

# Ethical, Policy, and Practice Implications of Nurses' Experiences With Assisted Death A Synthesis

**Barbara Pesut, PhD, RN; Sally Thorne, PhD, RN;  
Madeleine Greig, MSN, RN; Adam Fulton, BScN; Robert Janke, MLIS;  
Mathew Vis-Dunbar, MLIS**

The conceptualization of assisted death as an act performed by physicians has resulted in a lack of attention to nurses' roles and experiences with the processes that surround an assisted death. In this article, we synthesize evidence from 6 articles focusing on the experiences of 55 nurses from Canada, Belgium, and the Netherlands, with relevant ethical and policy implications derived from the literature. Nurses have a central role in negotiating inquiries about assisted death and in providing wraparound care for patients, families, and other health care providers. This role is impactful for nurses and requires significant personal and professional moral work. **Key words:** *assisted death, ethics, euthanasia, medical assistance in dying, nursing, policy, regulation, synthesis*

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**Author Affiliation:** University of British Columbia, Okanagan, Kelowna (Dr Pesut, Ms Greig, and Messrs Fulton, Janke, and Vis-Dunbar) and University of British Columbia, Vancouver (Dr Thorne), British Columbia, Canada.

*This work received funding from the Canadian Institutes of Health Research (201610PJT-376065). Dr Pesut is supported, in part, by the Canada Research Chairs Program.*

*The authors have disclosed that they have no significant relationships with, or financial interest in, any commercial companies pertaining to this article.*

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**Correspondence:** Barbara Pesut, PhD, RN, University of British Columbia, Okanagan, 1147 Research Rd, ARTS 3rd Floor, Kelowna, BC V1V 1V7, Canada (Barb.pesut@ubc.ca).

DOI: 10.1097/ANS.0000000000000276

*The most important predictor of how well a MAiD death will go is the presence of a nurse.*

**T**HE STATEMENT that begins this article was made by a physician at an international palliative conference while describing his experiences with Medical Assistance in Dying (MAiD) in the Canadian context. Yet, despite the importance of the nursing role and the number of jurisdictions internationally that allow, or are considering allowing, assisted death, relatively little empirical work has explored nurses' experiences in the context of assisted death. This may be because nursing involvement with assisted death is varied depending upon the jurisdictional context. For example, in Switzerland, assisted death is not provided within the health care system and in the United States assisted death can only occur through self-administration.

### **Statements of Significance**

#### **What is known or assumed to be true about this topic:**

Evidence surrounding assisted death has largely focused on physicians. Little empirical research has focused on the nursing role or nurses' experiences in the context of assisted death.

#### **What this article adds:**

In this article, we review evidence of nurses' experiences with assisted death and synthesize that evidence with relevant ethical and policy implications. This knowledge will contribute to high-quality support for nursing practice in the context of assisted death.

In these contexts, nurses may have little involvement with those seeking an assisted death. The paucity of evidence could further be explained by the stand taken by some advocacy bodies prohibiting nursing involvement in assisted death.<sup>1</sup> It is difficult to conduct research on a nursing topic in which nursing's involvement has been prohibited.

However, where assisted dying is legal, evidence has indicated that nurses experience common challenges. A recent scoping review of health care providers' perspectives on MAiD indicated that the 3 main challenges encountered by nurses included absence of clear professional and legal guidelines, role ambiguity, and lack of professional collaboration.<sup>2</sup> A similar review, this time focusing on nurses' moral experiences of assisted death, indicated that nurses experienced a profound sense of responsibility for patients, families, and other members of the health care team. Their moral experiences were shaped by factors such as time for in-depth conversations, quality of nurses' interactions with physicians, the frequency with which they have to deal with these requests, and the legality of the request. Moral experiences were further influenced by the degree of support nurses perceived as coming from within the professional team.<sup>3</sup>

These understandings of nurses' experiences can further be informed by research exploring a common question that nurses face in practice: "Can you help me to die?" Evidence has indicated that in jurisdictions where assisted death is *illegal*, 13% to 27% of nurses across practice contexts have received a request to hasten death.<sup>4,6</sup> A recent qualitative study of 11 oncology nurses' experiences of engaging with patients who desired a hastened death revealed the important role of nurses related to interpreting the request and practicing a therapeutic presence. However, their ability to do so was often constrained by lack of time and by the illegality of assisted death within the study context.<sup>7</sup> Whether an assisted death is sanctioned or not, the request for such a death is not uncommon for nurses working with patients at end of life.

In light of the important role that nurses have in assisted death, and with the recent legalization of MAiD in Canada, our research team conducted a systematic search of the policy, practice, and ethical implications of assisted death for nursing. In previous publications, we focused on synthesizing the ethical arguments for and against assisted death within a nursing context<sup>8</sup> and on synthesizing the policy documents created by Canadian nursing regulatory agencies to provide guidance about MAiD for nurses and nurse practitioners.<sup>9</sup> The synthesis of ethical arguments reviewed 43 articles that addressed a focused ethical question in relation to nursing and assisted death. These articles were arranged inductively into 4 themes: arguments from the nature of nursing; arguments from ethical principles, concepts, and theories; arguments for moral consistency; and arguments from the nature of the social good. The synthesis of Canadian regulatory guidelines reviewed 17 documents written to provide guidance for nurses and nurse practitioners as they engaged with MAiD in their practice. These documents varied substantially in the amount of content they provided as guidance for practice, suggesting that various provinces and territories weighted the significance of

the nursing role in MAiD differently. Specific safety concerns highlighted in these documents cautioned nurses to pay attention to the differences between counseling and informing patients and between administering and aiding in the MAiD process. The documents further cautioned nurses to know their role in ensuring safeguards were met, in obtaining informed consent, and in documenting their care. Guidance related to conscientious objection figured prominently across documents.

The purpose of this article is to synthesize data on nurses' experiences with relevant ethical and regulatory findings from these previous reviews. As the articles reviewed for this study were from Canada, Belgium, and the Netherlands, we first provide some relevant background to each of these contexts.

## ASSISTED DEATH IN GEOGRAPHICAL CONTEXT

### Canada

After many years of debate and court challenges, MAiD became legal in Canada in June 2016 through the passing of *Bill C-14*. In Canada, individuals are eligible for MAiD if they (a) are eligible for health services funded by a government in Canada; (b) are at least 18 years of age and capable of making decisions with respect to their health; (c) have a grievous and irremediable medical condition; (d) have made a voluntary request for MAiD that, in particular, was not made as a result of external pressure; and (e) give informed consent to receive MAiD after having been informed of the means that are available to relieve their suffering, including palliative care. Both clinician-administered death and self-administered death are allowable in Canada, although only 1 self-administered death out of a total of 1961 medically assisted deaths was recorded in Canada in 2017.<sup>10</sup>

Several factors have made the implementation of MAiD in Canada particularly complex. First, the language surrounding eligibility is vague and rests largely upon clinician interpretation.<sup>11</sup> This has the potential to lead to variability in practices across the country. Second, MAiD has been enacted through a leg-

islated process and, in particular, through the *Canadian Charter of Rights and Freedoms*. Legalization brings specific obligations on the part of health care providers and a degree of precision in how the process must unfold.<sup>12</sup> Those participating are legally bound by rules that guide their conduct in highly prescriptive ways. Third, Canada is the first country in the world to allow nurse practitioners to act as assessors and providers of MAiD. However, in many jurisdictions in Canada, employers have chosen to limit nurse practitioners' involvement, and less than 5% of the MAiD procedures in 2017 were performed by nurse practitioners.<sup>10</sup> Registered nurses who are not nurse practitioners also perform important roles in the MAiD process including (a) participating in assessment of competency and ability for self-administration; (b) providing information about MAiD; (c) coordinating the MAiD process; (d) preparing equipment and intravenous access; (e) coordinating and informing health care personnel; (f) documenting; (g) supporting patients and their significant others; and (h) providing postdeath care.<sup>9</sup> The Canadian context, therefore, is unique in the centrality of the role that is given to nurses in the assisted dying process.

### Belgium and the Netherlands

Euthanasia became legal in the Netherlands in 2001 and in Belgium in 2002. In the Netherlands, both euthanasia (ie, clinician-administered death) and physician-assisted suicide (ie, client-administered death) are permitted, whereas, in Belgium, only euthanasia is legal. The Belgian law stipulates that requests for euthanasia must be discussed by the nursing team that has regular contact with the patient. As such, it would be expected that nursing would play a role, at least, during the deliberation stage. An anonymous physician questionnaire administered in Belgium in 2017 revealed the extent of nursing involvement in this deliberation. Physicians discussed the euthanasia request with nurses in 100% of cases in nursing homes, in 58.6% of cases in hospital, and in 44.4% of cases at home. However, beyond discussing the suitability of the case, the extent

of nursing involvement in the act of euthanasia was surprising. Physicians indicated that nurses administered the lethal drugs in 43% of the cases in hospital and 13.5% in the cases at home (none in nursing homes).<sup>13</sup> As this was a follow-up to a previous survey exploring the same questions, the authors were able to conclude that since the enactment of the euthanasia law, physicians consulted more often with nurses and delegated the lethal administration of drugs to nurses less often.

The Euthanasia Act in the Netherlands contained no explicit role for nursing or reference to consultation with nursing. A questionnaire conducted with 1509 Dutch nurses between 2001 and 2003 indicated that just over half of the nurses surveyed did not think it was appropriate for physicians to consult with them about the euthanasia decision. The majority (62.9%) felt that nurses should not be preparing the medications, and just over half (54.1%) felt that nurses should not be establishing the intravenous access to deliver the medications.<sup>14</sup>

From the available evidence to date, we can see that assisted dying has substantial support from nurses across each of the 3 geographic contexts. A questionnaire survey of a random sample of 3321 nurses in Flanders, Belgium, indicated that 92% of nurses supported euthanasia for patients in uncontrollable pain and 57% supported euthanasia in this population without the patient providing an explicit request. Forty-three percent of nurses in this sample would be willing to administer the lethal drugs, but 53% believed the nursing role should be restricted to patient and family care. Nurses did, however, perform an important role in discerning a request for assisted death; 61% of nurses indicated that a patient is more likely to direct a euthanasia request to a nurse rather than a physician.<sup>15</sup> A survey conducted with a nonrandom sample of 1243 nurses in the Netherlands illustrated less robust support for assisted death. Forty-five percent of nurses agreed that patients should have access to euthanasia or physician-assisted death if they want; 64% disagreed that this option should only be available in the final weeks of life; and 77% agreed

that it should only be done with an explicit patient request.<sup>16</sup> Finally, two-thirds of a sample of 102 nurses in Canada indicated that they supported medically assisted death as an end-of-life option; however, a much smaller percentage saw it as a health care priority.<sup>17</sup>

In summary, where assisted death is legal, the nursing role seems considerably more substantial than what might be assumed from the amount of evidence published about nurses' experiences. Where it has been studied, assisted death is supported by a substantial proportion of nurses. Nurses are often the first to discern a request, and the medication that causes death may actually be administered by nurses—illegally by registered nurses in Belgium and legally by nurse practitioners in Canada. As such, our goal in this review was to better understand the policy, practice, and ethical implications of assisted death for nursing. In the remainder of this article, assisted death is the term used to describe both medical assistance in dying as it is known in Canada and euthanasia as it is known in the Netherlands and Belgium.

## **METHODS**

The search and retrieval process were informed by the method outlined by the Joanna Briggs Institute.<sup>18</sup> The analysis was informed by the critical reflective process of meta-synthesis.<sup>19</sup> Stage 1 of the search was conducted in MEDLINE and CINAHL using strategies developed through consulting team members and previously published reviews on this subject.<sup>20,21</sup> This stage 1 search was peer-reviewed (M.V.D.) using the PRESS checklist.<sup>22</sup> Terminology identified through the stage 1 search was then used to search 9 electronic databases (see Tables 1 and 2). Forward and backward citation searching, as well as consultation with experts, was used to identify additional sources. A total of 6715 articles were retrieved and loaded into EPPI-Reviewer where duplicates were identified and removed, leaving 3352 unique articles for review. Screening was conducted by 2 team members (M.G. and A.F.) after interrater

**Table 1.** Search Strategy

1. ((assist\$ or hasten\$ or prescribe\$ or aid or aided or aiding or directed) adj2 (death or dying or suicide)).tw. (4 597)
2. (dign* adj2 (death or dying)).tw. (845)
3. (suicide adj2 (rights or rational)).tw. (108)
4. ((choosing or choice) adj2 (death* or dying or suicide)).tw. (163)
5. euthanasia.tw. (9 684)
6. right to die.tw. (922)
7. end of life decision\$.tw. (1 872)
8. MAID.tw. (223)
9. life terminating.tw. (29)
10. ending the life.tw. (160)
11. lethal medication.tw. (23)
12. killing.tw. (51 612)
13. Suicide, Assisted/ (5 374)
14. Euthanasia/ or Euthanasia, Active/ or Euthanasia, Active, Voluntary/ (9 423)
15. Right to die/ (4 955)
16. nurs\$.tw. (402 340)
17. (midwife* or midwives).tw. (20 695)
18. ((physician or doctor) adj2 assistant*).tw. (2 787)
19. exp Nursing/ (245 723)
20. exp Nurses/ (82 289)
21. Nurse's Role/ (38 779)
22. exp Nursing Care/ (129 743)
23. exp Nursing Process/ (83 803)
24. exp Physician Assistants/ (5 204)
25. or/16-24 (588 847)
26. or/1-15 (74 742)
27. 25 and 26 (1 987)

screening reliability of “near perfect” using the kappa statistic was achieved.<sup>23</sup> To be included, articles had to address policy, practice, or ethical implications of assisted death for nursing. No date restrictions were set. Non-English language articles were excluded, as well as opinion pieces, news articles, legislative and lobbying summaries, and book reviews. Ethical articles that did not address a focused ethical question were also excluded (eg, commentaries, issue overviews). In addition, a focused gray literature search was conducted to identify policy documents from nursing regulatory bodies from all 10 provinces and 3 territories in Canada. The re-

**Table 2.** List of Electronic Databases Searched (August 31, 2017)

Database	Results
MEDLINE	1987
EMBASE	2352
Database of Abstracts of Review of Effects (DARE)	1
AgeLine	138
PsycINFO	438
Cumulative Index of Nursing and Allied Health (CINAHL)	1555
Social Services Abstracts	47
Sociological Abstracts	77
ProQuest Dissertations & Theses Global <sup>a</sup>	120
Total	6715

<sup>a</sup>Search conducted September 5, 2017.

sultant literature was then divided into articles that addressed nurses' experiences, articles that addressed a focused ethical question, and regulatory documents. A bibliography of the articles identified through this review is provided as Supplementary Material (available upon request). Literature was downloaded into NVivo for coding and analysis.

The purpose of this article is to synthesize data on nurses' experiences with relevant ethical<sup>8</sup> and regulatory<sup>9</sup> findings published previously. For the purposes of this article, studies of nurses' experiences were included if they were (1) qualitative, (2) conducted in a context where MAiD was legal, (3) published in a peer-reviewed journal, and (4) conducted in a country where nurses would have direct experience with the assisted death process. For example, studies from the United States were excluded because assisted death is only self-administered in that country and a health care provider does not need to be present at the time of death.

## FINDINGS

Six articles that focused on nurses' experiences with assisted dying met the inclusion criteria for this analysis (see Table 3).

**Table 3.** Studies That Met Inclusion Criteria Related to Nurses' Experiences

Country of Origin	Sample	Publication Focus	Thematic Structure
Canada <sup>24</sup>	N = 17 nurses working across care sites	Canadian nurses' experiences	Profession of nursing Personal impact Practice of nursing
The Netherlands <sup>25</sup>	N = 20 nurses from 1 hospital	The role of nurses	Observing a request Decision making Carrying out euthanasia Aftercare Nurses with conscientious objections
Belgium	N = 18 nurses from 9 hospitals	Nursing care of patients requesting euthanasia <sup>26</sup>	Seven stages: Period preceding the request; confrontation with the request; decision making; preceding the euthanasia moment; carrying out the euthanasia; immediate aftercare; later aftercare
		Involvement of nurses: 2 perspectives <sup>27</sup>	Procedural, action-focused perspective Existential interpretative perspective
		Communication <sup>28</sup>	Forms, attitudes, and purpose in the following: Patient and family context Interprofessional context
		Nurse's experiences <sup>29</sup>	Intense Development over time Supporting and aggravating factors

These 6 articles represented the experiences of 55 nurses from Canada,<sup>24</sup> Belgium,<sup>26-29</sup> and the Netherlands.<sup>25</sup> Despite the geographic differences in the countries from which these data were collected, there were common findings associated with nurses' roles and experiences. First, nurses performed a central role in discerning and negotiating initial patient inquiries about assisted death. Second, even in contexts where nurses were not providers of assisted death, they provided wraparound care for patients, families, and other health care providers. Third, participating in assisted death was impactful for nurses and required significant personal and professional moral work. Under each of these headings, we first discuss the primary qualitative findings from the 55 nurses and then synthesize those find-

ings with evidence from the ethical literature<sup>8</sup> and regulatory literature.<sup>9</sup>

**Nurses' central role in negotiating inquiries about assisted death**

Across studies, nurses performed an important role in recognizing and negotiating the inquiries around an assisted death. Once a potential request was recognized, nurses worked hard to discern the nature and reasonableness of the request.<sup>25,26</sup> Nurses were not surprised when patients broached the question with them; indeed, sometimes they anticipated it.<sup>26</sup> After identifying that this was a *possible* request for assisted death, nurses then tried to discern 3 critical things. "Is this truly a request for assisted death or is the

patient talking about something else?” The request for assisted death was not easy to discern, as the language could be veiled and the intent implicit.<sup>25</sup> After the nurse determined that this was truly an inquiry about assisted death, the nurse then asked, “Is there suffering that I can alleviate that would change this request?” Finally, the nurse would consider whether this decision was autonomous and uncoerced.<sup>25</sup> In essence, it was within the nursing role to determine whether this was a reasonable request for assisted death or whether it was a way to express some other unmet need that was within the nurses’ purview to solve. However, it is important to note that in the Dutch study in particular, there was evidence that nurses did not always interpret these requests correctly.<sup>25</sup>

Denier et al<sup>28</sup> provided an overview of nurses’ communication with patients requesting assisted death.<sup>28</sup> The negotiation of a request required superb communication skills and a willingness to engage in the question at hand. This communication took particular forms, required certain attitudes, and had explicit goals. Forms of communication included actively listening, providing information, translating medical information, consulting, and providing guidance. Important attitudes for nurses included openness, attentiveness, patience, and trustworthiness. The goals of communication around assisted death were not only to discern the intent of the request but also to advocate for the patient and to establish an atmosphere of peace in preparation for death. Transparency, tactfulness, and clarity were also important characteristics of communication around assisted death. Nurses acknowledged the importance of continuing conversations not related to the assisted death process as a way of sustaining the ongoing therapeutic relationship. Furthermore, open communication with both family and health care providers with respect to the goals of care was acknowledged as essential to properly navigating a request.<sup>28</sup>

The study from the Netherlands included data from nurses who were “conscientious objectors” in the sense of having formally

declared a desire not to participate in any form of assisted death. Holding a stance of conscientious objection could prove especially challenging for nurses as they considered these initial requests from patients. These nurses too worked hard to ensure that they had interpreted a request correctly. However, as conscientious objectors, they experienced the added challenge of not wanting to communicate their objecting views to the patient. They recognized that their personal views might not be understandable or relevant to patients, or could potentially be hurtful. However, they did find it difficult to know how to be honest and trustworthy within the ongoing nurse-patient relationship amidst these differing views.<sup>25</sup>

### *Ethical literature*

These data revealing nurses’ experiences in negotiating patient requests for assisted death illustrated their capacities to carefully balance the ethical principles of autonomy, beneficence, and nonmaleficence. In our synthesis of the ethical literature, autonomy was the principle used most frequently in defense of nursing’s participation in assisted death as an acceptable end-of-life option.<sup>8</sup> However, the limitations of autonomy generated significant debate in the literature. For example, some argued that patients may not be truly making an autonomous decision when confronted with a system that is unable to adequately address their suffering by providing accessible and high-quality palliative care.<sup>30,31</sup> In contrast, others argued that assisted death should not be seen as a failure of the health care system but rather should be seen as a central consideration of patient autonomy.<sup>32</sup> By being responsive to an assisted death request, and by engaging with it attentively, nurses were respecting the autonomy of the patient to make that request. However, the ways in which nurses paid particular attention to discerning whether this was a *reasonable request* illustrated that they did not view this decision from a perspective of unmitigated autonomy. Rather, nurses explored and attended to areas where suffering might be alleviated and thus there was clear attention

to beneficence. Furthermore, the nurses recognized that individuals exist within a constellation of relationships that influence their capacity to exercise that autonomy. Nurses therefore paid attention to that potential vulnerability as they sought to evaluate any potential coercion and thus diminish the risk of harm. Overall, the ways in which nurses negotiated these early requests illustrated that, at a practical level, nurses are conscious that an assisted death can indeed arise from a failure of health care, while holding in tension the conflicting idea that this may not necessarily be the case.

### **Regulatory literature**

The intense involvement of nurses in negotiating these early requests revealed important implications for the regulatory environment of nursing practice. Communication figured prominently in the Belgium study of nurses' experiences, perhaps because in Belgium physicians are required to consult with the nursing team.<sup>28</sup> However, it figured less prominently in the study of Canadian nurses' experiences.<sup>24</sup> This may be related to regulatory documents that cautioned nurses to refrain from anything that could be construed as encouraging an assisted death. In Canadian law, counseling to commit suicide remains a criminal offense and so regulatory documents created as guides for Canadian nurses reflected this caution. Indeed, in the language of one regulatory document, nurses were to use "extreme caution to ensure they do not recommend, incite, or encourage medical assistance in dying."<sup>33(p4)</sup> Furthermore, regulatory guidelines from some Canadian provinces stipulated that nurses must never introduce the topic of MAiD, while also emphasizing that clients have a constitutional right to accurate information. In effect, the regulatory landscape for nurses in Canada is such that it may be difficult for nurses to engage in these conversations effectively for fear that their intentions could be misconstrued. The effect that this has on how nurses do the ethical hard work of discerning and negotiating those difficult requests remains to be seen.

### **Nurses provide wraparound care**

With the exception of nurse practitioners in Canada, the provision of the lethal medication during an assisted death is outside of the scope of nursing (despite the evidence from Belgium that indicated that nurses are directly involved in administering the life-ending medication). However, the evidence of nurses' experiences with assisted death has indicated that nurses perform important roles in what can best be described as wraparound care. Once a decision for hastened death had been determined, nurses took responsibility for organizing the required care. Their overriding concern now turned to discerning what was most important to the patient during the time remaining and to paying meticulous attention to seeing those wishes fulfilled.<sup>25,26</sup> This required an intense focus on getting the details right, a process that nurses described as demanding and intense.<sup>24,25,29</sup> During the process of assisted death, nurses prepared equipment, fostered particular rituals, and monitored the situation to ensure that everything was going according to plan and that everyone felt supported. During aftercare, nurses stayed with families, answered questions, and debriefed with families and providers.<sup>24,25,27</sup> In the Canadian study, nurses focused on the importance of having excellent intravenous skills because the procedure could not go well without a patent intravenous access. Care was taken to ensure that expert clinicians in relation to this skill set were readily available prior to administration.<sup>24</sup>

This wraparound care provided by nurses during assisted death, which continued into the early bereavement period, extended to families and other health care providers with the goal of ensuring that "everything goes well and that every member of the team is okay with the situation."<sup>28(p3376)</sup> In analyzing how nurses approached their care in relation to an assisted death, Denier et al<sup>27</sup> described nurses as taking either a procedural focus or an existential focus. The procedurally focused nurse was action-oriented toward good organization and procedure. What became most

important was getting the organization and the procedure just right. In contrast, the existentially focused nurse worked toward educating and creating a communicational atmosphere in which the patient, family, and colleagues felt supported and in which the decision was perceived as right for all parties involved.<sup>27</sup>

### ***Ethical literature***

These data on nurses' wraparound care illustrated how the nature of nursing practice, and more specifically the moral nature of the nurse-patient relationship, influenced the nursing role. Much of the ethical debate in our review about nurses' involvement with assisted death referenced this unique relationship between nurses and patients that developed as a result of the intense and continuing nature of their interaction.<sup>8</sup> The ideal relationship between nurses and patients in this literature was characterized by caring, advocacy, mutual respect, faithfulness, and the ability to maintain the view that patients are—first and foremost—persons. Nurses were characterized as chief witnesses to the context and circumstances in which patients made their decisions and, more negatively, as chief witnesses to patient suffering at an intimate level. This special relationship between nurses and patients has been used in the ethical literature to argue both for and against assisted death.

Although relational ethics was referenced only once in the ethical literature we reviewed,<sup>34</sup> this lens may help deepen understanding of nurses' commitment to wraparound care. Relational ethics is built upon the assumption that good care can only be determined in the space between nurses and patients. This requires that nurses know patients well and connect to them as persons. This connection should be characterized by noncoercion, trust, openness, responsiveness, and appropriate boundaries. Furthermore, relational ethics takes into account how the environment affects the context of the nurse-patient relationship.<sup>35</sup> This relational ethics lens therefore provides insight

into why the nurses in this data set took their responsibility for person- and family-centered care so seriously and why that concern also extended to other team members. With the time-constrained urgency that an impending patient death implies, the pressing responsibility to discern and deliver what was most important to patients and families would help explain why nurses would experience this role as so demanding and intense.

### ***Regulatory literature***

If nurses do indeed take on significant responsibilities for the care of patients, families, and other health care providers during an assisted death, one would expect that to be reflected in the regulatory documents aimed at providing guidance for nurses. Our review of regulatory documents illustrated wide variability in this regard.<sup>9</sup> This can be seen at first in the amount of guidance provided to nurses. Documents we located ranged in length from 3 to 15 pages, suggesting that each province and territory weighted the significance of the nursing role quite differently. For example, one document emphasized that the contributions of interdisciplinary team members (ie, nurses) cannot be overstated<sup>36</sup> whereas another document described nursing as having a limited role.<sup>37</sup> This variability may potentially provide further insight into whether assisted death is viewed in such procedural documents as a *procedure* in which nurses have little direct responsibility or as a *process* in which nurses play a key role in all aspects *except* the delivery of the medication. Although for regulatory purposes it may be expedient to minimize the nursing role, evidence of nurses' experiences has indicated the latter to be a more accurate representation of what actually occurs in practice.

### **The moral work of negotiating nurses' personal and professional lives**

A key finding across these studies is that nurses sought to provide professional holistic care without judgment, irrespective of their moral stance toward assisted death.<sup>24</sup> They

honored patient choices in pursuit of a good death. As experienced nurses, many of these participants had witnessed the unmitigated suffering of patients and could not help but contrast an assisted death with those previous experiences.<sup>24,29</sup> Their moral work was informed by this contrast between suffering and a peaceful assisted death. However, the experience of witnessing an assisted death was impactful on nurses, largely because the death was different and surreal in its rapid nature. Nurses described how patients would be chatting with them one minute and dead the next, a stark contrast to past experiences with prolonged death trajectories.<sup>25</sup> Nurses described the moment of death as being charged by an array of emotions including feelings of being overwhelmed, uplifted, sad, and genuine.<sup>24,27</sup> Over time, nurses adjusted into their role both in terms of knowing how to better organize care and in terms of being able to reflect on how their involvement impacted their own beliefs and identities.<sup>27</sup>

The studies conducted in Canada and the Netherlands provided important insights into how nurses' beliefs about assisted death impacted their experiences. Those who identified as conscientious objectors in the Netherlands suggested that their beliefs made it difficult to fully support clients in care. Furthermore, they were reluctant to speak openly about their points of view even when they perceived that there was a mutual respect for differences in their work context.<sup>25</sup> The study conducted in Canada characterized nurses' comfort with assisted dying on 3 levels: strongly opposed, in-between, and strongly supported. The majority of nurses in this Canadian study located themselves in the in-between category. Many of those nurses who strongly supported assisted death explained their position as a result of the positive impact of having witnessed an assisted death. Significant moral work had to be done by those who identified as opposed or in-between, as they then bore the responsibility for determining the level of involvement they were willing to have. Those strongly opposed had concerns about being judged by their colleagues as lack-

ing compassion. What is important to note is that this study was conducted shortly after the legalization of assisted death in Canada; thus, some of these nurses may have perceived themselves as pioneers in a historic role.<sup>24</sup>

### ***Ethical literature***

From an ethical perspective, what is most interesting in this literature is that, with the exception of the Canadian study, little moral tension is explicit in the data of nurses' experiences. Nurses did not speak specifically of how they grappled with the moral tensions around assisted death. Instead, there were shades of moral tension such as that contained in the following quote:

I don't have difficulties with it, or feelings of guilt or something. But it is always so crazy: to see somebody lying there, to whom you brought a cup of tea that morning. And you know that everybody who gets a heart attack can die as well, but this was no heart attack. You know that, of course. So somebody has been killed, just like that ... that makes it different.<sup>25(p503)</sup>

This quote illustrates how a nurse who had no conscious feelings of guilt or difficulty characterized the procedure as "killing," which suggests something quite different. One cannot help but wonder whether illustrations such as this reveal a more widespread moral tension that has significant implications for nurses' moral personhood.

The impact that assisted death could have on nurses was a significant theme within our review of the published work on the ethical implications of assisted death for nursing.<sup>8</sup> This impact argument theorized about what it meant to be both a person and a professional when the requirements of these identities came into moral conflict. For example, in support of assisted death, Young<sup>38</sup> suggested that nurses do need to perform the difficult work of examining competing demands but that professional integrity must support client self-determination. In other words, when nurses take on the professional mantle, client autonomy trumps. In comparison, McCabe<sup>39</sup> argued that nurses never assume a perspective of unmitigated autonomy; rather, they

weigh what they know to be good outcomes for patients alongside patient expressed wishes. However, debunking the unmitigated autonomy perspective does not necessarily address how nurses reconcile their personal values and professional obligations when these two are in conflict. Zimbelman,<sup>40</sup> in arguing against assisted death, suggested that the debate is not really about nurses' or patients' individual convictions but rather about social good. Nurses gain their status through nursing's social recognition and prestige; therefore, nurses have an obligation to view the rightness or wrongness of actions through a lens of social good. Despite these differences, there was common agreement that failing to support nurses' moral reflections and subsequent convictions is certain to lead to moral harm.

### ***Regulatory literature***

In light of this potential for moral harm, the Canadian legislation enshrines the right of health care providers to conscientiously object to participation in an assisted death. Likewise, every regulatory document in Canada written for nurses emphasizes the right of nurses to be conscientious objectors to assisted death. In these documents, nurses are encouraged to reflect carefully upon their own values and beliefs in relation to assisted death. Subsequent to this deliberation, nurses are required to inform their employers if they are conscientious objectors, preferably prior to the start of their employment.<sup>9</sup> On paper, this seems to be a reasonable approach. Nurses discern their status and then inform their employers so that the pragmatics of care can be facilitated. However, this clear distinction in which nurses can describe themselves as a conscientious objector or not was not indicative of the experiences of nurses in the Canadian study reviewed here.<sup>24</sup> Many cannot confidently declare their position and those who can may fear judgment.<sup>25</sup> Furthermore, nurses tend to grow into their self-insight over time on the basis of ongoing learning and reflection.<sup>27</sup> As such, finding a comfortable moral space in the context of assisted

death seems considerably more complex than the Canadian regulatory documents would suggest.

### **DISCUSSION**

Findings from this synthesis indicate that nurses' experiences of assisted dying have important implications for nursing practice and education. However, these implications must be viewed within the limitations of this synthesis. The studies of nurses' experiences represented 55 nurses from 3 different jurisdictions, each with different approaches to assisted dying. The regulatory review drew only upon guidelines developed by regulatory associations from Canada's 10 provinces and 3 territories. The ethical review, albeit comprehensive, focused primarily on providing an overview of the ethical literature on whether nursing itself should be involved in assisted dying, although the arguments also foreshadowed the moral ambiguities nurses would confront.

The moral work and ambiguities reflected in this data set suggest that nurses do need to be well prepared for the different nature of an assisted death, something nurses have described as existentially surreal and highly impactful. This is particularly important in light of the anticipated increase in the acceptance of assisted death in Western jurisdictions.<sup>41</sup> The debate about legalizing assisted death is becoming more frequent across jurisdictions. Google mapping has indicated that more people are searching terms related to assisted death than palliative care.<sup>42</sup> Furthermore, there are data to suggest that, culturally, we are thinking about death in new ways. Data collected from jurisdictions where assisted death is legal have indicated that most individuals seek assisted death for existential reasons rather than due to suffering of an entirely physical nature.<sup>43</sup> The move toward assisted death for existential reasons is likely manifesting broad-scale cultural ideas about a good death and a good life. Sudden death has become the new ideal.<sup>43</sup> These kinds of broad cultural changes were reflected in a

recent discourse analysis of the *Carter* decision from the Supreme Court of Canada that led to the legalization of assisted dying in Canada. Beaman and Steele<sup>44</sup> revealed important distinctions between how religious and nonreligious interveners understood concepts such as suffering, pain, illness, and assisted dying. If current trends continue to shift toward different understandings of a good death, we can anticipate that increasingly nurses will need to be prepared for this new type of death.

We would suggest that this preparation of nurses is essential regardless of whether they are viewed to be playing a central role in assisted dying or not. The popular nomenclature of "physician-assisted death," and the overly narrow focus on assisted death as an act of medication administration, has too often obscured the centrality of the nursing role. The unique role of nursing within our health care systems means that they will inevitably be intimately involved. Thorne<sup>45</sup> referred to this unique role in health care as the "nursing gaze," or the collective shared voice that has earned nursing its fundamental trust with the public. This gaze is characterized by respect for human dignity, a service orientation, a responsibility for seamless and coordinated care, and, perhaps most importantly, a holistic approach that recognizes that at any point in time circumstances arise that are of utmost concern to patients and hence become the focal point of nursing.<sup>45</sup> This nursing gaze was robustly evident in the data reviewed here when nurses weighed requests for assisted death through a lens of human dignity; took responsibility for coordinating the process that included caring for patients, families, and colleagues; and committed themselves to intensely focusing on what was most important to that patient in the time left. This collective voice of nursing means that the process surrounding assisted death will be a central nursing concern, regardless of how the nurse feels about the act itself.

The preparation of nurses for assisted death should attend to 2 main areas of concern: moral work around assisted death and com-

munication in the context of assisted death. Evidence to date has indicated that the majority of nurses may not be adamantly opposed to, or in support of, assisted dying.<sup>15-17</sup> Rather, nurses are somewhere in between, in process, and in a state that might be better characterized by moral ambiguity.<sup>24</sup> Koenig suggested that, in light of the gravity of the act itself, we would be concerned if this moral ambiguity was not present.<sup>42</sup> However, this ambiguity is not well recognized in current policy approaches, whereby nurses are required to declare themselves as conscientious objectors or not, preferably prior to their employment. This "all or nothing" approach seems a clear departure from the complex moral journey described by nurses in this evidence to date. (However, it is important to acknowledge that many health care policy documents allow nurses to engage at varying levels.) Wasylenko<sup>46</sup> recommended that we equip clinicians and trainees with ways to develop their moral foundations in relation to this new approach to death. In addition, there is preliminary evidence to suggest that written ethics policies developed by health care agencies may help health care providers feel more supported during an assisted death; however, their impact on practice and ethical reflection is less clear.<sup>47</sup>

Specific ways in which nurses might go about developing these moral foundations include examining their moral intuitions, their decision in the context of relational ethics, and their moral coherence across end-of-life decisions.<sup>48</sup> This idea of examining moral coherence may be particularly impactful. Because of its contentious nature, assisted dying is often researched and discussed apart from other end-of-life options such as palliative sedation and voluntarily stopping eating and drinking.<sup>42</sup> Helping nurses to develop their moral reasoning by considering the relationship of assisted death to other end-of-life options may enable them to draw upon previously developed moral frameworks. Furthermore, providing nurses with the freedom to engage this moral journey may help prevent the latent moral distress evident in the data reviewed here, whereby a nurse

would confess to experiencing no moral difficulty while claiming to have “killed” someone.

Finally, the importance of nurses’ communication with patients in the context of assisted death cannot be overemphasized. In the data reviewed here, nurses played a central role in the communicative process, particularly in determining the nature and intent of the initial request. Evidence to date about the role of communication in assisted death has been compelling. For example, Norwood conducted an ethnographic study of assisted death in the Netherlands and found that the communicative process itself, and its unfolding over time, helped develop and maintain social bonds.<sup>42</sup> Once a request had been made, health care providers had permission to talk of things that they might not have otherwise introduced. Families became more involved in the process. These conversations, at times, averted the assisted death process, suggesting that something in the communicative process may have met a need that was leading to the assisted death request. The quality of communication also influences how healthcare providers experience an assisted death.<sup>42</sup> Reagan has proposed that communication that occurs over time is the most significant factor in why physicians experience an assisted death as so different from a death by suicide.<sup>42</sup> This suggests that nurses’ communicative actions can influence patients, families, and themselves during the process of assisted death.

In recognition of the importance of communication in the assisted death process, Wasylenko<sup>46</sup> recommended that formal assessment needs to be done by an expert and that all staff members should be prepared with sample scripts. These sample scripts enable nurses to feel more prepared and to think through the effectiveness of their responses. A document produced by the Royal College of Nursing in the United Kingdom is a good example of this type of communicative guide.<sup>49</sup> But communication cannot be simply prescriptive. Nurses can also prepare themselves by reflecting on the substantive is-

ssues that are coming to the fore in a request of this nature. In their philosophic analysis of qualitative studies of the wish to hasten death, Rodriguez-Prat and van Leeuwen<sup>50</sup> identified 4 moral themes inherent in these requests: dignity, autonomy, and authenticity; social interactions; the value of life; and the medicalization of care. As nurses reflect on these themes and how they influence a request to hasten death, they will be better prepared to engage authentically with patients across the spectrum of these evolving contexts.

Beyond engaging with those conversations about assisted death that patients introduce, nurses may need to explore their readiness to introduce assisted death as a care option. There is considerable debate within Canada about whether there is an obligation to discuss assisted death as an option, even if patients do not introduce the topic. To some extent, this discussion has arisen as a result of the recognition that not all members of society are equitably capable of finding a way to raise a topic such as this to a health care professional and that equitable access to care may require that opportunities be made more overt. Limited evidence from the United States has indicated that this practice does occur in that context.<sup>42</sup> Depending upon which way the debate goes in any given jurisdiction, it is not unrealistic to expect that this could become an important communicative concern of nurses in the near future. However, despite the essential role of communication, little is yet known about how health care providers communicate around assisted death or how they ought to engage in such communication.<sup>42</sup> There is an urgent need for research in this area.

## CONCLUSION

Data obtained from our systematic review of the policy, practice, and ethical implications of assisted death indicated the centrality of the role of nurses in the process of assisted death, even if they bear no responsibility for the act itself. Nurses take their responsibilities in this process seriously, and the experience

itself is deeply impactful. Agencies responsible for educating, preparing, and supporting nursing practice can acknowledge this important contribution by seeking ways to develop nursing-specific expertise in assisted dying. It seems critical to recognize that this needs to go beyond those nurses who have agreed to participate in assisted dying. All nurses

who care for those nearing end of life will find themselves communicating with a patient requesting a wish to die and will therefore need to do the necessary moral reflection about an increasing array of end-of-life options that have arisen as a result of the wider social context of changing ideas about a good death.

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