, attuning, and being comfortable with intense emotion as key to effective communication with patients and families. Nurses emphasized the importance of providing information “in a compassionate listening manner” and discerning what patients are actually asking when seeking information. One nurse described being clear and tactful by asking, “Can I explore more of what you’re wanting to know so I can send you in the right direction?”

There were stories of transparent communication on a “need to know” basis for the family and staff on a unit:

*I was just assuring everybody--“we are gonna have a death today. We know about this... if you have any concerns, there's always my open door.” And we just went about and provided care--I told nobody else, our site director knew but no one else needed to know. And then we had a tea party after. So I brought in goodies and the palliative care director brought in goodies and our unit clerk made us tea and we invited the son and daughter in, and the doctor, and the nurse that was in attendance, and the hospice workers and we all debriefed after and that was an amazing experience too. Like there were hardly any tears, everyone was just so glad that this person who was suffering and was so scared to be suffering any longer, that A, we respected her wishes and B, that she would not have to live out how she was living anymore.*  
(Jill)

Overall nurses described engaging deeply in interactions and conversations, acting with professionalism, and offering a range of intimate care prior to an assisted death.

## 6 | DISCUSSION

Legally providing care to persons having an assisted death in Canada is unprecedented. Our study reveals how MAiD brings to the fore personal, professional, religious, and social values for nurses. We found most nurses supported MAiD as an extension of their professional role; the valuing of advocacy and patient’s self-determination by nurses regarding MAiD decisions are reported elsewhere.<sup>6</sup> While the majority of participants welcomed MAiD as another resource reinforcing their professional commitment to advocate for patients, a small number expressed deep concerns about complying with a law that they perceived as morally wrong. Research into conscientious objection to assisted dying in Canada is limited.<sup>20</sup> However, the overlapping experience of moral distress more broadly has received attention.<sup>1,21</sup> Berlinger<sup>22</sup> defined moral distress as feeling “forced to do what feels like the wrong thing in the situation” and conscious objection as “refusing to do” (p. 33) something that the person believes to be wrong. One nurse in this study expressed fears of being judged and poten-

tially “being bullied” as a minority group of conscientious objectors, and points to moral distress. Ethical tensions or conflicting duties of nurses, who hold religious beliefs incongruent with their professional duty to provide care, must be openly discussed and compassionately explored.<sup>23</sup>

In a recent qualitative study in the Netherlands where assisted dying has been legal since 1990, van de Scheur and van der Arend<sup>24</sup> reported that nurses who conscientiously object to assisted dying had a difficult time caring for the patient on the day of their planned death and discussing their issues with colleagues. Our findings also suggested that nurses who conscientiously object may feel comfortable with some aspects of care for patients preparing for MAiD but not others. A better understanding of how to foster open conversations about moral distress and objection are needed to protect the integrity of everyone on the team. Fears of being stigmatized, labeled, and isolated were expressed and warrant further attention in research, education, and by leadership.

Another finding is the importance of communicating openly and nonjudgmentally with patients and families that is widely supported in research.<sup>25,26</sup> Most research into communication and assisted dying has been conducted in countries where it has been legalized for many years.<sup>27-30</sup> Even within the first 6 months and limited experience of nurses with assisted dying, our findings are consistent. Denier et al.<sup>30</sup> conducted a qualitative study into nurses’ communication with patients requesting euthanasia and found that nurses perceive communication as the central tool for ensuring a patient’s request is attended to practically, organizationally, and emotionally. Akin to our findings, nurses emphasized the importance of asking open questions, listening carefully to determine the reasons behind a request for assisted dying, along with providing information. However, unlike nurses in the study of Denier et al., our participants did not see their role as providing advice or contacting families a month later to evaluate their experience. This may be reflective of the early days as processes were being established.

Our study highlights challenges nurses found in describing the complexity of their emotions when witnessing a patient’s death. They were reticent and had difficulty finding effective words for the paradoxical experience of witnessing death that is, both “sad” and “beautiful.” Nurses’ discomfort may reflect cultural and social norms around acceptable attitudes (and ways of talking) of dying and death. Death has been a taboo subject,<sup>31</sup> where fear, discomfort, and avoidance remain appropriate, or at least understandable, responses. To speak otherwise may be construed as insensitive, inappropriate, and cause distress for others.<sup>32</sup> Nurses in this study are forging ahead by courageously, yet cautiously, grappling with positive language in describing their experiences of assisted dying. Further research is needed, however these findings point to a rapidly shifting context of dying that influences how nurses are experiencing, and learning to talk about this new way of dying.

### 6.1 | Strengths and limitations

The extensive nursing experience of participants (mean = 23.6 years) may be a significant factor shaping their perceptions of MAiD. As



pioneers navigating into uncharted waters, it may not be surprising since these nurses have both expertise and confidence to take a stand either for or against MAiD and be willing to share their experiences. As with all qualitative research, we are unable to generalize the findings since the sampling strategy was purposive rather than random, and participants were self-selecting. We collected data during the first 6 months when assisted dying was newly legislated. This provided a historic snapshot, but also must be considered when interpreting findings.

## 6.2 | Implications

Findings from this study can provide direction for nurses, nurse educators, and leaders in this new clinical and legal reality. Understanding the ongoing sensemaking process calls for spaces and ways of checking in: talking, listening, hearing, and supporting nurses; providing opportunities for debriefs and ethical conversations in safe venues where emotions can surface and issues of moral distress be expressed and addressed. Creating forums for nurses to discuss ethical questions or dilemmas related to religious or conscientious objection are vital. Misinformation and lack of clarity regarding the nursing Code of Ethics and legal requirements calls for nursing leadership to ensure mechanisms to regularly update and clarify misinformation.<sup>33</sup>

Even at this early juncture of the legislation, there are dynamic shifts occurring as aspects of the legislation are being challenged.<sup>34</sup> Government reports are pending that will address advanced requests for MAiD, requests by mature minors, and where mental illness is the sole underlying medical condition.<sup>35</sup> A change in any of these areas will have tremendous practice implications. Findings from this study indicate that sensemaking about MAiD is happening on a continuum. Nurse leaders and nursing organizations will need to be at the forefront to ensure nurses understand and feel prepared to respond to situations and questions they will face with patients and families, and indeed are facing now.

Findings from this study have implications for clinical educators to attend closely to the emotional nature of assisted dying for nurses. Educational approaches must go beyond information sharing via didactic presentations and explore simulation, role playing, and the creation of Communities of Practice.<sup>36</sup> These findings raise questions of how nurses in community and home care can develop and maintain the necessary skills of intravenous insertion to aid in assisted dying with patients they may have known for years. Findings also have implications for whether minimal education about MAiD should be mandatory.

At a policy level, these findings suggest nurse leaders should continue to advocate for patient choice at the end of life and the provision of compassionate, knowledgeable, and nonjudgmental care to patients, regardless of end-of-life treatment decisions. Further research into the impact of rural versus urban setting, educational preparation, religious, spiritual, cultural affiliation, and the context of specialty settings on nurses' experiences will add to current understanding of MAiD in the Canadian context.

## 7 | CONCLUSION

Little qualitative research has been done to explore Canadian nurses' perceptions of the impact of introducing medically assisted dying on their view of the profession, clinical practice, and personally. In the first 6 months of implementing MAiD, most nurses perceived assisted dying as an extension of their professional role of providing holistic care without judgment, advocating for patient choice, and supporting a new option for a good death. Stories from these pioneering nurses illustrated an ongoing sensemaking process, determining where they stand, and experiencing a spectrum of emotions that were predominantly and surprisingly positive. Some nurses described moral distress as they sought to negotiate what they considered to be morally wrong. Implications for practice leaders and educators included providing ongoing forums for nurses to talk openly and normalize sensemaking as a fluid process that may change over time. Debriefings address pragmatic and emotional needs arising from MAiD, ensuring nurses understand their legal responsibilities and professional codes of conduct.

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