


Constructing Good Nursing Practice for Medical Assistance in Dying in Canada: An Interpretive Descriptive Study

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Abstract

Nurses play a central role in Medical Assistance in Dying (MAiD) in Canada. However, we know little about nurses' experiences with this new end-of-life option. The purpose of this study was to explore how nurses construct good nursing practice in the context of MAiD. This was a qualitative interview study using Interpretive Description. Fifty-nine nurses participated in semi-structured telephone interviews. Data were analyzed inductively. The findings illustrated the ways in which nurses constructed artful practice to humanize what was otherwise a medicalized event. Registered nurses and nurse practitioners described creating a person-centered MAiD process that included establishing relationship, planning meticulously, orchestrating the MAiD death, and supporting the family. Nurses in this study illustrated how a nursing gaze focused on relationality crosses the moral divides that characterize MAiD. These findings provide an in-depth look at what constitutes good nursing practice in MAiD that can support the development of best practices.

Keywords

medical assistance in dying, MAiD, euthanasia, physician-assisted death, nursing practice, qualitative, interpretive description

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Introduction

In June of 2016, through the passing of Bill-C14 (Bill-C14 Parliament of Canada, 2016), *An Act to amend the Criminal Code and to make related amendments to other Acts*, medical assistance in dying (MAiD) was legalized in Canada. In Canada, MAiD is permissible through two means: (a) clinician-administered assisted death (commonly referred to as physician-assisted euthanasia outside of the Canadian context) and (b) client-administered assisted death (previously referred to as assisted suicide). As of October 31, 2018, the date of the most recent official report, only six of the 6,749 assisted deaths occurring as a result of *Bill C-14* in Canada have been client-administered (Health Canada, 2019).

In contrast to other countries where assisted death is also legal (i.e., the Netherlands, Belgium, Columbia, etc.), Canada is the first country to permit nurse practitioners to act as both assessors and providers of MAiD. This resulted, in part, from the lobbying of the Canadian Nurses' Association and the Canadian Nurses' Protective Society during the legislative process (Canadian Nurses' Association [CNA], 2015). However, the nurse practitioners' scope of practice is further set by regulations at the provincial and territorial

level and so, at this time, not all nurse practitioners in Canada are permitted to act as MAiD assessors and/or providers. Canada is also somewhat unique in its use of designated MAiD providers and teams who may not have preexisting or ongoing relationships with patients and their families. Registered nurses perform an important coordinating role on these teams.

The involvement of both registered nurses and nurse practitioners in MAiD in Canada has had a number of professional and legal implications. Regulatory bodies for nursing in Canada have been required to develop MAiD-specific

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policies to guide practice; although the breadth of these policies varies greatly across the country (Pesut et al., 2019). Furthermore, these policies must be written in accordance with the differing scopes of practice for registered nurses and nurse practitioners. Nurses and nurse practitioners' legal involvement is further regulated by health regions where the policies may be more restrictive than those outlined by the nursing regulatory body. This creates a complex regulatory landscape for nursing, which is exacerbated by the perception that participating in MAiD carries a degree of legal risk (Pesut et al., 2019).

With the recent legalization of MAiD, and evidence from other countries that points to the importance of the nursing role in this context (Denier et al., 2009; van de Scheur & van der Arend, 1998), the goal of our program of research is to better understand the policy, practice, and ethical implications of MAiD for nursing. We conducted a primary qualitative study of nurses' experiences. Other papers from this dataset discuss nurses' moral sense-making (Pesut, Thorne, Storch, et al., 2020) and policy and health system issues that affect their practice (Pesut, Thorne, Schiller, et al., 2020). In this article, we report on the qualitative findings that describe how nurses construct good nursing practice within the context of this new end-of-life option.

Method

This qualitative interview study was guided by Interpretive Description (Thorne, 2016). Interpretive description is a theoretically sensitive approach to qualitative work when there is a need to develop an understanding of what should occur within a practice context by reconciling theory with a situation-specific approach. Findings are thus sensitive to the unique contexts within which nurses, and other applied disciplines, do their work.

Participants were recruited through health regions, the Canadian Nurses' Association, and the Canadian Association of MAiD Assessors and Providers using purposive and snowball sampling techniques. Invitations to participate in the study were sent out through email and Twitter. Participants were asked to notify others who might be interested in participating. As we were seeking geographic variability in participants we also did targeted recruiting through MAiD providers who practiced in provinces where we had not had study participation. We stopped recruiting after we had interviewed the participants from all provinces in which MAiD was happening regularly and after data saturation was achieved.

Inclusion criteria were that participants be registered nurses or nurse practitioners who had experience with participating, or choosing not to participate, in MAiD. In Canada, registered nurses are typically educated at the baccalaureate level. Nurse practitioners are registered nurses who have additional education, typically at the level of graduate degrees, and have the ability to independently diagnose and prescribe. Interested participants contacted the research

coordinator who then conducted a conversation to explain the study and answer questions. For those who chose to participate, a research consent form was emailed to them, and the interview was conducted once the signed consent had been received. Ethical approval was obtained through the Behavioral Research Ethics Board of the University of British Columbia.

Fifty-nine nurses were interviewed by telephone or in-person, by the principal investigator and/or research coordinator, using a semi-structured interview guide that had been piloted and revised prior to data collection. Interviews averaged 51 minutes in length ranging from 23 to 88 minutes. The participants were invited to contact the investigators for a second interview if they had further contribution, and one participant did so. The interviews were digitally recorded, transcribed verbatim, and downloaded into qualitative software NVivo for analysis.

Analysis began with open codes that were derived inductively and negotiated by two research team members (B.P. and M.G.) after immersion in the first 6 interview transcripts. In keeping with Interpretive Descriptive methods, a number of interviews were conducted prior to coding and the naming of open codes was avoided until the codes were robust enough for description (Thorne, 2016). These open codes were refined by two additional investigators (ST & JR) as data collection continued. These refined codes were then used by MG and a research assistant to code the remaining transcripts. Data were analyzed using constant comparative analysis (Glaser & Strauss, 1967). Data were analyzed in relation to the nursing role, nursing context, years of practice experience, moral perspectives of MAiD, and amount of exposure to patients considering and receiving MAiD. Furthermore, the interpretation of these codes was informed by revisiting the original transcripts, by reading other accounts of nurses' experiences in the empirical literature and media, and by engaging in discussions with the research team and nurses at MAiD-related events (Thorne, 2016). From these codes, a thematic account of the data was constructed.

Integrity of the analysis was supported through field notes, reflective memos, investigator triangulation, and an audit trail (Thorne, 2016). The field notes were written after each interview and storylines were constructed that captured the main points of each interview. These notes were not coded but were consulted throughout the analysis. Reflexivity was supported through intensive discussions among team members in which we explored our impressions of the data, the paradoxes being presented by participants, and our surprises in terms of what we were not hearing. Supporting interpretive authority (Thorne, 2016) was particularly important in this study because MAiD is a morally contentious topic, and participant scenarios often provoked emotional responses in the investigators. To support interpretive integrity, we discussed these emotions and probed the values and beliefs that were underlying them. No transcripts were returned for participant comments; however, the participants

Table 1. Demographics of Study Participants.

Characteristic	Number of Participants <i>n</i> = 59
Province	British Columbia: <i>n</i> =28 (48%) Ontario: <i>n</i> =16 (27%) Manitoba: <i>n</i> =7 (12%) Alberta: <i>n</i> =5 (9%) Newfoundland and Labrador: <i>n</i> =2 (3%) Saskatchewan: <i>n</i> =1 (2%)
Age	25–44: <i>n</i> =27 (46%) 45–64: <i>n</i> =29 (49%) > 65: <i>n</i> =3 (5%)
Gender	Female: <i>n</i> =56 (95%) Male: <i>n</i> =3 (5%)
Ethnicity	Caucasian: <i>n</i> =57 (97%) Others: <i>n</i> =2 (3%)
Designation	Registered Nurse: <i>n</i> =43 (73%) Nurse Practitioner: <i>n</i> =13 (22%) Clinical Nurse Specialist: <i>n</i> =3 (5%)
Years Worked	2–4 years: <i>n</i> =4 (7%) 5–9 years: <i>n</i> =10 (17%) 10–14 years: <i>n</i> =13 (22%) 15–19 years: <i>n</i> =4 (7%) 20–24 years: <i>n</i> =6 (10%) >25 years: <i>n</i> =22 (38%)
Work Context	Home & community: <i>n</i> =32 (54%) Acute care: <i>n</i> =10 (17%) Long Term Care: <i>n</i> =5 (9%) Hospice: <i>n</i> =4 (7%) Clinic: <i>n</i> =3 (5%) Others: <i>n</i> =5 (9%)
Conscientious Objection	No/Unsure: <i>n</i> =50 (85%) Yes: <i>n</i> =9 (15%)
Spiritual or Religious Affiliation	Religious or spiritual: <i>n</i> =33 (56%) Neither: <i>n</i> =15 (25%) Spiritual but not religious: <i>n</i> =11 (19%)

were invited to provide feedback after viewing a webinar in which the findings were presented. Research participants receive copies of publications and webinar presentations as part of the dissemination plan.

Demographic data were collected for each participant (Table 1). These participants had significant experience with MAiD. For example, 24 of the 59 nurses had *each* conducted more than 25 conversations with patients about MAiD, and 11 of the 59 nurses had *each* been involved with more than 25 patients who went on to receive MAiD. Participants identified their preferred gender; in addition to male and female options, participants could specify “other” or “prefer not to say.” To protect the anonymity of the small number of self-identified male participants in this study, all participants will be referred to as female.

Results

From the perspective of the nurses in this study, the concept of “good nursing practice” in the MAiD context required

them to first grapple with the different type of death that MAiD represents. These nurses described a complex process of wrestling with the implications of specific distinctions between a planned death and a “natural death.” They then went on to describe the nursing principles that guide professional care in the context of this new end-of-life option. Finally, nurses reflected on what was necessary to become confident and competent in their MAiD-related practice (Table 2). These findings are represented by the following themes: a cesarean death, the nursing lens, a familiar conversation with new options, artful practice, and confidence and competence. There were common findings between registered nurses and nurse practitioners except in how conversations were conducted with patients. Findings are disaggregated within this theme to represent these differences.

A Cesarean Death

Birth and death are the most mysterious of life’s events. As such, it is fitting that one nurse, in attempting to describe the difference between a natural death and a MAiD death, used the analogy of a “Cesarean death.” “You do [natural] births and you do caesareans, they are the same kind of thing really but they are also different. I’m not sure exactly how they’re different but they are” (P29). Nurses indicated two things that characterized this Cesarean death. First, the day and the hour of a MAiD death would be known in advance so there was time for extensive planning. Second, the speed at which death occurred in a MAiD context contrasted starkly with the “*fading away*” that characterizes many natural death processes that are familiar and well understood within nursing.

Patient reasoning. In describing this different type of death, nurses often began by reflecting on reasons why patients might choose a MAiD option. They spoke of the suffering encountered by patients, such as pain, diminished mobility, disfiguring wounds, or difficulty breathing, all of which can lead to psychological suffering, and hence, a decision to undertake MAiD. For other patients, it was the anticipation of suffering or the desire for a different type of death that led to the decision to choose MAiD. As one participant described a client she worked with, “She said, ‘I’m 95 years old, I have all my marbles, I don’t want to suffer, I don’t want palliative care, I want my family at my bedside’” (P18). Although nurses knew that palliative care could be effective in many of these situations, they also acknowledged that some patients did not want the tradeoffs that might accompany such treatment. For example, a patient in extensive pain might not want to receive mind-altering medications.

Nurses felt that some patients were uncertain about whether they wanted MAiD, but rather they wanted the control that came with knowing they were eligible for it. They gave examples of how the presence of a MAiD plan had made an immediate impact on alleviating distressing symptoms; pain became more tolerable, nausea diminished, and

Table 2. Themes.

Major Themes	Sub-themes
A Cesarean Death	Patient Reasoning
The Nursing Lens	A different death
	Fit with nursing
	Conscientious objection and fit
	Respecting views and exclusionary practices
A Familiar Conversation with New Options	Nurse practitioner legacy conversations
	Inquiries to registered nurses
	Reflecting on biases
Artful Practice	Establishing the relational context
	Planning meticulously
	Orchestrating the act
	Supporting the family after death
Competence and Confidence	Competence and confidence

anxiety about losing control was removed from the equation. “We had one patient with this terrible nausea that we could not control. Once she had set her date for MAiD, suddenly we were controlling the nausea better” (P24). In the case of other patients, MAiD was clearly more than a back-up plan; it was something they were insistent upon. Nurses used the word *settled* many times to describe this patient’s insistence on a MAiD death.

A different death. Nurses described being deeply affected by the nature of the MAiD death. What was particularly impactful was the speed at which death occurred, especially because so many patients appeared relatively well in the moments prior to death. Watching a patient go from drinking champagne to death in a matter of minutes was utterly foreign to the way that nurses usually traveled the dying trajectory with their patients. “There’s traumatic deaths and prolonged painful deaths, and then there are MAiD deaths. The most obvious difference is the patient is able to talk to you, right up until the end, then five minutes later they are dead” (P51). Many explicitly referenced the impact of the moment in which patients turned from pink to gray, and they commonly used adjectives such as creepy, alarming, or surreal in their descriptions. However, most nurses had difficulty explaining why they experienced these deaths as so impactful. And in the context of this profound impact, they spoke of their difficulties in knowing how to intellectually and emotionally process the death. One nurse recalled:

One of my first experiences was with a patient who was very awake and alert. And he was my patient, and I consciously made the effort to say goodbye to him. And then afterwards I came in and cared for him after death. And it was just so fast. And these things, they’re so fast that it’s not the normal process. And it’s hard to take it all in and process it the normal way you would. (P16)

The control that patients had over arranging the details of their death, and the rapidity at which the dying process

happened, placed nurses in an entirely new landscape—one in which they had to formulate a nursing lens that was specific to this unique type of situation.

The Nursing Lens

Nurses held diverse views about the moral acceptability of MAiD and whether such an act was a fit with what they perceived nursing to be. They did not always know how to negotiate these different perspectives in the practice setting. Despite this diversity, what united participants was a desire to nurse well and compassionately in this new practice context.

Fit with nursing. Several nurses suggested that the care required during MAiD was care that was in some sense uniquely nursing. As one participant said, “there is really something about this being strong within nursing expertise” (P1). The participants described how nursing took a “*heart*” approach to health care that began with compassion and caring, and in which “curing was an add-on” (P30). Therefore, when cure was no longer possible, nurses were the perfect providers of MAiD. Others explained how the most important roles that nurses play in health care—patient support and advocacy—are roles that are central to the care of patients considering or receiving MAiD. One participant suggested that nurses are particularly adept at MAiD because they have “years of experience doing something technically well while immediately establishing relationship” (P8). Others explained how nurses are good at “thinking holistically while not forgetting the tiniest details” (P2) and how they are the providers who “accompany patients right to the end” (P5). Participants who were supportive of MAiD described it as actualizing the ideal of patient-centered care and something concrete they could do to alleviate suffering. “Patients are the ones guiding their care options. I’m helping someone in their suffering and that’s not in contrast to helping people” (P3).

Conscientious objection and fit. For those nurses who were identified as conscientious objectors, either on religious or philosophical grounds, MAiD was not a good fit with nursing. Resisting the idea that professionals only have a responsibility to fulfill patient wishes, these participants argued that two people were involved in this decision, patients and providers. For some participants, the issue was “a soul question and not a professional question” (P33). However, this did not mean that these conscientious objectors abdicated their professional responsibilities or their nursing interventions to alleviate suffering. “My approach to nursing care does not change at all. It doesn’t change my ability to listen to that person, my symptom management, or my eliciting of their wishes, goals, and perceptions of what is happening (P23). Rather, they felt challenged to find ways to embody the nursing lenses of compassion, caring, advocacy, holism, and staying with patients who desired MAiD while also staying true to their own convictions.

Respecting views and exclusionary practices. This common ground of the nursing lens was not always apparent to nurses on both sides of the moral divide. For example, nurses who were conscientious objectors might be excluded from the plan of care once their patient had chosen MAiD. Once that happened, they had difficulty addressing that exclusion. “It has been a difficult issue to discuss in a safe and productive way. People assume they know what you will be comfortable with and that you have nothing useful to contribute to the plan of care” (P23). This exclusionary practice was particularly problematic for those nurses who were conscientious objectors and whose roles entailed staying with patients over the palliative/MAiD trajectory (e.g., palliative clinicians and home care nurses).

Ironically, those nurses who were MAiD proponents suggested that no longer involving conscientiously objecting colleagues in conversations about the plan of care was a mark of respect for their moral position. What one side tended to perceive as respectful, the other side tended to perceive as exclusionary. Yet, despite this misunderstanding, both sides found common ground in how they worked to be with patients in a compassionate way as patients chose their end-of-life options.

A Familiar Conversation With New Options

Nurses in this study were learning how to have initial conversations about a MAiD request. Participants explained how in their years of working with palliative patients, even prior to the legalization of MAiD, they often encountered patients who stated that they wanted to die, and even asked for help from nurses to do so. This was a familiar conversation, one that nurses who worked with dying patients tended to be highly skilled at facilitating. However, what was new were the options now available to nurses to assist with that request. “This is what nursing always was. The options and

paperwork are new but lots of these questions are old, old, old” (P5). As such, nurses needed to adapt in their patterns of response to requests for assisted death. These conversations happened in different ways depending upon whether the nurse was a nurse practitioner trying to evaluate a patient’s eligibility for MAiD or a registered nurse trying to discern the nature and intent of the request.

Nurse practitioner legacy conversations. Nurse practitioners spoke about what they had learned when conducting the initial conversations to determine patient eligibility for MAiD. Several participants referred to these as “*legacy conversations*” because these “conversations and interactions were going to live with families forever” (P1). These conversations entailed meeting strangers for the first time and rapidly establishing rapport and intimacy so that they could hear the patient’s story of suffering, while at the same time taking on the responsibility of determining whether someone was eligible, or not, for MAiD. As one participant put it: There’s so much nursing and nurturing and caring that goes into these assessments and conversations and getting folks to tell us their story” (P1). Although these conversations provoked anxiety for new nurse practitioner assessors, they soon learned a conversational skillset that eased their anxiety. One participant described it as a progression from “pleasantries, to medical conditions, to the personal sufferings” that had led to the desire for an assisted death (P36). This conversational confidence was boosted by the typical patient response to their presence. Patients greeted them at the door with warmth and gratitude and allowed them immediate and intimate access to their stories. In the face of such patient responses, nurses learned to take a direct approach, avoiding all language that would euphemize the MAiD death: I “take away the fluffiness of a conversation and make it really raw and really real” (P36).

The ease with which these nurse practitioners talked about impending death was contrasted in the interviews with what normally happens in palliative care. When working in palliative care, nurses described themselves as being on guard about what could be said to patients, constantly trying to find the language that matched where patients saw themselves on the dying trajectory. In contrast, during a conversation about MAiD, the goal of the nurse practitioner assessors was to understand patients as fully as possible using a direct approach, while humanizing the experience and the request, so that they could determine whether this was “the right person, for the right reason, at the right time” (P40).

Inquiries to registered nurses. The directness characterized by nurse practitioners who were acting as MAiD assessors contrasted with the experiences of registered nurses whose patients were expressing what might be a MAiD request but within the context of everyday work. This latter conversation was complicated. First, nurses had to determine whether this was a true request for MAiD or whether it reflected an

impatience with the dying process that is common in palliative care. In these conversations, patients used an implicit or veiled request for death, rather than using the term MAiD. “They approach the topic in a roundabout way and then you have to clarify what they mean to ensure you are getting them the appropriate referral” (P32). This determination by nurses had pragmatic implications for patients. For example, it could lead either to a referral to the MAiD coordination service or to a referral to a palliative care social worker.

Second, registered nurses were often uncertain about their role and boundaries in these conversations. Could they talk to patients about MAiD or was that within the sole purview of physicians and nurse practitioners? Should nurses introduce the concept of a medically assisted death as part of the informed decision-making process or must they wait until patients use that exact terminology (e.g., “is it possible to have help to die”)? Nurses were highly conscious that their decisions in relation to these questions could have legal and regulatory ramifications for their practice. Many nurses described themselves as not knowing what they should do.

Third, nurses described the impact of significant time constraints. In the rushed atmosphere of institutional settings, nurses had little time to deeply explore patients’ intentions. In light of these conversational complexities and lack of time, nurses responded to these requests along a spectrum. Some simply handed patients pamphlets about MAiD, while others felt it was critically important to take the time to engage the conversation. “Although these conversations can create all kinds of anxieties, particularly if you feel misinformed, it is important not to run from them. Be open, be kind, this is a desperate point in someone’s life” (P43).

Reflecting on biases. This spectrum of conversational responses did not necessarily reflect nurses’ moral stance toward MAiD. Even nurses who had declared themselves to be conscientious objectors were often willing to engage in, and make all effort, to skillfully negotiate these conversations. Several of the conscientious objectors in this study reflected on the way that their own views could potentially affect patient choices in these conversations, and they described strategies they used to mitigate that. “Being a conscientious objector, I feel like I have perhaps even more of a duty to stay on top of my biases and to share with that client the way to access MAiD, if that is what they decide they want” (P23). Indeed, the seriousness with which they took part in these conversations reflected the seriousness with which they viewed the outcomes of the choice patients made. One participant described her interactions with a patient who clearly wanted to die on his own terms:

He just kept having the same conversation with me over and over and at first I kind of ignored the feeling I was having about my obligation. But then I needed to let him know that this was an option. I felt distressed by telling him and distressed by not telling him, but this was not my call to make. (P56)

Whether participants were nurse practitioners performing assessments or registered nurses fielding an inquiry, their conversational goal was the same, to know the patient. This was manifested through conversations that sought to preserve dignity, “do you know their fears, what they are most proud of, how they view all this?” (P50), while at the same time reflected deep humility. “These conversations are about listening and not being afraid of what you might hear or that you might have nothing to offer in return” (P15).

Artful Practice

This patient-centered approach to conversation was also reflected in how nurses constructed artful practice once the patients had chosen to proceed with MAiD. Artful practice describes the ways in which nurses sought to humanize and personalize the medical act of MAiD. This included establishing the relational context, engaging in meticulous planning, orchestrating the act of assisted death, and supporting families post death.

Establishing the relational context. Nurses spoke of how important it was to establish relationships with patients and families quickly and skillfully, knowing that, in some instances, the day of death could be their singular encounter with the patient and their family. For example, one registered nurse, who was responsible for establishing the intravenous through which MAiD medications would be delivered, described her relational approach:

So, it encompasses engaging in a short period of time with a family and a client, developing a rapport very quickly and being very sensitive and intuitive about what kind of presence is wanted and what might be needed. (P29)

As this nurse explained it, “you establish the relationship before the intravenous.” This relationship-building approach often included listening to stories, browsing family photo albums, and learning names and family relationships.

Participants described how important it was to extend that relational approach to their family. This family-centric care was considered essential as most of the difficulty nurses experienced during a MAiD death arose from family members who did not understand or agree with the patient’s decision. By being in tune with the emotions of the family, the participants were better able to get a handle on how the assisted death could play out. As part of their relational commitment to patients and families, the participants spoke of being “overly respectful” and caring as the day of death drew near:

I just tend to keep it in the back of my mind all the time and just be a little more precious with them. I know their time is limited and the time is coming so I want to take care of all of their needs as much as possible. (P6)

Planning meticulously. Setting this relational context was accompanied by meticulous planning for the actual moment of death. This included determining what patients wanted, preparing everyone for what to expect, establishing rituals, and managing nurses' own anxieties. Once patients had decided the date and time of their death, the nurses re-oriented their focus toward facilitating the most patient-centered death possible. As one participant described it, "Is there anything I can facilitate for that patient? Because on this date, at this time, they will be taking their last breath" (P11). This preparation for a good death entailed seeing that patients remained comfortable, calm, and (importantly in the Canadian context) cognitively capable of giving their final consent. Nurses would set the scene with patients to better stage a patient-centered death. They would ask questions such as "where do you want to be?," "who do you want with you?," and "what do you want surrounding you?" One nurse described how part of this preparation was establishing an "exit plan" for the patients. She proactively informed them that at any moment they could change their mind and it would not affect their eligibility for MAiD. She even crafted a plausible explanation for family members to hear should the patients change their mind about MAiD, so that patients would not feel the pressure to go forward in the face of efforts that loved ones may have made to be present on the day of the scheduled death (P42).

Nurses described preparing everyone for what to expect and reinforcing this preparation on a regular basis: "I go into quite a bit of detail about the day of the provision and what to expect and, you know, things to think about" (P2). This included preparing families for the medical-technical aspects of the intervention and for the rapidity of death and accompanying skin color changes. Nurses worked hard to think about what might be unexpected for patients and families, sometimes learning this the hard way, and adding this knowledge to their ongoing repertoire of teaching. Nurses did this recognizing that, in some ways, the ten-day waiting period required by Canadian law could be even more difficult for families than for patients, and a time characterized by anxiety and anticipatory grief.

Death without the usual trajectory leading up to it, or the usual response following it, required the creation of some new form of ritual and ceremony. "We needed some sort of ceremony around it because it felt so weird because there wasn't any preamble or post anything" (P13). As one nurse suggested, "it is a whole ritual that we go through. I call it a ritual because it has a pattern" (P4). One nurse brought pieces of rose quartz for family members to hold onto during the assisted death process, although she quickly realized that not all families wanted such rituals. This same nurse prepared patients with guided meditations but again soon realized that, at the final moment, it was often the family who set the tone. As she explained it, a guided meditation of the outdoors "might turn into Psalm 23" and being okay with that was an important part of family-centered care.

Nurses also had to manage their own potential anxiety in planning for the MAiD event. This was particularly true for those nurses who would be responsible for establishing intravenous access. Many of these patients were frail and hence it could be difficult to get reliable intravenous access. Participants told stories of lying awake the night before, worrying whether they would be able to get intravenous access quickly and painlessly. For many nurses, this anxiety never abated, although for others, it eased over subsequent MAiD deliveries. One nurse reflected, "Then after not too long I realized, I've been nursing for 40 years, I can start IVs, it's not an issue" (P14). Nurses also learned of the problems that could arise during the MAiD death and prepared themselves accordingly. This included bringing things that the MAiD provider was likely to forget (e.g., trays for medications, death certificates), obtaining extra medications and needles for specialized access (e.g., Huber needles), and arranging the room so that the family could be close to the patient and afterward so the funeral home could have easy access to the body.

Orchestrating the act. Nurses described how orchestrating the moment of the MAiD death entailed de-centering their role by making oneself "small" and the act itself "invisible." "We have figured out how to work together to make ourselves as small as possible in the room because this is never about the provider" (P1). They explained ways in which they tried to disguise the medications. The many syringes of medication that are required for an assisted death were often prepared outside of the room and then hidden from the family's view during administration. Providers got on their hands and knees at the bedside, and used extension tubing so that medications could be administered away from the bedside, or they shifted their bodies to hide what they were doing. Nurses also described arranging patients in the bed during medication delivery so that they would not look uncomfortable after death: "Family members have told me, thank you for moving his head. He looked like he was drowning" (P3). The final act of the nurse was to remove all equipment after the death: "We leave no trace. You bring all your stuff with you and you take it all away. Not even syringe wrappers in the garbage" (P42). These final moments could be somber or celebratory depending upon the tone set by the patient or family.

Supporting the family after death. Finally, once the act of MAiD was complete, nurses spoke of staying present for families. One reflected,

This whole experience is so unnatural for the family. I've just essentially gone in there and euthanized someone. They've met me for half an hour and you know, I'm like, . . .okay, goodbye, and I walk out the door and they're left there with the body in the bed. (P18)

To support continuity of care after the time of death, nurses often offered to stay with families if they so desired. Family

members who experienced difficult emotions during the MAiD death could also pose a challenge to the nurse. One nurse described frantically looking for a family member who had gone for a walk on her rural property rather than being present for the death. The nurse feared she had come to harm when she failed to return after an extended absence. When the family member finally returned, the nurse experienced a flood of emotions and reflected, “typically you leave feeling like you have helped someone and you feel good about what you have been able to do. . .that day I didn’t feel that” (P14). For these nurses, artful practice, such as family-focused care right into the bereavement period, was key to supporting the patient’s family in the way they needed.

Competence and Confidence

Nurses in this study were trying to create best practices with little guidance. As one nurse suggested she had never been in a situation in her nursing career in which she was actually creating new nursing knowledge: “It’s like living grounded theory. We’re making it up as we go along” (P24). The practice supports available to these nurses varied across the country. Some nurses worked in practice environments that had detailed policies and procedures while others were working in a policy and procedural vacuum. Some of the most difficult practice experiences recounted by nurses occurred early after the legislation had been passed, when nurses were expected to take part in a MAiD death despite little training or mentorship. Even after the legislation had been in place for some time, and there were many independent learning opportunities available, nurses suggested that learning modules were not enough. To be confident and competent, nurses required mentorship from individuals who had become experienced with MAiD and they required debriefing after the event with those who knew what it was like to be involved in these impactful provisions. Some nurses suggested that, ideally, they should be able to observe before they performed a role in a MAiD death. Timeliness of this education was also important. Some nurses noted that they had not been interested in education about MAiD until they were actually confronted with the possibility of a MAiD death: “There isn’t an appetite for information until there is an appetite” (P3).

Given their roles as MAiD assessors and providers, nurse practitioners often felt the lack of supportive education most acutely, although several of them were confident that this has improved over the years since the legislation was passed. A number of nurse practitioners had simply taken the initiative to create their own practice supports and to share them with their colleagues. Some suggested that there were vastly more resources available at the professional level for physicians than there were for nurse practitioners. This was particularly problematic because, in some situations, nurse practitioners were the sole MAiD providers in their community. Nurse practitioners also indicated that although there were many patient assessment instruments available to guide their evaluations (e.g., frailty scale), the lack of agreed-upon

best practices in MAiD made it difficult to choose the most appropriate ones. This was less of an issue for those nurse practitioners working within teams where they had the opportunity to discuss their MAiD assessments than for those working alone.

This need for further education and support was exacerbated by the more detailed reporting requirements introduced in November of 2018 by Health Canada, the national health ministry. As one participant suggested, the checklist made it feel as though there was a fine legal line between MAiD and murder (P30). Overall, among both registered nurses and nurse practitioners, there was agreement that confidence and competence required structured education, mentored experiences, and supportive debriefing.

Discussion

Findings from this study reveal the ways in which nurses construct good nursing practice for this new end-of-life option. Such radical practice changes do not happen very often within nursing. Not only is MAiD a radical practice change, but it is also morally contentious, and hence potentially divisive for nurses. For example, nurses have variously described MAiD as transforming their experiences of vicarious suffering in practice or as a morally wrong act in which they never imagined they would be asked to participate (Pesut, Thorne, Storch, et al., 2020). Such radical and morally divisive practice changes allow us the opportunity to identify and explore nursing’s unique angle of vision (Thorne, 2015). Exploring nurses’ experiences provides an opportunity to ask the question of whether there is some common nursing gaze even across these moral differences.

Amid decades-long debates about the unifying ontology of the nursing discipline, Bender recently proposed that the unique fundamental access point of nursing is relationality, “interdependent relations that constitute people, including, nurses, in their health/environment circumstance” (Bender, 2018, p. 6). She describes it as a “relation-sensing performance” in which “nurses create worlds where they can make a difference—where they can make things better” (p. 7). This relation-sensing performance was evident throughout our data. Nurses sought to understand the unique reasons individuals may choose MAiD, they practiced communication that honored the enduring impact of these conversations, and they described artful practice to make a medicalized act as person-centered as possible. Significantly, this emphasis on practicing a “*relation-sensing performance*” in this new context was characteristic of both proponents of, and conscientious objectors to MAiD. Just as proponents sought to create the best experience possible for patients and their families, conscientious objectors too sought ways to embody caring, advocacy, and holism, even as they chose not to participate in the act of MAiD. In doing so, these conscientious objectors recognized that the relation-sensing performance extended to themselves as they sought to enact good care while attending to their moral selves.

In this study, nurses rarely acknowledged, or explicitly talked about, this shared disciplinary gaze, focusing instead on respecting moral difference. This focus on difference could lead to nurses feeling excluded from patient care in the context of MAiD. Lamb et al. (2019) reported similar findings in their study of Canadian nurses who were conscientious objectors to MAiD. They reported feeling alone, uncertain, and stigmatized as a minority group. Therefore, identifying and developing this unifying gaze is an important axis upon which nurses of diverse viewpoints can come together to develop knowledge of best-practices, even within the context of morally contentious practices.

As part of their *relation-sensing* practice, nurses described the reasons that a patient might choose MAiD, the ways in which it was different from a natural death, and its subsequent impact upon their own experiences. Even as some nurses described being grateful that they could fulfill patient wishes for a MAiD death, the death itself provoked emotions that could be uncomfortable or disturbing. Studies of nurses' experiences with assisted death from Belgium (Bellens et al., 2020; Denier, Gastmans, et al., 2010), the Netherlands (Lewis, 2018; van de Scheur & van der Arend, 1998), and Canada (Beuthin et al., 2018) have similarly described a range of emotions that nurses experience in the context of an assisted death. Furthermore, other authors have noted the same sense of gratitude nurses describe at being part of a care system that provides an opportunity to fulfill patients' wishes and relieve their suffering (Bruce & Beuthin, 2019).

Nurses in this study were on the front lines of receiving and negotiating initial patient requests for MAiD. Registered nurses found these initial conversations complicated because potential requests were often couched in indirect and veiled language. Although it is not uncommon for palliative patients to express a wish to die (Wright et al., 2017), this does not necessarily mean they are requesting MAiD. Thus, highly developed communication skills and effort were required to clarify the nature of the request amid time-pressured clinical environments. Nurses from the Netherlands (van de Scheur & van der Arend, 1998) and Belgium (Denier, Gastmans, et al., 2010) have described similar experiences of receiving veiled requests that took time and skill to discern patient's intent. In this study, nurses who were self-declared conscientious objectors still engaged these conversations, while carefully reflecting on the ways that their own moral stances might influence the conversational exchange. Another Canadian study similarly found that nurses who were conscientious objectors felt a responsibility to engage in an in-depth conversation with patients who expressed a MAiD request (Sheridan, 2017). Such *relation-sensing* communication, therefore, was typical of nursing practice for both those who participated in MAiD, and those who did not.

Nurse practitioners in this study provided a rich look at the conversations that were important to their roles as assessors and providers of MAiD. This was an important finding given Canada's unique landscape in using nurse practitioners, in addition to physicians, as MAiD assessors

and providers. Best practices in these conversations were characterized as using a direct approach that was nevertheless couched within a caring and humanizing client encounter. This direct approach was necessary so that there could be no patient confusion about what the MAiD process entailed and what the ultimate outcome would be. A qualitative study from the Netherlands of physician and patient experiences with euthanasia requests similarly indicated that both patients and physicians valued "recurrent, profound, open communication" (Dees et al., 2013, p. 31). However, it is important to note that internationally, these conversations are often conducted in the context of preexisting patient-physician relationships. Canada is somewhat unique in the way that it uses designated physicians and nurses, who may not have met the patient previously, to conduct MAiD assessment and provision. This creates a unique communication context. Nurses had learned to skillfully negotiate this context, although the degree of comfort with these conversations varied across study participants.

Best nursing practices in the context of MAiD entailed applying artful practice to establish the relational context, and then using that relational context to plan for and orchestrate the MAiD death, and to care for family after the death. The strategies described by these nurses were used to humanize what could potentially be a highly medicalized event. Nurses had learned to counteract this medicalized approach by orchestrating a patient-centered context and by attempting to render the medical people and equipment invisible at the moment of death. As such, nurses had learned a *relation-sensing* performance that supported patients and families along the trajectory of considering MAiD through to family bereavement.

Evidence from other studies of nurses' experiences with assisted death depicts a similar supportive role for nurses (Fujioka et al., 2018). Across international contexts, nurses provide the wrap-around care of supporting last wishes, organizing the procedure, and providing support for patients, families, and other health care providers (Beuthin et al., 2018; Dierckx de Casterle et al., 2010; van de Scheur & van der Arend, 1998). Similar to the experiences of nurses in this study, preparing for the MAiD death has been described as highly anxiety producing even in other contexts. For example, nurses from the Netherlands described their supportive role as demanding and nerve-wracking (Lewis, 2018; van de Scheur & van der Arend, 1998). Nurses from Belgium described their role as intense, acknowledging that even though their comfort level develops over time, euthanasia is not something they become used to (Bellens et al., 2020; Denier, Dierckx de Casterle, et al., 2010).

The complexity of time and timing is something that is evident across studies of nurses' experiences. Negotiating initial requests can be time consuming, but once the date and time for the MAiD death is set, nurses work against that deadline to ensure that patients feel cared for, informed, and that their last wishes are met. The time intensive nature of this preparation process contrasts with the swiftness of the

MAiD death. This unique time-flow of MAiD planning and death contrasts with what nurses typically experience with a patient's death. The timing of a natural death is highly unpredictable, and many nurses, even palliative nurses, suggest that they are often not present at the moment of death. Furthermore, this unpredictable dying trajectory is often characterized by a fading away in which nurses spend a great deal of time with patients when those patients are in an unconscious, or semi-conscious state prior to death. With MAiD, time and its flow changes from a focus on the process to choreography of a point in time. Good nursing practice in the context of this study involved going to extraordinary lengths to choreograph the best possible experience for patients and their family for the time that was left. Bender's (2018) proposition that the unique access point of nursing is to create conditions that make a difference for patients was evident along this trajectory of care.

When considering the implications of these study findings, it is important to acknowledge the limitations. This was an ethnically homogeneous sample with a small number of male participants. In future, it would be important to explore diverse perspectives in more detail. Furthermore, there are inherent limitations to telephone interviews in that one is unable to view the context or certain aspects of nonverbal communication. However, the telephone did allow us to access a sample from across Canada.

Conclusion

Canadian nurses described important best-practices to facilitate a humanistic, patient-centered death, and these learnings can be used for educating nurses about MAiD-related practice. Such education is critically important in light of the need nurses expressed in this study for further education and support. In addition, understanding what unifies nurses who are proponents of, and conscientious objectors to, MAiD is an important beginning point of conversations regarding caring well for patients and for nurses across diverse moral viewpoints. In light of the emotional impact of MAiD upon nurses, conducting conversations about the well-being of the nursing workforce, while caring for those considering or receiving MAiD, is vitally important. Only then can nurses truly engage in that *relation-sensing performance* intended to make health care a better place for patients and families.

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References

- Bellens, M., Debien, E., Claessens, F., Gastmans, C., & Dierckx de Casterle, B. (2020). "It is still intense and not unambiguous." Nurses' experiences in the euthanasia care process 15 years after legislation. *Journal of Clinical Nursing*, *29*, 492–502. <https://doi.org/10.1111/jocn.15110>
- Bender, M. (2018). Re-conceptualizing the nursing metaparadigm: Articulating the philosophical ontology of the nursing discipline that orients inquiry and practice. *Nursing Inquiry*, *25*(3), e12257. <https://doi.org/10.1111/nin.12243>
- Beuthin, R., Bruce, A., & Scaia, M. (2018). Medical assistance in dying (MAiD): Canadian nurses' experiences. *Nursing Forum*, *53*(4), 511–520. <https://doi.org/10.1111/nuf.12280>
- Bill C-14 Parliament of Canada. (2016). *An act to amend the criminal code and to make related amendments to other acts (medical assistance in dying)*. <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>
- Bruce, A., & Beuthin, R. (2019). Medically assisted dying in Canada: "Beautiful death" is transforming nurses' experiences of suffering. *Canadian Journal of Nursing Research*. Published online June 12. <https://doi.org/doi/10.1177/0844562119856234>
- Canadian Nurses' Association. (2015). *Canadian Nurses' Association welcomes Supreme Court of Canada ruling on medically assisted dying*. https://www.cna-aicc.ca/~media/cna/page-content/pdf-en/suggested-amendments-to-the-text-of-bill-c-14_an-act-to-amend-the-criminal-code-and-to-make-related-amendments-to-other-acts.pdf?la=en
- Dees, M. K., Vernooij-Dassen, M., Dekkers, W. J., Elwyn, G., Vissers, K. C., & van Weel, C. (2013). Perspectives of decision-making in requests for euthanasia: A qualitative research among patients, relatives and treating physicians in the Netherlands. *Palliative Medicine*, *27*(1), 27–37. <https://doi.org/10.1177/0269216312463259>
- Denier, Y., Dierckx de Casterle, B., De Bal, N., & Gastmans, C. (2009). Involvement of nurses in the euthanasia care process in Flanders (Belgium): An exploration of two perspectives. *Journal of Palliative Care*, *25*(4), 264–274.
- Denier, Y., Dierckx de Casterle, B., De Bal, N., & Gastmans, C. (2010). "It's intense, you know." Nurses' experiences in caring for patients requesting euthanasia. *Medicine, Health Care & Philosophy*, *13*(1), 41–48. <https://doi.org/10.1007/s11019-009-9203-1>
- Denier, Y., Gastmans, C., Del Bal, N., & Dierckx de Casterle, B. (2010). Communication in nursing care for patients requesting euthanasia: A qualitative study. *Journal of Clinical Nursing*, *19*(23–24), 3372–3380. <https://doi.org/10.1111/j.1365-2702.2010.03367>
- Dierckx de Casterle, B., Denier, Y., De Bal, N., & Gastmans, C. (2010). Nursing care for patients requesting euthanasia

- in general hospitals in Flanders, Belgium. *Journal of Advanced Nursing*, 66(11), 2410–2420. <https://doi.org/10.1111/j.1365-2648.2010.05401>
- Fujioka, J. K., Mirza, R. M., McDonald, P. L., & Klinger, C. (2018). Implementation of medical assistance in dying: A scoping review of health care providers' perspectives. *Journal of Pain and Symptom Management*, 55(6), 1564–1576. <https://doi.org/10.1016/j.jpainsymman.2018.02.011>
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine Publishing.
- Health Canada. (2019). *Fourth interim report on medical assistance in dying*. <https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019.html>
- Lamb, C., Babenko-Mould, Y., Evans, M., Wong, C. A., & Kirkwood, K. (2019). Conscientious objection and nurses: Results of an interpretive phenomenological study. *Nursing Ethics*, 26(5), 1337–1349. <https://doi.org/10.1111/jan.13869>
- Lewis, D. A. (2018). *What is the experience of assisted dying for Dutch healthcare staff working in a hospice or chronic disease care centre?* [Doctoral dissertation]. Lancaster University.
- Pesut, B., Thorne, S., Schiller, C., Greig, M., & Roussel, J. (2020). The rocks and hard places of MAiD: A qualitative study of nursing practice in the context of legislated assisted death. *BMC Nursing*, 19, Article 12. <https://bmcnurs.biomedcentral.com/articles/10.1186/s12912-020-0404-5>
- Pesut, B., Thorne, S., Stager, M. L., Schiller, C., Penney, C., Hoffman, C., . . . Roussel, J. (2019). Medical assistance in dying: A narrative review of Canadian nursing regulatory documents. *Policy, Politics & Nursing Practice*, 20(3), 113–130. <https://journals.sagepub.com/doi/full/10.1177/1527154419845407>
- Pesut, B., Thorne, S., Storch, J., Chambaere, K., Greig, M., & Burgess, M. (2020). *Riding an elephant. A qualitative study of nurses' moral journeys in the context of medical assistance in dying (Maid)* [Manuscript submitted for publication].
- Sheridan, L. (2017). *When patients ask to die: The role of nurses in Medical Assistance in Dying* [Doctoral dissertation]. University of Western Ontario.
- Thorne, S. (2015). Does nursing represent a unique angle of vision? If so, what is it? *Nursing Inquiry*, 22(4), 283–284. <https://doi.org/10.1111/nin.12128>
- Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice*. Routledge.
- van de Scheur, A., & van der Arend, A. (1998). The role of nurses in euthanasia: A Dutch study. *Nursing Ethics*, 5(6), 497–508. <https://doi.org/10.1177/096973309800500604>
- Wright, D. K., Chirchikova, M., Daniel, V., Bitzas, V., Elmore, J., & Fortin, M. L. (2017). Engaging with patients who desire death: Interpretation, presence, and constraint. *Canadian Oncology Nursing Journal*, 27(1), 56–64. <https://doi.org/10.5737/236880762715664>

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