



## ORIGINAL ARTICLE

# Riding an elephant: A qualitative study of nurses' moral journeys in the context of Medical Assistance in Dying (MAiD)

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## Abstract

**Aims and objectives:** To describes nurses' moral experiences with Medical Assistance in Dying in the Canadian context.

**Background:** Nurses perform important roles in Medical Assistance in Dying in Canada and do so within a unique context in which Medical Assistance in Dying is provided through healthcare services and where accessibility is an important principle. International literature indicates that participating in Medical Assistance in Dying can be deeply impactful for nurses and requires a high degree of moral sense-making.

**Design:** A qualitative interview study guided by Interpretive Description using the COREQ checklist.

**Results:** Fifty-nine nurses from across Canada participated in the study. The decision to participate in Medical Assistance in Dying was influenced by family and community, professional experience and nurses' proximity to the act of Medical Assistance in Dying. Nurses described a range of deep and sometimes conflicting emotional reactions provoked by Medical Assistance in Dying. Nurses used a number of moral waypoints to make sense of their decision including patient choice, control and certainty; an understanding that it was not about the nurse; a commitment to staying with patients through suffering; consideration of moral consistency; issues related to the afterlife; and the peace and gratitude demonstrated by patients and families.

**Discussion:** The depth of nurses' intuitional moral responses and their need to make sense of these responses are consistent with Haidt's theory of moral experience in which individuals use reasoning primarily to explain their moral intuition and in which moral change occurs primarily through compassionate social interaction. Further, work on the moral identity of nursing provides robust explanation of how nurses' moral decisions are contextually and relationally mediated and how they seek to guard patient vulnerability, even at their own emotional cost.

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**Conclusion:** Medical Assistance in Dying is impactful for nurses, and for some, it requires intensive and ongoing moral sense-making.

**Relevance to clinical practice:** There is a need to provide support for nurses' moral deliberation and emotional well-being in the context of Medical Assistance in Dying care.

#### KEYWORDS

Canada, ethics, euthanasia, Interpretive Description, Medical Assistance in Dying (MAiD), moral, nursing, physician-assisted death, qualitative

## 1 | INTRODUCTION

Haidt (2012) has suggested that moral experience can be like riding an elephant. We experience moral intuitions as powerful as an elephant, and then, we try to control those responses through our moral reasoning. Few experiences provoke as much moral response in nurses as Medical Assistance in Dying (MAiD). MAiD was rendered legal in Canada in 2015. Subsequently, in June 2016, the Canadian government passed a legislative framework, known as *Bill C-14*, that laid out specific obligations and rights, eligibility requirements and safeguards (see Table 1). In doing so, Canada followed the lead of those few other countries, such as Belgium and the Netherlands, where euthanasia has been legal for many years. However, the Canadian context is unique in several ways. First, nurse practitioners, who are registered nurses with additional credentials that allow them to diagnose and prescribe, can act as MAiD assessors and providers, independent of physician oversight. Once a patient requests MAiD, two independent assessments are conducted by a nurse practitioner and/or physician to determine eligibility. If the patient is deemed to have met the criteria for an assisted death, the death is administered by a nurse practitioner and/or physician after a waiting period that is normally at least 10 days. Both clinician-administered (euthanasia) and patient-administered (physician-assisted death) are legal in Canada.

Second, because the provinces and territories of Canada are responsible for healthcare, as a national framework *Bill C-14* had to be contextualised for each unique jurisdiction. Third, as the provinces and territories are guided by the Canada Health Act (2018) in which a key guiding principle is accessibility, there has been a concerted effort to make MAiD accessible across healthcare services (Silvius, Memon, & Arain, 2019).

This unique Canadian context has practical implications for nursing. Guidelines and policies to support nurses vary in direction and specificity across provinces and territories (Pesut, Thorne, Stager, et al., 2019). Because MAiD is implemented through currently existing healthcare services, nurses encounter it in many practice contexts (e.g., medical units, palliative care, home care). *Bill C-14* supports the right of nurses to conscientiously object to participation in MAiD. However, there is a tension between nurses' right to conscientiously object and patients' rights to MAiD access (Banner, Schiller, & Freeman, 2019).

### What does this paper contribute to the wider global community?

- This paper provides a nuanced description of the morally relevant factors that influence nurses' decision to participate in MAiD, nurses' emotional experiences with MAiD, and the moral reasoning nurses use to make sense of their participation, or nonparticipation.
- These findings will assist other countries to better prepare and support nurses in contexts where MAiD is legal or anticipated to become legal in the near future.

In light of this unique Canadian landscape, and the central role of nursing in MAiD, our programme of research has sought to explore the policy, practice and ethical implications of MAiD for nursing. The purpose of this paper is to report on findings related to nurses' moral experiences in the context of MAiD from a qualitative interview study. This paper complements two other papers from the same set of interviews with 59 nurses in which we reported nurses' views on best practices and their experiences with health system issues (Pesut, Thorne, Schiller, Greig, & Roussel, 2020; Pesut et al., 2020).

## 2 | BACKGROUND

Several literature reviews have explored the implications of MAiD for nursing. A meta-synthesis of nurses' moral experiences with assisted death, conducted prior to the legalisation of MAiD, highlighted the sense of responsibility taken by nurses in an assisted death; the tensions nurses experienced when trying to alleviate suffering; the time-intensive role that nurses performed in negotiating inquiries around an assisted death; and the various ways in which nurses reconciled personal beliefs and professional obligations (Elmore, Wright, & Paradis, 2018). Another review of Canadian, Dutch and Belgian nurses' experiences with assisted death indicated that although nurses provided wrap-around care for patients and families considering this process, the assisted death itself was deeply impactful and produced an array of conflicting emotions (Pesut, Thorne, Greig, et al., 2019). Of particular interest in this review were

**TABLE 1** Legislative framework for MAiD in Canada (Bill C-14, 2016)

Eligibility requirements	Eligible for health services funded by a government in Canada 18 years of age and capable of making decisions with respect to their health Have a grievous and irremediable medical condition Have made a voluntary request that was not made as a result of external pressure Give informed consent after having been informed of the means available to relieve their suffering, including palliative care
Definition of grievous and irremediable medical condition	They have a serious and incurable illness, disease or disability They are in an advanced state of irreversible decline in capability That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining
Safeguards	Ensure that the persons' request for medical assistance in dying was (i) made in writing and signed and dated by the person or another person and (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition Be satisfied that the request was signed and dated by the person before two independent witnesses who then also signed and dated the request Ensure that the person has been informed that they may, at any time and in any manner, withdraw their request Ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all the criteria; Be satisfied that they and the other medical practitioner are independent Ensure that there are at least 10 clear days between the day on which the request was signed and the day on which the medical assistance is provided (this may be shortened if the persons death or loss of capacity to give consent is imminent) Immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent If the person has difficulty communicating take all necessary measures to provide a reliable means of communication

findings that moral sense-making in Canadian nurses was a dynamic process characterised by uncertainty and reflection (Beuthin, Bruce, & Scaia, 2018). Other reviews have focused more generally on the experiences of all healthcare providers but revealed similar findings of the emotional impact of MAiD (Fujioka, Mirza, McDonald, & Klinger, 2018) and the need for support and education for nursing, particularly in the ethical aspects of care and in conducting conversations around hastened death (Suva, Penney, & McPherson, 2019).

Recent qualitative studies have provided further evidence of nurses' experiences. A study of 26 Belgian nurses' experiences with euthanasia (Bellens, Debien, Claessens, Gastmans, & Dierckx de Casterle, 2019) revealed findings similar to an earlier study in the Belgian context (Denier, Dierckx de Casterle, De Bal, & Gastmans, 2010). Nurses experienced the euthanasia death as emotionally impactful. They took great responsibility in the provision of the best possible care and experienced this care as intensely rewarding if they were able to gain patients' confidence and fulfil their wishes. Difficulties were a result of ambiguous patient requests, poor teamwork, lack of time and the fact that nurses' supportive needs were often overlooked. The need for support for nurses, and particularly bereavement support, was also found in a recent Canadian study (Sheridan, 2017). Sheridan's study of nine palliative care nurses' experiences with MAiD indicated that support was required, in part, because some nurses were experiencing moral uncertainty. Another recent study in the Dutch context illustrated the importance of the assessment process to nurses' moral sense-making (Lewis, 2018). When these assessments were conducted with due care, and nurses were informed, they were more comfortable

with the assisted death process. In relation to this moral sense-making, study authors reported that nurse participants were reluctant to speak of their opinions in relation to assisted death, though they described the process as "*strange*" and "*never normal*" (Lewis, 2018). An earlier study of Dutch nurses' experiences revealed similar findings of nurses' reluctance to share their opinions about assisted death out of a respect for one another (van de Scheur & van der Arend, 1998). Finally, a recent study illustrated some of the challenges experienced by conscientiously objecting nurses in the Canadian context (Lamb, Babenko-Mould, Evans, Wong, & Kirkwood, 2019). Nurses found it difficult to take a stand against assisted death. When doing so, they felt alone, uncertain and stigmatised. Such findings of nurses' experiences have inherently moral underpinnings. However, no papers to date have focused on understanding the moral journeys of nurses involved, or choosing not to be involved, with MAiD in Canada.

### 3 | METHODS

#### 3.1 | Design

This was a qualitative study using Interpretive Description, a pragmatic approach to qualitative research designed for applied disciplines (Thorne, 2016). The Consolidated Criteria for Reporting Qualitative Research were used to report the data (Tong, Sainsbury, & Craig, 2007; Appendix S1). Purposive and snowball sampling were used to recruit participants through health regions, the Canadian Nurses' Association, and the Canadian Association

**TABLE 2** Demographics of study participants

Characteristic	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%) Other: <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%) LTC: <i>n</i> = 5 (9%) Hospice: <i>n</i> = 4 (7%) Clinic: <i>n</i> = 3 (5%) Other: <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%)
Estimate of the number of conversations that participants ( <i>n</i> ) have had with patients about MAiD	0–4: <i>n</i> = 5 (8%) 5–9: <i>n</i> = 6 (10%) 10–14: <i>n</i> = 8 (14%) 15–19: <i>n</i> = 4 (7%) 20–24: <i>n</i> = 5 (8%) >25: <i>n</i> = 24 (41%) N/A: <i>n</i> = 4 (7%) Unknown/Missing: <i>n</i> = 3 (5%)
Estimate of the number of patients in participants' ( <i>n</i> ) care who have requested MAiD	0–4: <i>n</i> = 13 (22%) 5–9: <i>n</i> = 12 (20%) 10–14: <i>n</i> = 7 (12%) 15–19: <i>n</i> = 4 (7%) 20–24: <i>n</i> = 4 (7%) >25: <i>n</i> = 11 (18%) N/A: <i>n</i> = 4 (7%) Unknown/Missing: <i>n</i> = 4 (7%)
Estimate of the number of patients in participants' ( <i>n</i> ) care who have received MAiD	0–4: <i>n</i> = 21 (36%) 5–9: <i>n</i> = 12 (20%) 10–14: <i>n</i> = 7 (12%) 15–19: <i>n</i> = 4 (7%) 20–24: <i>n</i> = 0 (0%) >25: <i>n</i> = 11 (18%) N/A: <i>n</i> = 4 (7%) Unknown/Missing: <i>n</i> = 0 (0%)

of MAiD Assessors and Providers. To be eligible to participate, nurses had to be registered nurses or nurse practitioners who had some experience with participating, or choosing not to participate, in MAiD. Interested participants contacted the research coordinator who then conducted a telephone or email conversation to explain the study and answer questions. After this conversation, a consent form was mailed. The interview was conducted after this signed consent was received, and participants had an opportunity to ask additional questions. Ethical approval was obtained through the Behavioural Research Ethics Board of the University of British Columbia.

### 3.2 | Data collection

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 was piloted and revised prior to data collection. Interviews averaged 51 min in length with a range of 23–88 min. Interviews were digitally recorded, transcribed verbatim and downloaded into qualitative software NVIVO for analysis. Field notes were written after each interview. Demographic data were collected for each participant (see Table 2). These participants had significant experience with MAiD.

### 3.3 | Analysis

Open codes were developed inductively by two research team members (BP and MG) after immersion in the first 6 interview transcripts. Codes were further refined by two additional investigators (ST and JR) as data collection continued. Data were analysed using constant comparative analysis (Glaser & Strauss, 1967). Integrity of the analysis was supported through field notes, reflective memos, investigator triangulation and an audit trail. Transcripts were not returned for participant comments; instead, participants were invited to provide feedback after a webinar of the findings. Data collection was completed once the investigators had a coherent account of the nurses' experiences and questions that arose during the analysis had been answered.

## 4 | FINDINGS

The following findings represent a variety of perspectives including those of registered nurses and nurse practitioners, those who have chosen to participate in MAiD and those who have not. To facilitate a more nuanced understanding of these diverse findings, where relevant, we identify participant characteristics (e.g., assessor/provider; conscientious objector). Further, to protect the anonymity of the small number of male participants, we will refer to all participants as female. Understanding nurses' moral journeys entailed understanding why nurses became involved, or chose not to be involved,

in MAiD, how they experienced MAiD, and how they made sense of those experiences (see Table 3).

#### 4.1 | Willingness to participate in MAiD: Morally relevant factors

As part of the interview process, we asked nurses to reflect on what influenced their initial decision to participate, or not, in MAiD. This decision was shaped by family and community influences, professional experience and their proximity to the act of MAiD.

##### 4.1.1 | Family and community influences

Family support was essential for nurses to consider when deciding whether or not to participate in MAiD. Participants considered partners, parents, grandparents and their children. For example, one participant who was currently acting as an assessor reflected on what her children might think about her should she decide to become a MAiD provider. *"If I came home at the end of the day and my family asked 'how was your day Mom?', would I feel comfortable saying, 'yeah, I killed someone today?'"* (P46).

Beyond family supportiveness, nurses described how their family of origin influenced their decision to participate. They described coming from families where the rights of women, the right to an abortion and the right to die were important social values. Other nurses described coming from religious families where sanctity of life was deeply inscribed. However, coming from these religious families did not always predict how their family members would respond if they found themselves in a position of needing MAiD. For example, one participant recounted the surprise she felt when she discussed her desire to become a MAiD assessor with her husband. *Interestingly, he's Catholic and he said to me, "What do you mean, you're not participating in this? If I were in that circumstance, I would want someone like you to help me with this"* (P1).

For nurses living in smaller communities, considerations of what family might think about them extended to community members. These nurses were acutely aware that their status as a nurse who assisted with MAiD might influence their reputation in the community, and hence, their personal and healthcare relationships. Some wondered whether the knowledge that they had killed somebody's mother (P17) might compromise trust in their professionalism. One nurse in a rural community suggested, *"In a small town it's scary. A lot of the family (of MAiD patients) live right in the community. So, I see them when I go grocery shopping and out for supper with my family. And you always wonder, what are they thinking?"* (P52). Overall, nurses' decision to participate was not made in isolation but with full view of the influence of, and impact on, their family and community networks.

**TABLE 3** Study themes

Willingness to participate in MAiD: Morally relevant factors	Family and community influences Professional experiences Proximity to the act of MAiD
Experiences of MAiD	Emotional experiences Attributions
Moral waypoints	Patient choice, control and certainty It's not about me Nurses' role in alleviating suffering Moral consistency Reflections on the afterlife Peace and gratitude

##### 4.1.2 | Professional experiences

The professional experiences that impacted nurses' decision to participate in MAiD included influential colleagues, clinical experiences with suffering, and commitments to personal and professional values. Colleagues were a source of moral influence when deciding whether to participate in MAiD. As this nurse practitioner, who acted as an assessor, suggested, it was her colleagues that finally helped her to make the tough decision:

I've spoken to a number of clinicians who are much more experienced at this than I am and said to them, 'You know, I didn't go into health care to end people's lives.' And so, a couple of the leaders, who I have great respect for, said to me, 'And nor did we, but, you know...'

(P02)

Clinical experiences of watching patients suffer were a significant factor in the decision to participate in MAiD. Nurses spoke to the iatrogenic suffering inflicted upon patients in high-acuity areas and how viewing that suffering impacted their own lives. *"I remember riding my bicycle home one day crying the entire time because I felt that we were torturing this patient"* (P13). Other nurses spoke of the moral distress they experienced when they were unable to alleviate suffering. *He [the patient] said to me, "Dying isn't supposed to hurt like this. I am in pain. Can't you give me anything?" And it broke my heart because it was a very regimented regime of narcotics that I was allowed to give him [voice breaking]"* (P58). MAiD provided a definitive way to end this suffering, and hence, provided relief for nurses who had to witness that suffering. *"Seeing them transition from a state of desperation and exhaustion to a state of relief and knowing that we're actually able to do something for these individuals was not just empowering, but it actually felt like we were doing something"* (P8).

Nurses further talked about their commitments to professional values. Those who were palliative care nurses spoke of the palliative philosophy of neither hastening nor postponing death. Older nurses spoke to the commitments that had guided their dedication to nursing and to healthcare. The socialisation that older nurses had experienced to be good employees and team players made it difficult to say no when there were not enough providers to make MAiD accessible. As one participant described it, she was socialised as a nurse to be obedient, respectful and to put her workplace first. When her manager asked her to participate in one of the first MAiD cases she said, *I didn't want to disappoint her. I'm going to really rise to the occasion and not disappoint* (P37). However, after assisting with a number of patients she had taken a step back, *"It's taken a toll on me and I don't know why"* (P37).

Other nurses described how MAiD in the Canadian context provided a unique opportunity for nursing as a profession. One nurse described MAiD as a ground-breaking area of nurse practitioner practice. Not only were they the only nurses in the world authorised to assess for and provide MAiD, but for many, it was a rare sphere of nurse practitioner practice that was entirely independent of physician oversight. As such, it was viewed as a practice that could make a significant difference both for the profession of nursing and for patients by filling the gap associated with insufficient numbers of physicians willing and able to provide MAiD.

#### 4.1.3 | Proximity to the act of MAiD

Finally, participants' decisions to participate in MAiD were influenced by their proximity to the act of administering the medications. They might agree with MAiD in theory, and in particular, the right of patients to make that choice, but that did not mean they were comfortable participating. *"I definitely believe in choice at end of life. But I never thought I would be part of hastening that end of life. Have I reconciled it? Not yet. But I am totally comfortable if a person makes that choice"* (P24). Another participant who acted as a MAiD assessor echoed a similar sentiment about providing MAiD. *Am I comfortable with being a provider? I don't know. You'd have to ask me that again later (laughs). Who wants to play God? I don't really want to play God. You can watch somebody skydive but do you want to skydive yourself?"* (P13). What was notable was that nurses described a continuum of participation with which they might be comfortable, but this comfort did not necessarily parallel their support for patient choice.

## 4.2 | Experiences of MAiD

Early decisions to participate were further influenced by nurses' ongoing experiences with MAiD. Those experiences allowed them to reflect further on their positioning, sometimes with unpredictable results. Nurses described a range of emotions that MAiD provoked and attributed those emotions to various factors.

### 4.2.1 | Emotional experiences

For some nurses, experiencing a MAiD death was emotionally impactful in a positive sense and thus reassured them about the moral goodness of MAiD. Adjectives such as *profound*, *amazing* and *humbling* were used to describe the transformative effect this experience could have on them. One participant likened it to entering the final frontier of a Star Trek episode—simply *"mind boggling"* (P27). Another participant, a MAiD provider, explained how during the provision she experienced an overwhelming feeling of kindness, and a confidence that this was the right thing to do. However, the impact was not always positive. One provider described the last poignant moments of a family together and its effect on her. *"I'm giving the medications at end of life and the experience is bonkers. Where is the psychologist in this room, where is the social worker, who do I turn to?"* This same participant went on to describe her coping strategy, *"My partner is my psychologist. I have a drink of Scotch, I don't sleep, I think about it the next day, I ruminate. I never forget these people and situations. I'm okay because I know that it's the right thing and I've relieved the suffering"* (P18). The providers who had these more troubling experiences were often those who were involved in multiple MAiD deaths or who did so without sufficient collegial support.

Experiencing an overwhelming flood of emotions after a MAiD provision was not uncommon. For example, a MAiD provider described being unable to stop weeping after the death. Another participant described going back to her car after a provision and being unable to function. *"I couldn't get in the car and drive. Like literally I was just sitting there and going, I need to think about doing this [driving] before if I am actually fit to operate a car because my brain is literally overloaded, emotionally overloaded."* (P4) This same participant went on to describe how this unexpected emotional response did not fade over time but rather she came to accept it as normal when her mentor told her that she still cries with every death.

Those who felt the emotional impact most acutely were the MAiD providers. However, others also experienced an emotional impact. One registered nurse, who gave the MAiD coordination service telephone number to a client who was unaware of the MAiD option, pondered the feelings she experienced related to her moral culpability. *"I went through this process of just allowing myself to feel like, Oh my God, he never would have done that had I not given him the number. He wouldn't have asked for it. I offered it."* She reflected on how this sense of culpability, and hence her emotional responses, changed over time. *"Now I have no problem giving someone that number"* (P56).

For conscientious objectors, experiencing a MAiD death vicariously could result in a sadness that overshadowed their work-life. One participant described how she had naively believed that being a conscientious objector would limit her emotional involvement. But, because of her commitment to engaging with patients and families as they walked through the process, she too experienced an emotional impact. *"I've removed myself from participating in MAiD but it certainly doesn't remove you from being affected emotionally"* (P34).

## 4.2.2 | Attributions

The emotional impact described by nurses was attributed to various factors. For example, the palliative care nurse who experienced the emotional overload described above, said, *"because even though I did not know the patient, I couldn't figure out why I cried. In my twenty years of experience of watching people die, usually I am not the cause of it"* (P4). Another MAiD assessor spoke to the deep-seated culture within healthcare of doing no harm. *"It's weird the first time. When you have been in the medical profession all your life and we do no harm, then you are killing somebody, or participating in that, it's a boundary that is hard to cross. Nobody wants to play God"* (P13). Participants reflected on how patient prognosis and presentation influenced their emotional perceptions of the moral rightness of MAiD. One MAiD provider suggested that the length of time until death did not matter in the situation of intent *"If the person is going to die in 10 min or 10 years, we are hastening their death, we are the cause of it"* (P30). Yet, viscerally, it was more difficult for nurses when patients appeared relatively well. *"They don't use a walker and they aren't old. They answer the door and walk swiftly, they just look at me and 10 minutes later they are dead"* (P37). This same participant wondered if perhaps the reason for the early death was a failure of good palliative care and went on to say, *"that's the stuff that messes with you"* (P37).

It is important to re-emphasise that there was considerable variation across the data set in terms of participants' emotional reactions. Some described MAiD as among the most profound and rewarding of their experiences in nursing; others experienced it with a sense of sadness, despair and disbelief. What was common in these accounts, however, was how MAiD could change nurses' lives and careers. Some nurses described it as the highest privilege and some of the most meaningful work they had ever done. *"It's now become some of the most powerful palliative experiences I have ever had"* (P2). Others had chosen to change jobs or to retire from nursing entirely because of how MAiD had changed the care landscape. This was the case if MAiD became part of their employment responsibilities and subsequently influenced their ability to provide continuity of care (e.g., palliative nurse clinicians).

## 4.3 | Moral waypoints

Even as participants experienced uncertainty around this new end of life option, they reflected on moral waypoints that revealed their moral compass, and hence, helped them make sense of their experiences. These moral waypoints were different than their initial reasons for involvement for they represented nurses' ongoing reflections as they experienced the impact of their initial choices to be involved or not. *"I am a Buddhist so it was a struggle for me to decide. Everybody's arguing for religious reasons but I felt I needed to explore it a bit more. So, I thought, let's just get involved and see if that makes any difference"* (P4).

In many cases, the same waypoints were used by those who decided to participate and those who chose not to participate in MAiD. They were simply interpreted differently. These waypoints included

patient choice, control and certainty; an understanding that it was not about the nurse; a commitment to staying with patients through suffering; consideration of moral consistency; issues related to the afterlife; and the peace and gratitude demonstrated by patients and families.

### 4.3.1 | Patient choice, control and certainty

In reasoning through the moral complexities of MAiD, a frequent waypoint was that MAiD provided patients with choice, control and some degree of certainty. *"I'm doing something that I believe very, very strongly in and it's totally at the request of that individual lying there"* (P29). This assumption of the importance of choice and control was so compelling that it could be difficult for participants to understand why some questioned the moral rightness of MAiD. For example, this MAiD assessor and provider stated, *"the ability to have choice and control is an empowering gift. There is no reason to make people suffer unnecessarily. It's just common sense and I don't understand why it is so controversial"* (P25). Participants recognised that patients gained this control irrespective of whether they chose to complete MAiD. Knowing that they were eligible, and that they could receive MAiD if their dying trajectory became too difficult, was in itself empowering for patients. This patient control was important because of the perception that the healthcare system all too often takes control of the lives of patients. *"We take a lot of responsibility away from patients and put a lot of control on them"* (P20). Participants acknowledged that, even without MAiD, patients will take control of their dying. They shared stories of patients in their care who had tried to commit suicide, sometimes with horrific results. In light of such experiences, one assessor suggested that MAiD provided a *"civilized, respectful, and dignified"* (P13) alternative for those who were determined to control their own deaths.

Alongside choice and control was the assumption that *"patients know themselves best"* (P38). Patients who chose MAiD were characterised as firm and determined in that choice. *"One thing I've learned with the 19 cases, and only 5 went to procedure, is that they know what they want"* (P24). A MAiD assessor described how this patient certainty made it easier for the nurse. *"So there was no question in their minds that this was something that was for them. Which you know always makes your life easy...right?"* (P13). Patients who chose MAiD were further characterised as independent, self-assured and strong, and these characteristics were seen to be a major factor in the justification of MAiD. *"The amount of assurance that these people have and the certainty they have is what really drives this"* (P62).

Other participants, however, were less certain about whether individual choice was sufficient grounds upon which to be involved in such a final act. One participant suggested that it is difficult to rest in the certainty of choice if the system was not providing other options, namely good palliative care (P34). Another participant suggested that the idea of autonomous choice needed to be considered alongside the impacts on family, communities and society overall (P33). Others worried about the stability of patient choices, particularly when they observed patients who went back and forth in their decision. *"She was not confused but she just kept changing her mind about*

whether she wanted MAiD" (P5). The 10-day waiting period was seen to be particularly beneficial in terms of ensuring that MAiD really was what patients wanted. One participant visited patients regularly during that 10-day waiting period to ensure that the choice was a stable one, and hence, something that she could live with in the long haul. "This is what has cushioned me psychologically in being able to understand that this individual truly has no doubts about what they are doing and this is absolutely what they wanted" (P51).

#### 4.3.2 | It's not about me

Closely related to the idea of patient autonomy was the recognition that for nurses, this decision was not about them. This moral waypoint was closely related to how nurses felt their own values should impact practice. For a group of participants, patient-centred, holistic care meant that nurses' personal beliefs did not have a role in practice. As one assessor and provider put it, "it shouldn't matter what your personal values are. We have a moral and ethical obligation to put the patient at the centre of everything" (P8). Another rural participant expressed a similar waypoint while acknowledging that this perspective could come at a personal cost. "This is about validating them as a person. So that turns everything around. It is all about them, it's not about me. And that's why I can suffer silently when these things occur because it is not about me" (P14). This decentering that included a personal cost to the nurse was not uncommon in the data. For example, this participant described how "stunned" she felt after a MAiD death but how she reconciled that vicarious suffering. "I don't know how to deal with it because it is such a strange thing, but I just go back to what the patient wants. That's my landing place (P6).

Another aspect of this decentering was staying neutral and withholding judgment. *It's the patient that decides, I'm completely impartial and all I want to do is help them achieve whatever they are wanting* (P12). Participants recognised that suffering was subjective and so it was impossible to pass judgement both on the suffering and on what the patient felt was necessary to end that suffering. "I've stayed very neutral, neutral because I feel like I am not the one suffering" (P31). This idea of neutrality was prevalent in the data. Neutrality was the place where participants could live with the tough decision. One assessor and provider suggested, "This is not a right or wrong issue with the people at the end of life who are suffering. This is their decision and we can't judge them" (P18).

The idea that *it's not about me* took on a somewhat different expression for those who were conscientious objectors. In this case, it was not about them but about a bigger moral horizon, often linked to a higher power. For example, one participant had watched two family members die difficult deaths, and it caused her great angst to be witness to such suffering. She believed in the patients' freedom of choice to end their lives, but when it came to her own participation in that choice, she was accountable to something greater. *I am accountable not just to that person but something else. My line is drawn at intention. Life is a gift. God gives it. It is not ours to take away*" (P53). This rationale was also a decentering move

because participants did not necessarily say that patients did not have a right to take their own lives, they simply acknowledged that according to their traditions, it was not within their right to participate in it. *I see human beings as having great value. And so, in their great value, I don't have a right to participate in ending someone's life* (P35). This larger moral horizon also included considerations of society. "It's not about making a decision about what's best in the moment or best for an individual, but having a bigger perspective on what's best within a [societal] narrative arc" (P33). Across the diversity of participant perspectives, nurses recognised the importance of the other in their decision but that other could mean the patient, a higher power, or even society overall.

#### 4.3.3 | Nurses' role in alleviating suffering

Just as nurses talked about witnessing suffering as a primary reason for choosing to participate in MAiD, this same suffering was a waypoint for making sense of their experiences.

For MAiD proponents, resolving patients' suffering was a moral imperative. For example, one participant reflected on the night-time conversations she had with patients about their suffering. "They are most vulnerable and alone. They say they find no meaning in their suffering and are tired of enduring it. It doesn't require a lot of mental gymnastics. If we can't get them comfortable then we have an ethical responsibility to do MAiD" (P11).

But for others, the nursing role in relation to suffering was less clear. For example, one nurse questioned whether holistic care meant solving everything, including suffering. "Holistic care isn't always about making everything perfectly better. We need to start being okay that we're not going to fix everything" (P20). Another nurse wondered whether working in high-acuity areas of nursing, where everything tends to get "fixed" also influenced nurses towards seeing their role as fixing suffering through MAiD. Palliative care nurses had particularly strong ideas about seeing MAiD as nursing's answer to fixing suffering. For example, a palliative nurse reflected on the differences in the nursing role when aiming to relieve suffering through palliative care or extinguishing suffering through MAiD. "When we are talking about people's voices and hearing what they are asking for, what they are telling us, is that they're suffering, suffering so badly that they want to end their life. And what you do when you extinguish that voice is that it no longer exists" P23. This participant saw a cruel irony in silencing the voice that appealed for help. Although some nurses had quite strong opinions about the nursing role in relation to suffering, others were less certain, pondering the nature of suffering itself. "Why are we saying that you have to suffer in order to die? Is that part of the process? I don't know. I don't really know the answer to that myself" (P13).

Irrespective of their differences about the nursing role in suffering, nurses held to a common value of staying with patients and families during that suffering. Those who were conscientious objectors struggled deeply with the implications of this staying with patients. "Religious people carry this kind of ethics with them to be there and to sort out how you can still contribute, but in a way that does



not compromise your own ethics" (P33). One palliative clinician pondered what it meant to conscientiously object. She concluded that although she would never see MAiD as an extension of her palliative practice, conscientious objection was never "intended for us to wipe our hands clean of something" (P23). Another participant agonised over her decision to step out of the room during the time of MAiD medication administration, "Part of me still feels like I am abandoning them a little bit by choosing not to go in. Especially when the family has said, 'are you going to be there' because they are comfortable with you and you have established that relationship" (P34). A nurse who worked in a conscientiously objecting organisation, and was herself a conscientious objector, had to make a difficult decision about what she told her patients about not being present at the provision. "I used my company as an excuse, my company does not participate and therefore I can't be present. But I felt awful too, because I kind of felt like I was abandoning my patients" (P32). Other nurses chose to stay with patients despite their conscientiously objecting status because the anxiety that resulted from not staying with patients was too high.

#### 4.3.4 | Moral consistency

Another way in which nurses grappled with the moral complexities of MAiD was to compare it to other morally contentious issues. For example, one participant who worked as an assessor described how she was adamantly opposed to MAiD initially but then changed her mind after reflecting on her position in relation to abortion. She decided that it all came down to the importance of personal choice (P50). Palliative sedation was another reference point for moral equivalency. One participant spoke of how this was a natural extension of the palliative sedation process, in that patient autonomy is removed, and so there was really little difference (P24). Another participant had seen palliative sedation go very wrong, and so decided that MAiD was actually the more compassionate choice (P27). Moral distinctions between removing life support and MAiD were also considered. "I don't think practitioners who remove someone from life support consider themselves to be killing someone either" (P30). The difference between clinician-administration and self-administration of the medication was also cited. This participant, who was a provider, suggested that self-administration might ease the process for the nurse psychologically, but at the end of the day they were still accountable for their practice. "It's not me giving the medication. But in terms of being judged, how am I going to be judged at the end of life? It would still be me signing off on allowing that person to do that because I've arranged the medications. So, it's not that much different you know" (P18).

#### 4.3.5 | Reflections on the afterlife

The mysteriousness of the soul, and of death, was a waypoint for making sense of MAiD. Participants spoke to the profundity of death and the mystery of life. "What does your body do when you are passing away naturally? MAiD really triggers more thoughts with me. Where is

your soul going if you think you have a soul? It's just so thought-provoking and heavy" (P31). Another participant reflected on the possibility of natural patterns in life and death. "I don't follow a formal religion but I think there must be some patterns we don't understand and if we are intervening, could we possibly be putting things off track?" (P39). This idea of the seriousness of intervening with death and with the divine was not uncommon. "That always lurks in your mind. Are we playing God? It's a very serious thing, right?" (P13).

Moral culpability and judgement could be a source of anxiety, even if the participant felt that what they were doing was ultimately a good thing. For example, a participant who was a provider explained how she engaged in certain self-talk that helped her through the process. She reminded herself that it was only the body going and that she believed in reincarnation so it was good for them to move on. This self-talk had helped her over time as she reflected on the body after death. "It's not the person I interacted with. So, I am still struggling, and I still get upset, but it's not like the first few cases where I completely lost it" (P4). This final quote typifies the soul struggle that can occur for both patients and providers:

The patient said to me, 'how am I going to be judged?' I said, 'what do you mean?' She said, 'when I'm in front of our Maker, the pearly gates.' And I said to her as comically as I could, 'You? What about me?' She laughed and said, 'I'll save a place for you.' And I was so honored to be helping her and we talked about how we were going to be judged laughingly. But, in the back of our minds this is no joke at all. It's a huge thing. That is a big reason why most people aren't doing it (MAiD). I'm not a religious person, but you can't not think about it because I'm a human being".

(P18)

#### 4.3.6 | Peace and gratitude

One of the strongest waypoints for participants was how peaceful the MAiD death was and how grateful patients and families were for their assistance. Indeed, quick and peaceful were two of the most common adjectives used to describe a MAiD death. As one participant who was a provider suggested, it is the peacefulness that helps her get through the process. *They are totally unaware and it's very peaceful. So that helps me in the psychology of things* (P18). Another participant who was a provider spoke of her uncertainty about what to expect in her first MAiD death but how quickly that uncertainty was resolved:

It's shockingly easy and fast and peaceful. I said to the patient, to reassure her, you'd be surprised just how calm everything is. And that was the one thing her husband told me after it. He says, you weren't kidding, it was fast and easy.

(P46)

Another participant, a long-time palliative nurse who had been present for a number of MAiD deaths, reflected on her tendency to cry less at the death of a MAiD patient, even pondering whether she was becoming desensitised. But, she concluded that it was largely the peacefulness of the death that evoked similar emotions in her:

But to me, these are most peaceful deaths. I feel peaceful in those times. That is not harmful either because I don't think that it has come from a place of, like, coldness or complacency or just not caring. It's just as severe... it's not severe... an extensive level of comfort and peace in these deaths.

(P55)

Similar to the experience of the peaceful death, participants spoke of the gratitude they received from patients and families. *"Every patient I've ever encountered has expressed and been truly grateful they have the opportunity to do this"* (P20). One participant, who had been present at over 50 MAiD deaths, reflected on how she still gets emotional but how gratitude eases that emotion:

The patients always say that they're grateful that their suffering is going to be over and the family members, whether they agree with the care option or not, because a lot of family members think this is awful, even after the assisted death has happened, the family members usually say, I'm happy that their suffering's over.

(P3)

A nurse practitioner, who was an assessor, had a similar experience with a family member who was both conflicted and grateful at the same time. Prior to thanking her, the family member inquired how she was able to do this and said, *"you guys are kind of like executioners' and I was like, Oh My God. I have not been able to shake that out of my brain."* (P01) Another provider reflected a similar experience. *"They all seem so grateful when we come [to provide MAiD]. We try to get consent from them and all they'll say is, 'Yes, I'm ready. You know, I've been waiting for this and, you know, this is my day'"*(P30). The gratitude was a reward that offset some of the challenges of a MAiD death. *"When you get a warm and fuzzy from somebody or a hug from a family member. That's a reward in itself"* (P14).

## 5 | DISCUSSION

The moral journey of making sense of MAiD was often a complex and arduous one. Participants described a moral intuition deeply shaped by personal, social and professional experiences. This intuition was further shaped by reflections, conversations and direct experiences with a MAiD death. Participants used reasoning tactics as waypoints that helped them think through the moral complexity of MAiD. Nurses in this study illustrated a diversity of experiences as they sought to build a level of moral comfort with their decision to

participate, or not, and their subsequent care of patients. In this discussion, the work of Jonathan Haidt (2001, 2012), psychologist and moral philosopher, and work on the moral identity of nursing, may provide possible theoretical explanations for such diverse findings.

Haidt (2012) uses the analogy of a rider and an elephant to describe moral experience. Drawing upon a robust body of evidence within psychology, he suggests that moral judgement is made up of two types of cognition: intuition and reason. The intuitive aspect of cognition relies heavily upon emotion, and this emotional experience is so primal and influential that he likens it to an elephant. Further, he argues that the reasoning aspect of cognition is typically used to justify these moral intuitions in a post hoc sense. Reasoning becomes the rider that seeks to control (explain) the powerful intuitional elephant. As such, moral intuitions are difficult to change, at least through argument and reason. They change primarily through engagements with others that are characterised by empathy, warmth, respect and openness.

This analogy of the rider and the elephant provides an interesting framework through which to view the interplay between nurses' emotional experiences and their subsequent professional reasoning and judgement. The emotional impact of MAiD on nurses described in many studies, the variability and enduring nature of nurses' responses, and the life-changing impact fits well with the analogy of the moral intuitional elephant. The magnitude of nurses' emotional responses and the difficulty they had in explaining those responses, even if they believed they were doing something good, suggested a deep intuitional process. In contrast, the rider in this data set represents the many moral reasoning waypoints that nurses used to make sense of their journey. Whether these reasons were related to patient control, selflessness, suffering, moral comparisons, the after-life or patient impact, they all functioned as a means of providing a form of reasoning through which to try to make sense of both their moral experiences and their moral stance in relation to MAiD.

Haidt's (2012) argument that our moral intuitions are largely shaped through social interaction is echoed by Doane's (2002) suggestion that moral identity in nursing is relationally and contextually mediated. Further, Doane argued that this mediation occurs through the construction of narratives in which nurses bring their many identities to the task of figuring out a right course of action. Such identity construction has been found in other studies of nurses' experiences (Denier, Dierckx de Casterle, De Bal, & Gastmans, 2009). Findings from this study illustrate this contextually mediated moral identity. Decisions to participate were influenced by family, friends and colleagues. Unique contexts, such as rural practice, influenced whether nurses could participate in MAiD without compromising trust and relationships within their communities. Nurses grappled with their multiple identities of family member, professional, obedient nurse, person of faith, vicarious sufferer and champion of autonomy to construct narratives of whether MAiD was a moral fit for them.

Finally, it is important to think about how these nurses' experiences fit with the grand moral narratives of nursing. Peter, Simmonds, and Liaschenko (2018) have argued that these narratives are twofold: (a) making a difference in the lives of individuals and communities and (b) holding the identities of the vulnerable.

This second narrative entails holding fast to the dignity of patients' unique identities even as their bodies deteriorate. This moral identity of nursing explained much of what was evident in our findings. MAiD was viewed as a way to support the autonomy and control of potentially vulnerable patients, and hence, support for their unique identities as their bodies faded away. Nurses who participated in MAiD believed they were making a real difference in the lives of suffering patients and families, and in doing so, experienced new meaning and purpose in nursing, a finding that has been echoed in other studies (Beuthin, 2018; Bruce & Beuthin, 2019).

As part of their commitment to guarding patients' identities and vulnerabilities, nurses were unequivocally protective of patients. They wanted to be assured that their patients were free to change their minds, were not being pressured towards MAiD and were not making the decision to seek MAiD because of failures in the system's capacity to provide good palliative care. Because nurses know that high-quality palliative care is not always available to all patients who have reached the point in their suffering that leads them to wish for death, they are often left with a lingering uncertainty. Has the system, or have they by virtue of their complicity with the system, let patients down? This is but one example of the moral uncertainties that characterised nurses' focus on protecting vulnerability within a complex moral landscape.

Further, a commitment to guarding patient vulnerability was evident across the moral divide of MAiD proponents and conscientious objectors. Proponents of MAiD believed they were making a profound difference by protecting the autonomy of patients to control vulnerability. Conscientious objectors believed they were making a difference by providing compassionate care through the process of vulnerability. Nurses on both sides were profoundly committed to making a difference amidst the realities of the dying process. The only difference was in how they chose to address that vulnerability. On both sides of this apparent divide, nurses reflected on the mystery of life, death and suffering, and how difficult it was to really know right action in the face of such mystery.

## 5.1 | Limitations

Although this was a purposive sample in the sense that these participants could richly inform our findings because of their experiences, it was also a convenience sample. It is likely that those who had been most impacted were also the most likely to contact us to participate. The depth of emotion evident in these interviews would support this. The use of telephone interviews may also have limitations with such a sensitive topic. However, participants were so forthcoming with their experiences that it is possible that the telephone provided a necessary anonymity. Further, we chose to analyse these diverse experiences together, while paying attention to relevant factors such as role, decision to participate or not, and geographic context. Our findings not only illustrate that complexity, but also demonstrate that a deeper understanding could be gained by studying the common experiences within these subgroups of participants (e.g., rural nurses; conscientious objectors; assessors/providers).

## 6 | CONCLUSION

Nurses in this study provided an intimate look at what influenced their decision to participate in MAiD, or not, and their moral sense-making as they incorporated that decision into the care context. These findings support a growing body of literature that attests to the importance of the nursing role in high-quality assisted death care, and the impact such care can have on the lives and careers of nurses. The moral identity of nursing, which directs nurses to guard the vulnerabilities of patients, means that nurses take great responsibility in ensuring the best death possible, and hence, experience the moral weight of such involvement in what remains a morally contentious act.

## 7 | RELEVANCE TO CLINICAL PRACTICE

There is a need to better support nurses' moral journeys in clinical practice. Nurses in this study experienced the impactful nature of MAiD while holding to the nursing moral identity that it was about patients and "not about them." The combination of a morally difficult act, a deep commitment to vulnerable patients and the sublimation of nurses' experiences is a perfect storm for moral distress. Facilitating the compassionate conversations identified by Haidt (2012), and considering the type of moral community that would support such conversations, is an important step to supporting nurses. Liaschenko and Peter (2016) have suggested that such communities are best created by making moral space where conversations can happen, where moral language can flourish, and where we imagine narratives to support a flourishing ecology. This means establishing clinical contexts in which nurses have the opportunity to debrief around patient deaths by sharing their stories of care that support compassion amidst difference. Such empathetic sharing has the potential to nurture clinical practice environments that provide good patient care while supporting nursing well-being amidst this new end of life option. Within such an environment, nurses have the potential to cross the moral divide that characterises MAiD to build upon the shared moral identity of making a difference in the lives of patients and communities while protecting the identities of the vulnerable.

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## CONFLICT OF INTEREST

Authors have no conflict of interest to declare.

## AUTHORS CONTRIBUTIONS

BP, ST, JS, KC, MG and MB made substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data, were involved in drafting the manuscript or revising it critically for important intellectual content, gave final approval of

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## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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