

Knowledge and education needs of nurses regarding Medical Assistance in Dying

**Knowledge and education needs of nurses regarding Medical Assistance in Dying (MAiD):
A qualitative systematic review**

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Nursing

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Preface

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As my thesis supervisor, Dr. Jane Tyerman co-authored my monograph and provided guidance on the overall thesis design, including a substantial contribution to the development of the final document.

2. Amanda Vandyk RN, PhD Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

As a member of my thesis committee, Dr. Amanda Vandyk co-authored my manuscript and provided guidance on the overall thesis design with a particular contribution to adhering to a high-quality systematic review methodology.

Thesis Abstract

All nurses must be adequately prepared to care for individuals requesting Medical Assistance in Dying (MAiD) due to the practical, ethical, personal, and legal ramifications associated with MAiD. Nurses are both professionally and legally obligated to be knowledgeable and skilled in navigating the care of individuals requesting MAiD. This qualitative systematic review explored the knowledge and education needs identified by nurses regarding MAiD. This qualitative systematic review was conducted following the JBI methodology for systematic reviews of qualitative evidence, including critical appraisal, study selection, data extraction and data synthesis. Four themes were identified: 1) ethical and moral challenges, 2) legislation and standards, 3) communication, and 4) mandatory MAiD education. The information and practice recommendations found within this review can be used to support the knowledge and education needs of all nursing students and practicing nurses throughout Canada.

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Conflicts of interest

There are no conflicts of interest to declare.

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Chapter 1: Introduction

1.1 Background

In 2016, the Canadian government passed Bill C-14 – *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, effectively legalizing medical assistance in dying (MAiD) within Canada. Canada is the first country to include Nurse Practitioners as assessors and providers of assisted dying, a role traditionally reserved only for physicians (Pesut et al., 2020). This role holds significant obligations for the Nurse Practitioner to provide legally and ethically sound care (Pesut et al., 2020). Beyond the inclusion of Nurse Practitioners, MAiD further incorporates all required healthcare team members who are responsible for providing high-quality care to individuals requesting MAiD, such as nurses. This new and non-prescriptive MAiD legislation has been deeply impactful on the practice of nursing in Canada and has presented challenges regarding role establishment, role ambiguity, and education for these roles. Based on the legislation, MAiD has not been isolated to a specific healthcare sector but integrated throughout the entire healthcare system (Pesut et al., 2020). As MAiD requests and provisions are not confined to a particular setting, nurses must be properly supported throughout all practice settings to gain the knowledge required to care for individuals requesting MAiD and their families and/or caregivers. A lack of knowledge and/or training for healthcare professionals related to MAiD and end-of-life care has been identified as a key concern suggesting improved education should be incorporated into healthcare curricula and ongoing training (Fujioka et al., 2018). As the sixth year of MAiD legalization in Canada and with the recent amendment to the MAiD legislation, now is the time to review the knowledge and education nurses need to provide competent, ethical care.

1.2 Problem Statement

The Canadian Nurses Association states in their MAiD Framework that “nursing regulatory bodies across the country have the legal mandate to protect the public by ensuring that nurses who practise are qualified and provide safe, competent, ethical care (Canadian Nurses Association, 2017, p. 8)”. However, specific mandatory MAiD education has not been incorporated into nursing education programs and continuing education throughout most provinces and territories (Beuthin et al., 2018) and has been identified as a gap to be addressed (Fujioka et al., 2018; Pesut et al., 2020). An overall gap in knowledge, training and/or education has also been identified throughout the literature (Ay & Oz, 2019; Beuthin et al., 2018; Fujioka et al., 2018; Suva et al., 2019). As nurses are both professionally and legally obligated to be knowledgeable and skilled in navigating the care of individuals requesting MAiD (Suva et al., 2019), completing a systematic review of nursing-specific education needs regarding MAiD will provide a better understanding of the knowledge required to provide competent, ethical MAiD care.

1.3 Research Question

In the context of Medical Assistance in Dying (MAiD), what knowledge and education needs do nurses identify?

1.4 Thesis Overview and Organization

This thesis is written in a traditional style, beginning with this introduction, followed by Chapter Two, which includes a thorough literature review on the current state of Medical Assistance in Dying. This will include a description of MAiD, the criteria of the legislation, the MAiD framework and competencies outlined by the Canadian Nurses Association, provincial and territorial regulation of MAiD, practice settings, the concept of conscientious objection, and views and attitudes of nurses regarding MAiD. Chapter Two concludes with the identification

and rationale for the selected paradigm and theory guiding this thesis. Chapter Three describes the methodology involved in this qualitative systematic review, including a description and rationale of the inclusion criteria, the search strategy design and key search terms, the databases included in the review and rationale for selection, the methods used for assessing methodological quality, and the aggregation procedures. Chapter Four focuses on the results identified throughout the data extraction and aggregation process. Chapter Five discusses the findings, including a section identifying the strengths and limitations of this review, before concluding with sections on proposed future nursing practice, research, and educational endeavours. A conclusion is provided at the end of Chapter Five.

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Chapter 2: Literature Review

In this chapter, the findings from a thorough initial literature review are described to provide an overall view of Medical Assistance in Dying (MAiD). The sections included in the literature review chapter are a description of MAiD, the criteria of the legislation, the current state of MAiD within Canada, the MAiD framework and competencies outlined by the Canadian Nurses Association, provincial and territorial regulation of MAiD, practice settings, the concept of conscientious objection, views and attitudes of nurses regarding MAiD, and a preliminary search for existing reviews and the need for the conduct of a review of knowledge and education needs of nurses regarding MAiD. A section identifying the paradigm and theory underpinning this thesis and systematic review follows the literature review.

2.1 What is MAiD

In Canada, Quebec was the first province to introduce medical aid in dying, whereby a person at the end of life can request a physician to administer a substance to hasten that person's death, into their provincial legislation in 2014 within *An Act Respecting End-of-Life Care* (Government of Canada, 2020; Suva et al., 2019). Quebec also founded a Commission on End-of-Life Care (*la Commission sur les soins de fin de vie*) to oversee the review of end-of-life cases and the application of medical aid in dying (Government of Canada, 2020). In 2016, the Canadian government passed Bill C-14 – *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, effectively legalizing MAiD in Canada. Previously, assisted dying was not permitted in Canada, and if performed, it would be considered an offence of culpable homicide (Parliament of Canada, 2016). This amendment evolved after a ground-breaking case in 2015 of *Carter v. Canada (Attorney General)*, where the Supreme Court of Canada ruled that portions of the criminal code which prohibited assisted

dying directly opposed the *Canadian Charter of Rights and Freedoms* (Edwards, 2016; Pesut et al., 2019a). The Supreme Court of Canada made a declaration in the case, ruling that

Section 241(b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. (Carter v. Canada (Attorney General), 2015, para. 4)

The Supreme Court suspended the declaration in their ruling to provide the federal government with a one-year timeframe to establish new assisted dying legislation, at which point the portions of the criminal code that oppose assisted dying would no longer be valid (Edwards, 2016; Government of Canada, 2020). After a granted extension, a Special Joint Committee on Physician-Assisted Dying was founded with members of the House of Commons and the Senate of Canada to meet with stakeholders to develop recommendations for a legislative framework (Edwards, 2016). On June 17, 2016, Bill C-14 was passed and received Royal Assent (Edwards, 2016).

As defined in Bill C-14, MAiD is:

a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

(Parliament of Canada, 2016, Chapter 3, section 241)

By this definition, MAiD encompasses both assisted death (a medical or nurse practitioner prescribes a lethal dose of medication that a patient then self-administers) and clinician-assisted euthanasia (a lethal dose of medication is administered by a medical or nurse practitioner) (Beuthin et al., 2018; Fujioka et al., 2018; Pesut et al., 2019b).

Assisted dying involves an individual with capacity and a terminal illness requesting assistance from a third party to help them die (Holt, 2019). Assisted dying has been previously legalized in other countries, including The Netherlands, Switzerland, Belgium, Luxembourg, Germany, Colombia, eight states in the United States of America, and, most recently, Victoria, Australia and Spain (British Broadcasting Corporation, 2021; Dyer et al., 2015; Fujioka et al., 2018; Holt, 2019). There has been robust dialogue within New Zealand, the United Kingdom, France, Japan, and South Africa surrounding the consideration of implementing assisted dying in their legislation (Fujioka et al., 2018; Holt, 2019).

Terminology regarding assisted dying differs depending on the country and existing practices. In the Netherlands, Belgium, and Luxembourg, assisted dying is legal and termed voluntary euthanasia (VE) or physician-assisted suicide (PAS) (Suva et al., 2019). Both situations require a voluntary request by a patient to end their life. VE involves a physician administering lethal medication(s) resulting in that person's death (Suva et al., 2019). Alternatively, PAS or physician-assisted death (PAD) involves the person knowingly self-administering the physician-prescribed medication intended to cause death (Suva et al., 2019). PAS is currently legalized in eight US states, including California, Colorado, the District of Columbia, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington, D.C. (Death with Dignity, 2020; Suva et al., 2019).

The Canadian federal government constructed the concept of MAiD, as opposed to utilizing pre-existing terms of “physician assisted dying” or “physician assisted suicide.” Broadening the term to Medical Assistance supported the integration of Nurse Practitioners to take more of a leadership role within this practice (Banner et al., 2019; Pesut, Thorne, Greig, Fulton, et al., 2019). Canada is the first country to include Nurse Practitioners as assessors and providers of assisted dying, a role traditionally reserved only for physicians (Pesut et al., 2020). This role holds significant obligations for the Nurse Practitioner to provide legally and ethically sound care (Pesut et al., 2020). Beyond the inclusion of Nurse Practitioners, MAiD further incorporates all required healthcare team members who are responsible for providing high-quality care to individuals requesting MAiD, such as nurses, pharmacists, and social workers.

2.2 Criteria and Legislation

Specific criteria for eligibility and safeguards have been built into the legislation for medical assistance in dying to support the appropriate and safe provision of MAiD (Parliament of Canada, 2016). When Bill C-14 was passed in 2016, it included a clause that legislation must undergo a mandatory independent review in five years from Royal Assent of the amendment by a committee consisting of the Senate, the House of Commons or both Houses of Parliament (Parliament of Canada, 2016). Another crucial court case, *Truchon v. Canada*, received a ruling by the Superior Court of Quebec on September 11th, 2019, that the eligibility criteria outlined in Bill C-14 specifying that natural death must be “reasonably foreseeable” and the criteria in Quebec’s *Act Respecting End-of-Life Care* specifying a person must be in their “end-of-life” is unconstitutional (Department of Justice, 2021). These criteria were ruled to be in opposition to section 7 and section 15 of the *Canadian Charter of Rights and Freedoms*, which “protects against deprivations of life, liberty and security of the person” and “guarantees the right to the

equal protection and equal benefit of the law without discrimination”, respectively (Department of Justice, 2021, section 3). In February of 2020, the Minister of Justice and Attorney General of Canada proposed a new bill, entitled *An Act to amend the Criminal Code (medical assistance in dying) (Bill C-7)*, with changes to the MAiD provisions in the Criminal Code (Department of Justice, 2020). On October 5th, 2020, Bill C-7 was reintroduced with the included proposed changes: retaining nearly all of the current eligibility criteria but removing “reasonable foreseeability of natural death” from the list of requirements, excluding all people who are solely suffering from mental illness, a two-track safeguard system that: a) maintains and eases current safeguards for those whose natural death is reasonably foreseeable, and b) adds new safeguards and strengthens existing safeguards for those who do not have a reasonably foreseeable natural death, and allows for a waiver of final consent to the provision of MAiD based upon meeting specified criteria (Department of Justice, 2021). Bill C-7 received Royal Assent on March 17th, 2021 (Parliament of Canada, 2021).

Currently, as per Bill C-14 and Bill C-7 (Parliament of Canada, 2016; Parliament of Canada, 2021), the eligibility criteria for MAiD provision includes:

- a) the person is eligible to receive government-funded health services in Canada;
- b) the person is at least 18 years of age and capable of making their own health care decisions;
- c) they have a grievous and irremediable medical condition;
 - a. a serious and incurable illness, disease, or disability
 - b. in an advanced state of irreversible decline

- c. the person is enduring intolerable physical or psychological suffering – that cannot be relieved under personally acceptable conditions – as a result of their illness, disease or disability or the state of decline
- d) the person – without evidence of external pressure – has voluntarily requested MAiD; and
- e) the person is informed of the options available to relieve their suffering, including palliative care, and they have provided informed consent to receive MAiD after receiving information on available options.

In the MAiD legislation, safeguards instituted include necessary steps that practitioners must take before the provision of MAiD. Should a medical or nurse practitioner fail to comply with the outlined safeguards, they will be found guilty of a legal offence and liable to imprisonment based on the level of conviction (Parliament of Canada, 2016). Therefore, it is of the utmost importance that healthcare practitioners and providers participating in MAiD are extremely well versed in the criteria and safeguards embedded in the legislation. As per Bill C-14 (Parliament of Canada, 2016), the safeguards include:

- a) ensuring that the person meets all of the MAiD criteria;
- b) once the person has been informed and/or confirmed by a medical practitioner that they have a grievous and irremediable medical condition, the person requesting MAiD signs and dates a written request for MAiD;
- c) the request for MAiD provision will be signed and dated in the presence of two independent witnesses; the witnesses will then sign and date the request signifying that they bore witness;

- d) the person is informed that they may withdraw their request at any time or in any manner; the person also must be given the opportunity immediately before the actual provision of MAiD to withdraw their request and to confirm their consent to begin the provision;
- e) ensure that two independent medical or nurse practitioners have completed a written opinion that the person has been confirmed to meet all of the eligibility criteria;
- f) ten full days between the date on which the request was signed, dated and witnessed and the day on which the provision of MAiD will take place must be instituted to allow appropriate time for reflection; and
- g) if the person has communication challenges, they must be provided with the appropriate supportive measures to comprehend the information provided to them, as well as communicate their choices.

2.3 Current State of MAiD in Canada

On November 1, 2018, Canada launched a country-wide federal monitoring and reporting system to enhance the reporting requirements and standardize data collection methods based on the collaboration of the provincial, territorial, and federal government data on medical assistance in dying (Government of Canada, 2020). To support this federal monitoring system, the Canadian government instituted Regulations for the Monitoring of Medical Assistance in Dying (Government of Canada, 2020) to establish standardized and consistent data reporting guidelines. “The First Annual Report on Medical Assistance in Dying in Canada, 2019” presents a summary of data collected on written requests for MAiD from January to December 2019, submitted by medical and nurse practitioners and pharmacists across Canada (Government of Canada, 2020). Before this report, provinces and territories voluntarily submitted data on MAiD to the Canadian

government (Government of Canada, 2020). The voluntary submission of data may have led to the underreporting of data and lower data quality (Government of Canada, 2020).

Data from the First Annual Report demonstrates the rising occurrence of medically assisted deaths throughout Canada. The total number of MAiD cases in 2019 accounted for 2.0% of all deaths within Canada, with a total of 5,631 people who received MAiD – a 26.1% increase since 2018 (Government of Canada, 2020). Less than seven individuals who received MAiD had done so through self-administration of lethal medications (Government of Canada, 2020). The demographic data of those who had received MAiD in 2019 revealed gender to be nearly equal, with 50.9% of individuals being men and 49.1% being women (Government of Canada, 2020). More than 80% of the individuals who had received MAiD were 65 years or older, with an average age of 75.2 years (Government of Canada, 2020). Chronic conditions leading to the decision for MAiD included cancer (67.2%), respiratory (10.8%), neurological conditions (10.4%), cardiovascular (10.1%), multiple comorbidities (9.1%), other conditions, such as frailty (6.1%), and other organ failure (4.6%) (Government of Canada, 2020). Those with multiple medical conditions are accounted for in each respective category, as demonstrated by the total percentages of all categories resulting in greater than 100% (Government of Canada, 2020).

It is important to note that, out of the 7,336 written requests for MAiD, 26.5% did not result in a MAiD provision (Government of Canada, 2020). Reasons included the individual dying before MAiD could be provided, the individual not meeting the eligibility criteria, or the request being withdrawn (Government of Canada, 2020). For individuals who did not meet the eligibility criteria and have had their request declined, this presents another facet of MAiD.

Nurses play a crucial role in supporting individuals as they process this outcome (Suva et al., 2019).

2.4 CNA MAiD Framework and Competencies

The Canadian Nurses Association, as the national voice for nursing in Canada, developed a Medical Assistance in Dying Framework in 2017 to provide general, overarching guidance for nurses throughout the country regarding MAiD (Canadian Nurses Association, 2017). The purpose of the framework is to: provide guidance to all nurses regarding federal law changes; the role of nursing surrounding MAiD; support reflection on ethical issues that may be experienced in practice; highlight the impact of nursing on end-of-life care and MAiD; and act as an educational resource for nurses and nursing policymakers (Canadian Nurses Association, 2017). The framework has three main sections: a descriptive statement on the seven nursing values and responsibilities of MAiD, a generic pathway is presented to support Nurse Practitioners and all nurses who assist in the stepwise provision of MAiD, and four case studies discussed to support the application of the nursing values and responsibilities (Canadian Nurses Association, 2017).

Within the framework, the seven nursing values and responsibilities were developed from nursing codes of ethics and adapted to the practice of MAiD. They are meant to provide an ethical perspective and direction when reviewing decisions about MAiD (Canadian Nurses Association, 2017). The values and responsibilities include: 1) providing safe, compassionate, competent, and ethical care, 2) promoting health and well-being, 3) promoting and respecting informed decision-making, 4) preserving dignity, 5) maintaining privacy and confidentiality, 6) promoting justice, and 7) being accountable (Canadian Nurses Association, 2017). The four steps presented in the generic MAiD pathway are: 1) determining a person's eligibility for MAiD, 2) ensuring that all legislative safeguards are met, 3) the actual provision (for Nurse

Practitioners) or aiding in the provision (for all nurses), and 4) filing the required information and reports (Canadian Nurses Association, 2017). Similar to the MAiD legislation, the CNA's MAiD Framework is purposefully non-prescriptive, allowing provincial or territorial governments, nursing regulatory bodies, and employers the flexibility to determine their MAiD processes, including the roles of healthcare professionals participating in MAiD requests, assessments and provisions (Canadian Nurses Association, 2017).

2.5 Provincially & Territorially Regulated Roles

While federal MAiD legislation regarding eligibility criteria and safeguards for MAiD provision applies to all Canadians, the actual practice of MAiD is regulated provincially and territorially, as they are responsible for the delivery of health care services and the provision of justice (Government of Canada, 2020). Once MAiD legislation passed, provincial and territorial governments and professional governing bodies quickly developed practices, policies, and training, determining how MAiD would fit within their healthcare model (Banner et al., 2019). The ground-breaking inclusion of Nurse Practitioners as MAiD assessors and providers required role clarity for these nurses without any pre-existing experience or research to draw upon outside of that of physicians. This new and non-prescriptive MAiD legislation has been deeply impactful on the practice of nursing in Canada and has presented challenges regarding role establishment, role ambiguity, and education for these roles.

As nurses work and learn in various settings and contexts, their roles within MAiD are highly variable and inconsistent throughout provinces and territories due to differing provincial and territorial standards and guidelines (Pesut et al., 2019b). A systematic review of 17 Canadian regulatory guidelines established to support the nursing practice of MAiD found substantial variability in the volume and quality of content provided throughout the regulatory

documents (Pesut et al., 2019b). The degree to which the regulatory documents were based upon evidence-informed research also varied, with reference lists specifying a single reference to two pages of cited references in the documents (Pesut et al., 2019b). The range in quantity and quality of regulatory documents demonstrates a diverse amount of support for nurses practicing throughout the country.

Nursing roles and responsibilities related to MAiD include: 1) knowledge responsibilities, 2) care responsibilities, 3) procedural responsibilities, 4) moral responsibilities, 5) collegial responsibilities, 6) societal responsibilities, and 7) institutional responsibilities (Pesut et al., 2019a). The language used to describe the contribution of the nurse's role ranged from only "aiding" the practitioner to playing a valuable relational role in the entire MAiD process (Pesut et al., 2019a). The wide variation in the emphasis on nursing roles and the supportive resources in place throughout Canadian provinces and territories presents role ambiguity for nurses (Fujioka et al., 2018).

Amongst various qualitative and quantitative studies published from the Netherlands and Belgium, there were numerous roles and responsibilities assumed by nurses in euthanasia care such as

Receiving the request from a patient for information about the option of physician-assisted dying; receiving the request from a patient for assistance in dying; participating as a member of the health care team in the decision-making process related to the request for assistance in dying; care of the patient if the request is denied; care of the patient if the request is agreed to, including presence or assistance during the administration of the drugs; aftercare of the patient; aftercare of the family; and debriefing of the team.

(Edwards, 2016, p. 20)

Specific to Nurse Practitioners, the Canadian Nurses Protective Society has advised that a review of legislation, regulatory documents, and organizational policies must be completed prior to engaging in MAiD assessment and provision (Canadian Nurses Protective Society, 2016; Edwards, 2016). Furthermore, Nurse Practitioners must ensure that they have the “knowledge, skills, and judgment to fulfill their responsibilities” within their established scope of practice (Edwards, 2016, p. 20; Canadian Nurses Protective Society, 2016).

2.6 Practice Settings

Based on the legislation, MAiD has not been isolated to a specific healthcare sector but integrated throughout the entire healthcare system (Pesut, Thorne & Greig, 2020). MAiD provision takes place in hospitals (36.5%), private individual residences (35.2%), palliative care units (20.6%), residential care (6.9%), and the remainder in other settings (1.0%) (Government of Canada, 2020). Approximately 1,271 independent practitioners performed a MAiD provision in 2019; 94.1% (1,196) were physicians and 5.9% (75) were nurse practitioners (Government of Canada, 2020). The majority of these independent practitioners were family medicine physicians (65.0%), palliative medicine specialists (9.1%), and anesthesiologists (5.0%) (Government of Canada, 2020). As MAiD requests and provisions are not confined to a particular setting, nurses must be properly supported throughout all practice settings to gain the knowledge required to care for individuals requesting MAiD and their families and/or caregivers.

For nurses who work in areas that do not often deal with end-of-life care, encountering a request for MAiD can be challenging. End-of-life care requires nurses to adjust their perspective lens to incorporate holistic care in the provision of end-of-life interventions, which can be a challenge for many nurses as it may be viewed as an opposition to their training, values, and beliefs (O’Shea & Mager, 2019). For nurses who are accustomed to providing end-of-life care,

MAiD is a further adjustment to their practice, as it involves assisting with directly hastening and causing death (Beuthin et al., 2018). Palliative care nurses have the same challenges in terms of role ambiguity, interprofessional collaboration, and navigating conscientious objection as nurses working in other areas (Fujioka et al., 2018). Conscientious objection can be defined as the act of a nurse self-identifying that their values and/or beliefs do not align with the person in their care (Canadian Nurses Association, 2017). In a quasi-experimental study conducted by O'Shea and Mager (2019), 61 nurses from the United States were provided with an educational program on end-of-life care entitled the End-of-Life Nursing Education Consortium. Nurses' knowledge of palliative care was assessed pre- and post-intervention using the Palliative Care Quiz for Nursing (PCCQN). Results from the pre-test knowledge score revealed that the nurses experienced in caring for terminally ill individuals and providing end-of-life care interventions had a baseline knowledge deficit (O'Shea & Mager, 2019). After participating in the educational intervention, post-test knowledge scores significantly improved to an average score of 75% (O'Shea & Mager, 2019). This study highlights the need for improved end-of-life care education in nursing programs and continuing education on end-of-life care for all nurses, regardless of whether they are currently practicing within palliative or end-of-life care.

2.7 Conscientious Objection

Nurses have a professional and ethical accountability to ensure that they critically reflect on whether or not they choose to participate in MAiD (Pesut, Thorne & Greig, 2020). Under the *Act to Amend the Criminal Code and to Make Related Amendments to Other Acts* are the statements, "everyone has the freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms*", "whereas nothing in this Act affects the guarantee of freedom of conscience and religion" and "...whereas the Government of Canada has

committed to develop non-legislative measures that... respect the personal convictions of health care providers” (Parliament of Canada, 2016, Chapter 3, paras. 11 and 13). These statements support health care providers in reflecting upon their values and morals and conscientiously deciding whether they choose to participate in MAiD without legal repercussions. For nurses who choose to conscientiously object to participate in MAiD provision in some capacity, they continue to have the professional obligation to inform their employers of their decision, never abandon the people they care for, and report any requests from people for MAiD services (Canadian Nurses Association, 2017). The obligation to report their decision of conscientious objection to their employer presumes the decision is an all-or-nothing position. However, the literature details that most nurses fall in the middle where they are morally and ethically uncertain of their overarching stance of whether to engage in MAiD or to conscientiously object, as nurses are ongoingly reflecting and trying to make sense of their thoughts and feelings (Beuthin et al., 2018; Pesut, Thorne & Greig, 2020). As MAiD assessors and providers, nurse practitioners have further stipulations embedded into the MAiD legislation to support conscientious objection. The *Eligibility for medical assistance in dying 241.2 (9)* indicates “for greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying” (Parliament of Canada, 2016, Chapter 3, section 9).

As conscientious objection is a complex concept and process, professional guidelines do not provide sufficient guidance in the complexities encountered through clinical practice (Pesut, Thorne & Greig, 2020). Nurses should be supported to engage in continuous moral learning, reflecting upon their moral intuition, the impact of their personal and professional relationships, and coherence with existing morals to help deliberate whether to participate in MAiD care (Pesut, Thorne & Greig, 2020).

2.8 Views and Attitudes

Nurses' views and attitudes towards death affect the quality of care provided to individuals undergoing end-of-life care (Ay & Oz, 2019). When these views and attitudes are intense and negative, they can impact the ability of nurses to communicate with individuals effectively, lead to avoidance of interaction, and lead to strong emotional reactions, such as distress, hopelessness, disappointment, anxiety, burnout, and ambiguity (Ay & Oz, 2019). Nurses' negative attitudes can be positively modified through the provision of death education, resulting in improved quality of end-of-life care (Ay & Oz, 2019). In a study conducted by Ay & Oz (2019), 340 nurses throughout 25 metropolitan hospitals throughout Ankara, Turkey, were provided with a "Nurse Information Form" and "Attitude Scale about Euthanasia, Death, and Dying Patients (DAS)" to evaluate nurses' attitudes and views towards end-of-life care. Results revealed that most of the nurses in the study displayed negative attitudes towards death, the dying patient, and euthanasia and that those who stated that they had knowledge regarding the concepts had more positive attitudes (Ay & Oz, 2019). Half of the nurses in their study also identified an educational need for the concepts. Having the requisite knowledge and skills regarding end-of-life care and learning effective coping strategies can provide a higher quality of care (Ay & Oz, 2019).

Fujioka et al. (2018) conducted a scoping review on health care providers' perspectives concerning their involvement in MAiD. Their review included 33 international articles involving various health care professionals, including nurses, and they sought to understand the roles of multiple providers and what challenges were encountered with requests for MAiD. Nurses were often the first point of contact for requests for MAiD and played an integral role throughout the entire care process, from the initial consult to the provision of MAiD to aftercare

support to bereaved family and/or caregivers (Fujioka et al., 2018). Challenges experienced by nurses included role ambiguity, unclear professional and/or legal guidelines, lack of interprofessional collaboration, difficulty safely navigating conscientious objection, and a lack of knowledge and/or training (Fujioka et al., 2018). A lack of knowledge and/or training for healthcare professionals related to MAiD and end-of-life care has been identified as a key concern suggesting improved education should be incorporated into healthcare curricula and ongoing training (Fujioka et al., 2018).

2.9 Review of Knowledge and Education

Entering the sixth year of MAiD legalization in Canada and the recent amendment to the MAiD legislation, now is the time to review the knowledge and education nurses need to provide competent, ethical care. The Canadian Nurses Association states in their MAiD Framework that “nursing regulatory bodies across the country have the legal mandate to protect the public by ensuring that nurses who practise are qualified and provide safe, competent, ethical care” (Canadian Nurses Association, 2017, p. 8). However, specific, mandatory MAiD education has not been incorporated into nursing education programs and continuing education throughout most provinces (Beuthin et al., 2018) and has been identified as a gap to be addressed (Fujioka et al., 2018; Pesut et al., 2019b). An overall gap in knowledge, training and/or education has also been identified throughout the literature (Ay & Oz, 2019; Beuthin et al., 2018; Fujioka et al., 2018; Suva et al., 2019). As nurses are both professionally and legally obligated to be knowledgeable and skilled in navigating the care of individuals requesting MAiD (Suva, Penney & McPherson, 2019), performing a systematic review of the knowledge and education needs identified by nurses regarding MAiD will provide a better understanding of the knowledge required to provide competent, ethical MAiD care.

A preliminary literature search was conducted of the JBI Database of Systematic Reviews and Implementation Reports, Prospero, Cochrane Database of Systematic Reviews, Medline, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and it was found that no systematic reviews or scoping reviews have been conducted or are underway on the knowledge and education needs of nurses regarding MAiD. As MAiD remains in its relative infancy, very few systematic reviews or scoping reviews were found. Systematic reviews and scoping reviews conducted, or protocols registered, regarding MAiD have focused on pharmacological barriers and strategies, the experiences, perspectives and attitudes of health professionals, and barriers and facilitators to assisted dying. There is one ongoing systematic review involving the concept of continuing education regarding end-of-life care (including palliation and MAiD), but it is focused on primary care providers.

Embedded in the legislation of Bill C-14 is the stipulation that “medical assistance in dying must be provided with reasonable knowledge, care, and skill and in accordance with any applicable provincial laws, rules, or standards (Parliament of Canada, 2016, Chapter 3, section 7).” As healthcare professionals, all nurses must be adequately prepared to care for individuals requesting MAiD due to the practical, ethical, personal, and legal ramifications associated with this end-of-life care option (Beuthin et al., 2018; Suva et al., 2019). The objective of this qualitative systematic review was to explore the knowledge and education needs identified by nurses regarding MAiD to provide direction and guidance for future research, nurse education, and training (Peters et al., 2020). A systematic review methodology was chosen to utilize transparent and rigorous methods to deliver an unbiased, comprehensive synthesis of existing international evidence (Joanna Briggs Institute, 2020). With MAiD in its relative infancy, a qualitative approach was chosen to explore the knowledge and education required by nurses, as

identified by nurses themselves through their experiences of MAiD (Joanna Briggs Institute, 2020).

2.10 Philosophical Assumptions/Theoretical Framework

The JBI Manual of Evidence Synthesis (2020) supports interpretive and critical paradigms as philosophical perspectives appropriately associated with qualitative evidence. An interpretive/constructivist lens was thoroughly considered and discussed with the thesis team as social constructivism, from the paradigm of interpretivism/constructivism, has grown and developed from the roots of educational psychology, particularly the learning theory from Piaget and Vygotsky (Aburn et al., 2020). Using the lens of social constructivism, it can be viewed that knowledge is constructed individually through experience and that individuals construct their own views of ‘truth,’ ‘reality’ and ‘knowledge’ (Aburn et al., 2020). Furthermore, incorporating social constructionism (often used interchangeably, inter-related or combined with constructivism) assumes that knowledge is reconstructed within relationships and social dynamics with others and within the environment (Aburn et al., 2020). Although JBI supports interpretivism for a qualitative synthesis (Joanna Briggs Institute, 2020), when reflecting on the ontology and epistemology of various paradigms, pragmatism aligned best with the investigator's belief system and approach in conducting this qualitative synthesis.

A paradigm serves as a “basic belief system or world view that guides the investigator, not only in choices of methods but in ontologically and epistemologically fundamental ways” (Guba & Lincoln, 1994, p. 105). Although a systematic review does not involve direct interaction with study participants, approaching any research endeavour with an identified paradigm will provide the focus for the researcher’s ontological and epistemological stance and direction for the most appropriate methods (Kelly et al., 2018). Philosophical focus may

strengthen research design, resulting in an enriched depth of enquiry and higher quality of research outcomes (Halcomb, 2018; Mills et al., 2006). Pragmatism aims to investigate real-world problems by utilizing the best and most appropriate methods, allowing for both qualitative and/or quantitative studies and methods to be used as needed (Allemang et al., 2021).

The objective of this qualitative systematic review was to investigate what knowledge and education needs are identified by nurses themselves in the context of MAiD, and to ultimately provide further information, insight, and guidance for the development of education, training, and resources to support nursing regarding MAiD. The ontology of pragmatism purports that reality is viewed and interpreted based on usefulness in specific contexts (Allemang et al., 2021). In this review, the reviewers (CM & JT) focused on the reality of the experiences and opinions of nurses to identify knowledge and education needs regarding MAiD. The pragmatic epistemology of transactional realism is centred on the belief that knowledge is constructed from interactions between people (in this review, this includes the nurses) and their environments (in this review, this includes the experience of exposure to MAiD in Canada) (Allemang et al., 2021). Although MAiD is a relatively novel end-of-life option, nurses are currently practicing at a time when MAiD is a very real and legal option. Nurses need to be adequately prepared to respond appropriately to MAiD requests and MAiD provisions. As pragmatism focuses on action-oriented inquiry, the assumptions of the pragmatic paradigm supported the reviewers (CM and JT) to explore the experiences described in various studies of nurses' experiences in the context of MAiD, linking meaning to these experiences and to, ultimately, aggregate knowledge as to the nurses' identified knowledge gaps and learning needs regarding MAiD (Allemang et al., 2021).

2.11 Adult Learning Theory

The decision to focus on a qualitative systematic review, and not quantitative or mixed studies, was driven by the adult learning theory approach. Considering the principles of andragogy introduced by Malcolm Knowles, his model of adult learning supports the assumptions that adult learners: 1) have accumulated life experience to draw upon as knowledge; 2) are self-directed and autonomous; 3) are driven by goals; 4) require relevancy and practicality to learn; 5) require respect; 6) are driven by internal and external motivation; 7) need to participate in the learning process actively; 8) benefit from immediate feedback; 9) thrive in a learning environment that is more informal and personal; and 10) not every person learns the same way (Collins, 2004; Tomei, 2010). Since 2016, nurses have had the opportunity to encounter MAiD within their practice, positioning nurses in a more ready mindset to learn about MAiD as they experience a need to cope with real-life tasks or implications (Jarvis, 2001). Focusing on the qualitative studies surrounding nurses' experiences, the reviewers leveraged the increasing self-directedness of adult learners and identified the pivotal needs for MAiD knowledge or education without the imposed boundaries or criteria found within quantitative studies (Jarvis, 2001).

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Chapter 3: Methodology

In this chapter, the methodology used for this systematic review of qualitative evidence was described. The sections in this chapter include a description and rationale of the inclusion criteria, the search strategy design and key search terms, the databases included in the review and rationale for selection, the methods used for assessing methodological quality, and the aggregation procedures. To maintain complete, accurate and transparent methods and results, sections were included that address the reviewer's risk of bias and overall rigour. Following this chapter, the results identified from this review were provided in Chapter Four.

3.1 Inclusion criteria

The inclusion criteria were determined based on the PICO acronym used to develop the research question, examining the population, the phenomenon of interest and the context (Joanna Briggs Institute, 2020). All licensed nurses and student nurses were included in the population, the phenomenon of interest included knowledge and education needs, and the context was focused on MAiD.

3.1.1 Types of participants

This review considered studies that included Registered Nurses, Licensed Practical Nurses, nursing students, advanced practice nurses, and Nurse Practitioners. Nursing students were included to investigate their perspectives and experiences during formative nursing education. Furthermore, nursing students can potentially encounter requests for MAiD or MAiD procedures during their practical placements with patients or family members. Although the scope and role of Nurse Practitioners regarding MAiD is different from other licensed nurses and students, Nurse Practitioners were included in the review to investigate the full spectrum of nursing perspectives regarding MAiD. Studies from all settings (e.g., community-based,

hospital-based, hospice care) that include the participants stated above were included in this review.

3.1.2 Types of intervention(s)/phenomena of interest

This review considered qualitative studies investigating nurses' knowledge, education and/or learning regarding medical assistance in dying. This review considered publications that describe the knowledge, education, information, learning, development, and teaching of nurses.

3.1.3 Context

This review considered all international studies that involve MAiD, euthanasia, assisted suicide, assisted dying, assisted death, and/or patient-directed dying. Studies were further evaluated as to their applicability to the MAiD Canadian legislative context. Settings included any setting where licensed nurses or student nurses practice, including but not limited to acute care, primary health care, and community care.

3.1.4 Types of studies

This review included studies of all kinds reporting on qualitative data.

3.2 Search strategy

This qualitative systematic review was conducted following the JBI methodology for systematic reviews of qualitative evidence (Joanna Briggs Institute, 2020). The search strategy aimed to find both published and unpublished studies. The unpublished studies included theses and dissertations. A three-step search strategy was developed in collaboration with an academic health science librarian. This search strategy included a preliminary search, comprehensive search, and hand search of reference lists of articles retained for full-text review.

3.2.1 Step one

Step one consisted of an initial limited search of MEDLINE and CINAHL to identify index terms and keywords. A logic grid of keywords was created from the index terms and keywords identified from titles and abstracts from papers and bibliographic databases to establish a specific and comprehensive search strategy tailored to the separate identified databases. The logic grid was presented below in Table 1: Search Strategy Terms.

3.2.2 Step two

Step two was the conduct of a second comprehensive search utilizing the identified index terms and keywords using the following databases: Cochrane, Joanna Briggs, Medline, CINAHL, Nursing and Allied Health, Embase, ERIC, PsychInfo, Web of Science, Education Source, and Proquest Dissertation and Theses Abstracts. The search of all databases was conducted on May 30th, 2021. A full detailed search strategy for each database was presented to detail how the database searches were executed to allow for transparency and reproducibility (see Appendix A). A total of 7473 articles were found when all database search results were combined, and a total of 4779 remained once duplicates were initially removed.

3.2.3 Step three

Step three involved a hand search of the reference lists of all sources identified for full-text review to identify reports, articles, and associations for additional relevant studies. Only studies available in English were considered for inclusion in this review due to language constraints of the main reviewers, cost of translation, and feasibility. The dates of publication included in this review spanned from 2001 to 2021. The date restriction was based on the first year that voluntary euthanasia was legalized in the first country, the Netherlands (World Health Organization, 2001).

3.3 The databases included in the search and rationale

A total of 11 databases were included in the search to ensure a broad amount of studies were captured. All databases were categorized according to their focus (see below), and a rationale for inclusion was included alongside each database.

3.3.1 Databases included to review published and current systematic reviews and scoping reviews:

Cochrane Library: a collection of evidence-based medicine databases, including The Cochrane Database of Systematic Reviews.

Joanna Briggs Institute EBP Database: searches an extensive range of summarized and appraised health care evidence, including nursing and medical care.

3.3.2 Databases included based on their focus of nursing, biomedical, and health sciences domains:

Medline: international literature relating to medicine and health care, including allied health fields, biological and physical sciences, humanities, and information science.

Cumulative Index to Nursing and Allied Health Literature (CINAHL): database that provides indexing for journals from the fields of nursing and allied health.

Nursing and Allied Health: database of journals, evidence-based resources and dissertations focused on nursing and allied health professions.

Excerpta Medica database (Embase): major international biomedical and pharmaceutical database.

APA PsycInfo (formerly PsycInfo): access to international scholarly literature (journal articles, books, dissertations, and technical reports) in the domains of psychology, social, behavioral, and health sciences.

Web of Science: database includes journals and conference papers in science, engineering, medicine, social sciences, and humanities.

3.3.3 Databases included based on their educational focus:

Educational Resources Information Center (ERIC): access to literature focused on education, and related domains of psychology and sociology.

Education Source: journals, books and conference papers that covers all education levels, including subspecialties of health education, assessment, and evaluation. Intended for students, professionals, and policymakers in education.

3.3.4 The search for unpublished studies included:

Dissertation Abstracts (Proquest Dissertation and Theses Abstracts).

3.5 Keywords used included

Medical assistance in dying, MAiD, euthanasia, assisted suicide, assisted dying, assisted death, patient-directed dying, nurs*.

Table 1

Search Strategy Terms

Search Strategy		
Use of main concepts, index terms and keywords identified from titles and abstracts from papers.		
	Concept 1	AND
	Medical assistance in dying	Concept 2
OR	MAiD	Nurses
OR	Euthanasia	Nursing
OR	Assisted suicide	Nurs*
OR	Physician assisted dying	
OR	Assisted death	
OR	Voluntary euthanasia	
OR	Physician assisted death	
OR	Physician assisted suicide	
OR	Right to die	
OR	Wish to die	

OR	Assisted dying	
OR	Patient-directed dying	

3.6 Initial text screening

All 4779 article results from the combined search of all databases were initially screened using their titles and abstracts. During the initial text screening process, all titles and abstracts that were not a study, such as opinion papers and conference abstracts, or were not a qualitative study, such as quantitative studies or synthesis reviews, were removed. Furthermore, all titles and abstracts that were not applicable to the topic of nurses and MAiD were also removed.

3.7 Full-text screening

A total of three rounds of full-text reviews were conducted. Records selected for inclusion in all rounds of full-text review met the following inclusion criteria: qualitative study methods, included nurses as study participants, applicable to the context of MAiD, and identified findings specifically labelled by the original study authors as “education”, “knowledge”, “information”, “learning”, “training”, or “development” required by nurses regarding MAiD and/or by light interpretation of the findings by the independent reviewers (CM & JT). All relevant sources were retrieved in full, and their citation details were imported into Covidence. The full text of selected citations was assessed in detail against the inclusion criteria by two independent reviewers (CM & JT). A narrative description of selection process was reported, including specific details and reasons as to why sources were selected for inclusion and exclusion. Accompanying the narrative description was a flowchart of the review process according to the PRISMA flow diagram in Figure 1 (Page et al., 2021). The flowchart demonstrates the flow of the search, source selection at each step in the process (from title/abstract to full-text review), removal of duplicates, and any additions from full-text review

(i.e. articles identified through a review of reference lists). Disagreements that arose between the reviewers at each stage of the selection process were resolved through discussion and did not require the assessment from an additional reviewer(s).

3.8 Assessment of methodological quality

The papers that passed the full-text screening were assessed by two independent reviewers (CM and JT) for methodological quality prior to inclusion in the review using the JBI critical appraisal instrument for qualitative research (see Appendix B). From the ten questions in the JBI critical appraisal instrument, each question that was marked as 'yes' received a score of 1 and any question marked as 'no', 'unclear' or 'not applicable' received a score of 0, with a total possible score of 10. The total scores were categorized, with a score of 0-3 indicating low quality, a score of 4-6 indicating moderate quality and a score of 7-10 indicating high quality. Each source selected from the full-text screening was appraised and scored, and those sources with a score of moderate or high quality were selected for inclusion. The decisions about the scoring system, categories and cut-off score for exclusion were discussed and agreed upon by the main reviewers (CM & JT) (Joanna Briggs Institute, 2020). The reviewers each performed the appraisals separately and were blinded to one another's assessments. Any disagreements that arose between the reviewers were resolved through discussion and consensus. There was no need for a third reviewer.

3.9 Data extraction/collection

Qualitative data were extracted from the papers included in the review using a revised version of the standardized data extraction tool Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (see Appendix C). A full article read was conducted by each independent reviewer (CM & JT) to identify data and findings for extraction, with repeated

reading of articles performed as needed to confirm findings. The data extracted includes specific details about the inclusion/exclusion criteria, evidence source details and characteristics, populations, phenomena of interest, context, study methods, and outcomes of significance to the review question and specific objectives. Detailed data extraction tables were created for each article, including the findings, summary statements, and supporting quotes (see Appendix E). Findings that were considered relevant to the review were findings specifically labelled by the original study authors as “education”, “knowledge”, “information”, “learning”, “training”, or “development” required by nurses regarding MAiD and/or by light interpretation of the findings by the independent reviewers (CM & JT). Light interpretation was defined as the quick and easy determination of opinion that an education or knowledge requirement was detailed in a paper but not overtly labelled as such. Light interpretation was conducted by the reviewers independently upon full-text review of the included articles, and the judgment of the finding was agreed upon by the independent reviewers (CM & JT) through discussion and consensus. Each finding included is accompanied by an illustration, either a direct quote from the original study authors’ own words or supportive information in the paper with a description of relevancy by the reviewer.

A level of credibility was assigned to each finding based on the perceived level of support the illustration provides for the finding. The three levels of credibility are: *unequivocal* (findings include an illustration that is beyond a reasonable doubt; therefore, not open to challenge), *credible* (findings include an illustration that lacks clear association; therefore, open to challenge) and *not supported* (findings not supported by data) (Joanna Briggs Institute, 2020). The process of how the level of credibility was determined, whether an agreement was reached

between the reviewers (CM & JT) and any issues encountered during the process is described in the results section in Chapter Four.

3.10 Data Synthesis

Qualitative research findings were pooled according to their level of quality and the categorization of findings on the basis of similarity of meaning (Joanna Briggs Institute, 2020). A qualitative synopsis table and synthesis figure (see Table 4 and Figure 2) were created to report on the findings, categories and synthesis topics identified throughout the data synthesis process. The categories established were subjected to a meta-synthesis to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice. Included in the aggregation are only credible and unequivocal findings. Unsupported findings were only discussed and presented in a table (see Table 4) but were not included in aggregation.

3.11 Risks of Bias and Rigour

The primary reviewer and author of this thesis (CM) were employed by the Ottawa Hospital as a Nurse Educator in the Intensive Care Unit. CM completed a placement with the MAiD team of the Ottawa Hospital during a course on Advanced Practice Nursing, and she continued to participate as a nurse during MAiD provisions with the Ottawa Hospital. It was during her placement that CM identified a knowledge and education gap throughout various nursing units within the Ottawa Hospital and proceeded to develop a thesis proposal surrounding this need. To address CM's potential risk of bias, CM instituted the rigorous strategies below to minimize the potential risk of bias from impacting the integrity of this thesis. An ongoing iterative reflective practice was carried out throughout each step of the review process among CM, her advisor (JT) and the committee team (AVD).

Throughout the systematic review process, strategies were used to ensure a rigorous process, including maintaining complete, accurate and transparent methods and results and an auditable search strategy. The reporting guidelines outlined in the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) statement were followed to ensure that the systematic review process is transparent (Page et al., 2021). The PRISMA guidelines also supported the necessary capture of information on how studies were identified, selected, appraised, and synthesized throughout the review process (Page et al., 2021). The Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement was also used to improve the conduct and reporting of the systematic review process to achieve transparency, reproducibility, and comprehensiveness (Tong et al., 2012). The ENTREQ statement (see Appendix D) consisted of a table with 21 items divided into five sections: introduction, methods and methodology, literature search and selection, appraisal, and synthesis of findings (Tong et al., 2012). Including an academic research librarian throughout the search methods also helped develop a high-quality search process.

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Chapter 4: Results

This chapter presented the results from the review process following the JBI methodology for systematic reviews of qualitative evidence (Joanna Briggs Institute, 2020). The sections in this chapter presented and summarized the results from the search process, the results from the assessment of methodological quality, the characteristics of the included studies, the results identified from the data collection and extraction process, and, ultimately, the findings from the meta-aggregation of credible and unequivocal data. The meta-aggregative approach is extremely valuable in aiming to provide generalizable statements that can be used as practice recommendations to guide nurses, educators, and policy makers (Joanna Briggs Institute, 2020).

4.1 Study Inclusion

A total of 7473 records were identified upon the completed search of the 11 databases, including Cochrane, Joanna Briggs, Medline, CINAHL, Nursing and Allied Health, Embase, ERIC, PsychInfo, Web of Science, Education Source, and Proquest (Figure 1). From the initial total records, 2694 records were identified as duplicates and were removed. The resulting 4779 records were added to Covidence and underwent the initial title and abstract screening by the two independent reviewers (CM & JT). Records were included if they appeared to be qualitative articles and applicable to nurses and Medical Assistance in Dying, MAiD, euthanasia, assisted suicide, assisted dying, assisted death, and/or patient-directed dying. Records were also included if there was uncertainty about whether they met the inclusion or exclusion criteria during the title and abstract screening. A total of 4555 records were excluded during title and abstract screening. The majority were excluded because they were quantitative or mixed methods studies, were written as opinion pieces or news articles, targeted the wrong population (e.g.,

physicians, pharmacists), or targeted the wrong context (not related to MAiD or the above-listed context terms). The remaining 224 articles underwent a full-text review.

A total of three rounds of full-text review were conducted. During the first round of full-text review, the two reviewers (CM & JT) independently evaluated the articles for inclusion and exclusion criteria. Records selected for inclusion in all rounds of full-text review met the following inclusion criteria: qualitative study methods, included nurses as study participants, applicable to the context of MAiD (or above-listed context terms), and identified findings specifically labelled by the original study authors as “education”, “knowledge”, “information”, “learning”, “training”, or “development” required by nurses regarding MAiD and/or by light interpretation of the findings by the independent reviewers (CM & JT). During this first round, 160 records were excluded based on the following: no discussion of knowledge or education need (n=45), wrong study design (n=39), did not identify specific knowledge or education need (n=27), did not identify needs and wrong study design (n=26), wrong context (n=16), duplicate (n=4), wrong setting (n=1), wrong outcomes (n=2), or wrong participants (n=1). This round of full-text review focused on inclusion and exclusion criteria that were easily identifiable.

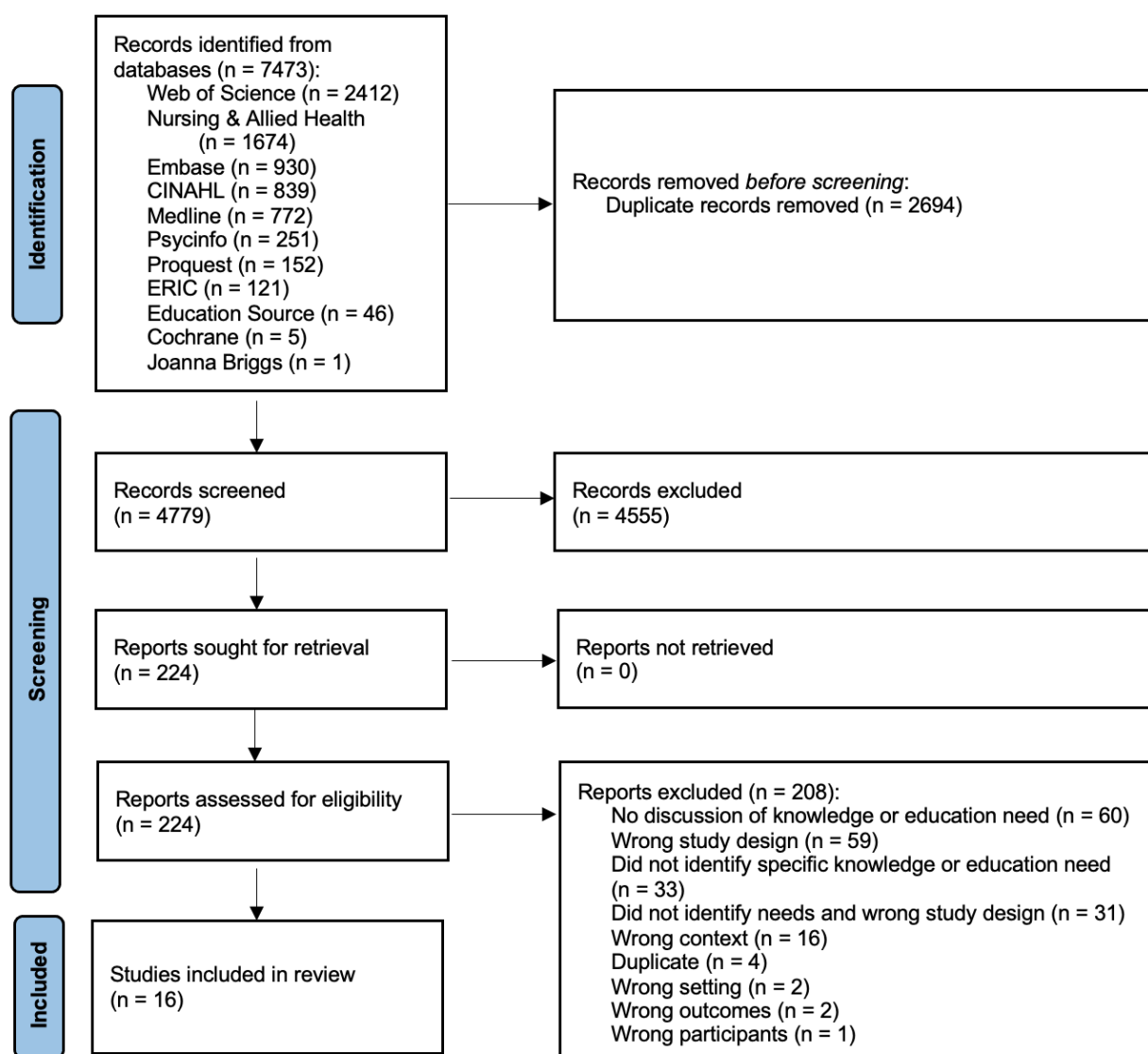
During the second round of full-text review, 37 records were excluded based on the following: no discussion of knowledge or education needs (n=14), wrong study design (n=18), did not identify needs and wrong study design (n=4), and wrong setting (n=1). The second round of full-text review required a more thorough discussion between the two independent reviewers (CM & JT).

During the third round of full-text review, ten records were excluded based on the following: no discussion of knowledge or education need (n=1), wrong study design (n=2), did not identify specific knowledge or education need (n=6), and did not identify needs and wrong

study design (n=1). Many of the articles during the final round of review (n=8) were excluded as they stated that further knowledge or education was needed for nurses, but they did not identify any specific knowledge or education needs. The remaining 16 articles were included for further assessment of methodological quality. A hand search was also performed of the reference lists of the selected 16 articles, and no further studies were identified for review.

Figure 1

Search Results flowchart



4.2 Methodological Quality

The final 16 articles selected for inclusion in the review were assessed for methodological quality using the JBI critical appraisal instrument for qualitative research (see Appendix B). Table 2 details the scoring of articles based on the JBI critical appraisal instrument. Out of the total 16 articles included in the review, nine articles scored 7/10, four articles scored 8/10, one article scored 9/10, and two articles scored 10/10. The average score was 7.8/10 for all articles. Therefore, all 16 articles were selected for inclusion after critical appraisal as none of the articles were assessed to be of low quality, with all articles appraised to be of high quality.

Question 1 from the JBI Critical Appraisal Checklist (Joanna Briggs Institute, 2020) evaluates whether there is congruity between the stated philosophical perspective and the research methodology. Over half of the articles (n=10) were given a response of “unclear”. The rationale for scoring “unclear” for this question is that although these articles did not overtly specify their philosophical perspective, there was potential for inference based on the wording and how the article was written. In scoring Question 6, the majority (n=12) of the articles did not include a statement that located the researcher culturally or theoretically beyond the listed country of origin for the author(s). Question 7 evaluates the researcher's influence on the research (or vice-versa). Results indicated that five of the 16 articles identified researcher influence, nine of the 16 articles made no mention of researcher influence, and two of the 16 articles were “unclear” regarding researcher influence.

Table 2

Critical Appraisal Results from use of JBI Critical Appraisal Checklist for Qualitative Research

Author Name; Year	Q. 1	Q. 2	Q. 3	Q. 4	Q. 5	Q. 6	Q. 7	Q. 8	Q. 9	Q. 10	Total Score
Beuthin, R., Bruce, A. & Scaia, M.; 2018	Unclear	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	7/10
Brown, J., Goodridge, D., Harrison, A., Kemp, J. Thorpe, L., & Weiler, R.; 2020	Unclear	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	7/10
Brown, J., Goodridge, D., & Thorpe, L.; 2020	Unclear	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	7/10
Bruce, A. & Beuthin, R.; 2020	Unclear	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	7/10
De Bal, N., Dierckx de Casterle, B., De Beer, T., & Gastmans, C.; 2006	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	9/10
Denier, Y., Gastmans, C., De Bal, N, & Dierckx de Casterle, B.; 2010	Unclear	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes	7/10
Freeman, S., Banner, D. & Ward, V.; 2021	Unclear	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	7/10
Ho, A., Joolae, S., Jameson, K., & Ng, C.; 2021	Unclear	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	7/10
Kopchek, L.; 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10
Mathews, J.J., Hausner, D., Avery, J., Hannon, B., Zimmermann, C., & al-Awamer, A.; 2021	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9/10
McMechan, C., Bruce, A. & Beuthin, R.; 2019	Unclear	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	8/10
Oczkowski, S.J.W., Crawshaw, D., Austin, P., Versluis, D., Kalles-Chan,	Unclear	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes	7/10

G., Kekewich, M., Curran, D., Miller, P.Q., Kelly, M., Wiebe, E., Dees, M., & Frolic, A.; 2021											
Pesut, B., Thorne, S., Schiller, C., Greig, M., Roussel, J., & Tishelman, C.; 2020	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	8/10
Schwarz, J.K.K.; 2002	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10
Volker, D.L.; 2001	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	8/10
Ward, V., Freeman, S. & Banner, D.; 2021	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	8/10

Q.1: Is there congruity between the stated philosophical perspective and the research methodology? Q.2: Is there congruity between the research methodology and the research question or objectives? Q.3: Is there congruity between the research methodology and the methods used to collect data? Q.4: Is there congruity between the research methodology and the representation and analysis of data? Q.5: Is there congruity between the research methodology and the interpretation of results? Q.6: Is there a statement locating the researcher culturally or theoretically? Q.7: Is the influence of the researcher on the research, and vice-versa, addressed? Q.8: Are participants, and their voices, adequately represented? Q.9: Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body? Q.10: Do the conclusions drawn in the research report flow from the analysis or interpretation of the data?

4.3 Characteristics of Included Studies

As this review considered all international studies involving medical assistance in dying (MAiD), euthanasia, assisted suicide, assisted dying, assisted death, and/or patient-directed dying, studies were further evaluated on their applicability to the MAiD Canadian legislative context. Only two criteria were used to evaluate whether the studies were applicable to the MAiD Canadian legislation context with the intention to be relatively inclusive and capture as much applicable data as possible. The two criteria were: 1) that the studies needed to have been based in Canada or 2) international studies needed to have active legislation in assisted dying at the time of study. Of the final 16 articles included in the review, 12 of the 16 were from Canada, two of the 16 from Belgium, and two of the 16 from the United States. The dates of publication ranged from 2001 to 2021. A table summarizing the characteristics of the included studies is found below in this section (Table 3). As MAiD is a legislative regime specific to Canada, it is appropriate that most of the studies were conducted in Canada, because they specifically apply to the MAiD context. The two studies from Belgium focused on euthanasia as the phenomenon of interest. Euthanasia is defined in the Belgian Euthanasia Act as the act of a physician administering lethal drugs with the explicit intent of ending a person's life after receiving an explicit request from that person to end their life (De Bal et al., 2006). The only mention of nursing involvement in the Belgian legislation is that nurses who have regular contact with the person who has requested euthanasia must be informed of the request and included in discussion with the team (De Bal et al., 2006). The two studies from the United States were focused on assisted dying and assistance in dying as the phenomena of interest. The broad phenomenon of assisted dying was defined as any means of provision to intentionally end a person's life, which may include assisted suicide, active euthanasia, providing a person with resources to support the

person to end their own life, actively assisting a person to end their life, or not providing interventions to prevent a person from ending their own life (Volker, 2001). Assistance in dying was more specific as an intervention that included either assisted suicide or active euthanasia (Schwarz, 2002). Both reviewers (CM & JT) agreed that the phenomena of interest identified in the studies from Belgium and the United States were applicable to the Canadian context.

There was a total of 16 qualitative studies included in the review. The study designs included 3/16 narrative inquiry, 3/16 interpretive descriptive, 2/16 grounded theory, 1/16 exploratory descriptive, 4/16 qualitative descriptive, 1/16 descriptive, naturalistic and 2/16 phenomenological approach. Most studies (n=15) involved semi-structured interviews by telephone, Skype, or in-person with an interviewer(s). One study by Volker (2001) used anonymously submitted written stories that were transcribed and analyzed.

The sample sizes of the included studies ranged from eight to 59 participants. The study by Pesut, Thorne, Schiller, Greig, Roussel, et al. (2020) included the largest sample size of 59 nurses. There was a combined total of 318 participants included in the 16 studies, but it is important to note that 7/16 studies included a sample of mixed participants and did not include nurses solely. The study by Brown, Goodridge, Harrison, et al., (2020) included patients (n=5), family members (n=11), and health care providers [physicians (n=3), social workers (n=4), and nurses (n=7)] in their participant sample to explore the variety of perspectives on MAiD care access and delivery and provide recommendations to improve a regional MAiD program. Ten key informants from the disciplines of pharmacy (n=1), social work (n=2), medicine (n=1), and nursing (n=6) were included in the sample from the study by Brown, Goodridge, & Thorpe (2020). This provided insight into the drivers and restrainers influencing MAiD inclusion into curricula, reviewed the required resources for teaching MAiD, and examined the current

placement of MAID concepts concerning existing end-of-life concepts in curricula. Freeman et al. (2021), in a similar study, interviewed hospice care providers (n=8), including formal care providers (e.g., registered nurse, care aide, grief support worker, and care manager) or facility-affiliated informal care providers (e.g., trained hospice volunteer or program coordinator), to explore how the experience caring for patients who chose to undergo MAiD affected their professional role.

The study by Ho et al. (2021) included physicians (n=7), nurses (n=12), social workers (n=5), and spiritual health practitioners (n=2), exploring the challenges palliative and hospice care providers face and resources that can support clinicians' work in providing person-centred end-of-life (EOL) care after the legalization of MAiD. Physicians (n=13) and nurses (n=10) were involved in the study by Mathews et al. (2021), as their study sought to understand how MAiD has impacted palliative care practice for physicians and nurses. Oczkowski et al. (2021) incorporated physicians (n=14), nurse practitioners (n=3), a social worker (n=1), a clinical manager (n=1), and a nurse (n=1) in their study describing MAID clinicians' perspectives on quality of care in MAID, including challenges, successes, and clinical practice suggestions. In the study by Ward et al. (2021), they described the perception of MAiD in an inpatient hospice facility that does not provide MAiD from the view of hospice care providers (n=8) (grief support workers, hospice volunteers, registered nurses, care aides, unit clerks, and administrators).

Throughout the data extraction and data analysis process of this systematic review, findings were diligently selected that focused on the data from nurses and nurse practitioners from all the studies that involved samples of mixed participants. However, out of the 7 studies with mixed samples, 4 studies did not clearly differentiate their findings from specific

participants and instead grouped all participants together, making it difficult for the reviewer (CM) to determine findings specific to nurses or nurse practitioners from the overall sample.

Ten of the 16 studies included nurses only: some included a mix of nurses ($n=3$), such as registered nurses, licensed practical nurses, and nurse practitioners. One study focused only on nursing students ($n=1$), and some studies only included practicing nurses ($n=5$). From the studies that included a mix of nurses, Beuthin et al. (2018) selected 17 nurses (NPs, RNs, and LPNs) to understand the range of nurses' experiences in providing care for someone choosing MAiD or declining to participate. To understand how nurses' experiences of suffering are being shaped through caring for patients and families choosing MAiD, Bruce & Beuthin (2020) selected 15 nurses (RNs, NP and LPN) as their sample participants. Schwarz (2002) included nurses and 1 NP in their study to explore nurses' experiences and responses to patient requests for assistance in dying. One study that included only nursing students in their sample of participants did so to explore their perspectives of the curricula surrounding MAiD and to identify potential gaps in existing knowledge and skills (McMechan et al., 2019). The remaining five studies that only included nurses focused on exploring the involvement of nurses in the care of patients requesting euthanasia, including communication and ethical decision making, and describing how nurses construct good nursing practice within the context of MAiD (De Bal et al., 2010; Kopchek, 2020; Pesut, Thorne, Schiller, Greig, Roussel, et al., 2020).

Table 3

Summary of Included Articles

Author	Year; Country	Title	Research Question; Aim/Objectives	Study Design	Phenomenon of Interest	Participants	Data Collection
Beuthin, R., Bruce, A. & Scaia, M.	2018; Canada	Medical assistance in dying (MAiD): Canadian nurses' experience.	To understand the range of nurses' experience in providing care for someone choosing MAiD, whether directly aiding, providing supportive care, or declining to participate.	Narrative inquiry	Medical Assistance in Dying	17 nurses (NPs, RNs, and LPNs) from urban and rural areas across Vancouver Island, British Columbia, working across settings including acute care, residential care, primary care clinics, and community and palliative care.	Semi-structured interviews.
Brown, J., Goodridge, D., Harrison, A., Kemp, J. Thorpe, L., & Weiler, R.	2020; Canada	Medical Assistance in Dying: Patients', Families', and Health Care Providers' Perspectives on Access and Care Delivery.	To explore patient, family, and health care provider perspectives on MAiD care access and delivery, and provide recommendations to improve a regional MAiD program.	Interpretive descriptive	Medical Assistance in Dying	5 patients, 11 family members, and 14 health care providers (3 physicians, 4 social workers, and 7 nurses). Setting was in a Saskatchewan regional health authority.	Semi-structured interviews.

Brown, J., Goodridge, D., & Thorpe, L.	2020; Canada	Medical Assistance in Dying in health sciences curricula: A qualitative exploratory study.	To (1) provide insight into the drivers and restrainers influencing MAiD inclusion into curricula, (2) review the required resources for teaching MAiD, and (3) examine the current placement of MAiD concepts in relation to existing end-of-life (including palliative care) concepts.	Exploratory-descriptive	Medical Assistance in Dying	10 key informants. Key informants: pharmacy (1), social work (2), medicine (1), nursing (6).	Semi-structured interviews.
Bruce, A. & Beuthin, R.	2020; Canada	Medically Assisted Dying in Canada: "Beautiful Death" is Transforming Nurses' Experiences of Suffering.	To understand how nurses' experiences of suffering are being shaped through caring for patients and families choosing MAiD.	Narrative inquiry	Medical Assistance in Dying	15 nurses (RNs, NP, and licensed practical nurse); worked in diverse settings, including acute care, community-home care, and specialty areas including emergency room and palliative care.	Semi-structured interviews.
De Bal, N., Dierckx de Casterle, B., De Beer, T.,	2006; Belgium	Involvement of nurses in caring for patients requesting euthanasia in	To explore nurses' involvement in the care for patients	Grounded theory	Euthanasia	15 nurses, including 1 intensive care, 1 oncology, 8 palliative care, and 5 internal medicine nurses.	Semi-structured interviews.

<p>& Gastmans, C.</p>		<p>Flanders (Belgium): A qualitative study.</p>	<p>requesting euthanasia. To provide an in-depth understanding of the experiences of Belgian nurses who are involved in the care of patients with a euthanasia request (prior to euthanasia legalization).</p>			<p>Setting: two general hospitals and a palliative care setting in Flanders (Belgium).</p>	
<p>Denier, Y., Gastmans, C., De Bal, N, & Dierckx de Casterle, B.</p>	<p>2010; Belgium</p>	<p>Communication in nursing care for patients requesting euthanasia: a qualitative study.</p>	<p>How does nurses' communication contribute to the euthanasia care process in a legal context?</p>	<p>Grounded theory</p>	<p>Euthanasia</p>	<p>18 Flemish nurses; 9 different hospitals throughout 5 provinces in Flanders; nurses working in different units.</p>	<p>Semi-structured interviews.</p>
<p>Freeman, S., Banner, D. & Ward, V.</p>	<p>2021; Canada</p>	<p>Hospice care providers experiences of grappling with medical assistance in dying in a hospice setting: a qualitative descriptive study.</p>	<p>To focus more narrowly on how the care provider experience caring for patients who chose to undergo MAiD effects their role as a hospice care provider.</p>	<p>Qualitative descriptive</p>	<p>Medical Assistance in Dying</p>	<p>8 hospice care staff; including formal care provider (e.g., registered nurse, care aide, grief support worker, and care manager) or facility-affiliated informal care providers (e.g., trained hospice volunteer or program coordinator). Western Canada</p>	<p>Semi-structured interviews.</p>

<p>Ho, A., Joolae, S., Jameson, K., & Ng, C.</p>	<p>2021; Canada</p>	<p>The Seismic Shift in End-of-Life Care: Palliative Care Challenges in the Era of Medical Assistance in Dying.</p>	<p>To examine palliative and hospice care providers' (PHCP) experiences and perspectives in providing EOL care after the legalization of MAiD. To explore challenges PHCPs face and resources that can support clinicians' work in providing person-centered EOL care.</p>	<p>Phenomenological</p>	<p>Medical Assistance in Dying</p>	<p>26 PHCP participants, including 7 physicians, 12 nurse, 5 social workers, and 2 spiritual health practitioners. Participants worked in community, hospice, hospital palliative care, or multiple site settings in Vancouver, Canada.</p>	<p>Semi-structured interviews.</p>
<p>Kopchek, L.</p>	<p>2020; Canada</p>	<p>How do Palliative Care Registered Nurses Apply Concepts of Ethical Decision-Making When Caring for Patients who Request Medical Assistance in Dying? An Interpretive Descriptive</p>	<p>To understand how palliative care RNs apply the concepts of ethical decision-making when caring for patients who request MAiD. Research questions: 1) How do palliative care RNs apply concepts of ethical decision-making when</p>	<p>Interpretive descriptive</p>	<p>Medical Assistance in Dying</p>	<p>10 palliative care nurses, including 3 acute care, 4 hospice care, 1 long-term care, and 2 community care. 9 worked in an urban setting and 1 worked in a rural area. 1 palliative care nurse identified as disagreeing with MAiD. All participants work in Ontario, Canada.</p>	<p>Semi-structured interviews.</p>

		Qualitative Study.	caring for patients who request MAiD?, and 2) What are the educational needs of RNs related to ethical decision-making and MAiD?				
Mathews, J.J., Hausner, D., Avery, J., Hannon, B., Zimmermann, C., & al-Awamer, A.	2021; Canada	Impact of Medical Assistance in Dying on palliative care: A qualitative study.	To understand how Medical Assistance in Dying has impacted palliative care practice for physicians and nurses. Research question: How has Medical Assistance in Dying impacted palliative care practice for physicians and nurses in Canada?	Qualitative descriptive	Medical Assistance in Dying	23 palliative care providers from Southern Ontario, Canada. 13 physicians and 10 nurses who worked in various settings, including inpatient consult services, inpatient palliative care units, outpatient clinics, home-based palliative care, and residential hospices, with several participants working in more than one setting.	Semi-structured interviews.
McMechan, C., Bruce, A. & Beuthin, R.	2019; Canada	Canadian Nursing Students' Experiences with Medical Assistance in Dying.	To explore the experiences of senior nursing students in caring for patients who choose a medically assisted death. To understand	Narrative inquiry	Medical Assistance in Dying	9 fourth-year students in a Bachelor of Science in Nursing program in a Canadian university. 2 students were practicing licensed	Semi-structured interviews.

			students' perceptions of their educational preparation regarding MAiD and to identify potential gaps in existing knowledge and skills.			practical nurses at the time of interviews.	
Oczkowski, S.J.W., Crawshaw, D., Austin, P., Versluis, D., Kalles-Chan, G., Kekewich, M., Curran, D., Miller, P.Q., Kelly, M., Wiebe, E., Dees, M., & Frolic, A.	2021; Canada	How We Can Improve the Quality of Care for Patients Requesting Medical Assistance in Dying: A Qualitative Study of Health Care Providers.	To describe MAiD clinicians' perspectives on quality of care in MAiD, including challenges, successes, and clinical practice suggestions.	Qualitative descriptive	Medical Assistance in Dying	20 healthcare providers from four Canadian centers (Hamilton, Niagara, Ottawa and Vancouver). 3 centers had hospital-based MAiD teams, and the fourth was an outpatient clinic. Participants included physicians (n=14), NP (n=3), Social worker (n=1), Clinical manager (n=1), and nurse (n=1).	Semi-structured interviews.
Pesut, B., Thorne, S., Schiller, C., Greig, M., Roussel, J., & Tishelman, C.	2020; Canada	Constructing Good Nursing Practice for Medical Assistance in Dying in Canada: An Interpretive	To better understand the policy, practice, and ethical implications of MAiD for nursing. To describe how nurses construct	Interpretive descriptive	Medical Assistance in Dying	59 nurses.	Semi-structured interviews.

		Descriptive Study.	good nursing practice within the context of this new end-of-life option.				
Schwarz, J.K.K.	2002; United States	Assistance in Dying: The Nurse's Experience.	To explore nurses' experiences and responses to patient requests for AID. Research question: how do professional nurses experience and respond to a request for AID from a decisionally capable person?	Phenomenological approach (hermeneutic)	Assistance in Dying	10 nurses, including 4 in home hospice care, 2 in critical care, 1 a family nurse practitioner and expert AIDS nurse.	Interviews - participants told their stories of experiencing patient requests for AID.
Volker, D.L.	2001; United States	Oncology Nurses' Experiences with Requests for Assisted Dying from Terminally Ill Patients with Cancer.	To explore oncology nurses' experiences with receiving requests from terminally ill patients with cancer for assisted dying.	Descriptive, naturalistic	Assisted Dying	40 nurses; clinical nurse specialist group was purposively heavily sampled.	Anonymously submitted written stories.
Ward, V., Freeman, S. & Banner, D.	2021; Canada	Hospice Care Provider Perspectives of Medical Assistance in Dying in a Canadian	To describe hospice care provider perceptions of MAiD in an in-patient hospice facility that does	Qualitative descriptive	Medical Assistance in Dying	8 participants including grief support workers, hospice volunteers, registered nurses, care aides, unit clerks, and	Semi-structured interviews.

		Hospice That Does Not Provide Medical Assistance in Dying.	not provide MAiD.			administrators from an independent hospice facility that does not provide MAiD on site. Smaller community setting within a western region of Canada.	
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4.4 Extracted Findings

There were 99 extracted findings from all 16 studies included in the review. All extracted findings were evaluated for their level of credibility (unequivocal, credible, or unsupported) based on whether the finding was supported by an illustration and the perceived level of support the illustration provides for the finding (Joanna Briggs Institute, 2020). All extracted findings were evaluated by both reviewers (CM & JT). Twenty-four findings were assessed to be unequivocal (findings included an illustration that was found to be beyond a reasonable doubt; therefore, not open to challenge), and 56 findings were assessed to be credible (findings included an illustration that lacked clear association; therefore, open to challenge) (Joanna Briggs Institute, 2020). A total of 19 findings were unsupported (findings not supported by data/illustration) (Joanna Briggs Institute, 2020); therefore, these findings were not included in the meta-aggregation. All extracted findings and their level of credibility are summarized in Table 4. Detailed data extraction tables were created for each article with illustrations and can be found in Appendix E. There was full agreement between both reviewers regarding the assessment of the level of credibility for all findings, resulting in no disagreements or need for a third reviewer. Ultimately, 80 extracted findings were included in the meta-aggregation and final synthesis.

Table 4

Extracted Findings

Findings/Themes (as labeled by the author(s))	Illustrative Codes YES/NO	Beuthin, R., Bruce, A. & Scaia, M. (2018)	Brown, J., Goodridge, D., Harrison, A., Kemp, J. Thorpe, L., & Weiler, R. (2020)	Brown, J., Goodridge, D., & Thorpe, L. (2020)	Bruce, A. & Beuthin, R. (2020)	De Bal, N., Dierckx de Casterle, B., De Beer, T., & Gastmans, C. (2006)
Diverse levels of comfort and competence reflected in varying levels of engagement	NO	U				
Drawing on existing competencies	NO	U				
Technical skills – Intravenous Insertion	YES	C				
Communication skills	YES	C				
Foster open conversations about moral distress and objection	YES	UE				
Understand and feel prepared to respond to situations (<i>requests</i>) and questions from patients and families	YES	UE				
Understand the ongoing sensemaking process (<i>debriefs, ethical conversations, forums</i>)	YES	C				
Update and clarify Code of Ethics	YES	C				
Update and clarify legal requirements	YES	C				

Simulation and role play	NO	U				
Mandatory MAiD education	NO	U				
Program procedures and care standards (<i>care pathways</i>)	YES		C			
Practice relational care	NO		U			
Post death documentation	YES		C			
Mentorship	NO		U			
The role and scope of practice of interdisciplinary team members	YES		UE			
Sensitive and holistic communication with patients and families	NO		U			
Respect and support for care practice choices	YES		UE			
Professional association direction/guidelines	YES			C		
Care Pathways	YES			C		
Case Studies				C		
Interprofessional problem-based learning				C		
MAiD curriculum	YES			UE		
Content Champion/Lead	YES			UE		
Enhanced understanding of MAiD for faculty	YES			C		
Student role/scope of practice	YES			C		

Curriculum placement/clinical encounters	YES			C		
Mandatory education	YES				UE	
Openness and reflection	YES				C	
Engage in conversations and deeper philosophical and ethical discussions	YES				C	
Coping with a request	YES					C
Role in caring for patients with a euthanasia request	YES					C
Competencies for each stage in process	YES					C
Team skills	YES					C

UE = Unequivocal, C = Credible, U = Unsupported

Findings/Themes (as labeled by the author(s))	Illustrative Codes YES/NO	Denier, Y., Gastmans, C., De Bal, N, & Dierckx de Casterle, B. (2010)	Freeman, S., Banner, D. & Ward, V. (2021)	Ho, A., Joolae, S., Jameson, K., & Ng, C. (2021)	Kopchek, L. (2020)	Mathews, J.J., Hausner, D., Avery, J., Hannon, B., Zimmermann, C., & al-Awamer, A. (2021)
Communication in the context of care for the patient and family	YES	UE				
Communication in the interprofessional context	YES	UE				
Knowledge of Act on Euthanasia (<i>legislation</i>)	YES	C				
Guidelines for nursing communication during euthanasia care process	YES	C				

Communication tools to support discussion regarding MAiD	YES		C			
Space to reflect and connect with others about their experiences	YES		C			
MAiD legislation	NO			U		
Institutional policies	NO			U		
Professional colleges' and health authorities' procedural requirements	NO			U		
MAiD communication	YES			UE		
Team and individual debriefs	YES			UE		
Legislation rules and/or guidelines	YES				C	
Legal ramifications for nurses	YES				C	
Ethical training to make ethical decisions	YES				UE	
Self-reflection	YES				UE	
Answer questions and have conversations	YES				UE	
Formal and informal debriefing	YES				UE	
Mandatory education	YES				UE	
Compassion fatigue	NO				U	
Resilience training	NO				U	
Communication teaching and difficult conversations	YES					C
Sense-making	YES					C
Ethical decision-making	YES					UE

UE = Unequivocal, C = Credible, U = Unsupported

Findings/Themes (as labeled by the author(s))	Illustrative Codes YES/NO	McMechan, C., Bruce, A. & Beuthin, R. (2019)	Oczkowski, S.J.W., Crawshaw, D., Austin, P., Versluis, D., Kalles-Chan, G., Kekewich, M., Curran, D., Miller, P.Q., Kelly, M., Wiebe, E., Dees, M., & Frolic, A. (2021)	Pesut, B., Thorne, S., Schiller, C., Greig, M., Roussel, J., & Tishelman, C. (2020)	Schwarz, J.K.K. (2002)	Volker, D.L. (2001)
Roles and responsibilities (<i>nurses and student nurses</i>)	YES	UE				
Fear of saying the wrong thing	YES	UE				
Honouring patient autonomy	YES	UE				
Lectures and workshops by health professionals with MAiD experience	YES	C				
Exposure to MAiD in nursing program	YES	C				
Understand conscientious objection	YES	C				
Opportunities to clarify and work through feelings	YES	C				
Engaging in reflective activities	YES	C				
Formalized MAiD curricula	YES	C				
Informed of evolving legislation and guidelines - professional organizations	YES	C				

Informed of evolving legislation and guidelines - regulatory standards	YES	C				
Informed of evolving legislation and guidelines - institutional policies	YES	C				
Simulation and role play	YES	C				
Ethical decision making and using ethical frameworks	YES	C				
Peer debriefing	YES		UE			
Standardized assessment guides and documentation	YES		C			
How to handle unique conversations	YES		UE			
Mentorship during MAiD assessment and provision	NO		U			
Regular feedback sessions	NO		U			
Continuing education (<i>conferences, research</i>)	NO		U			
Conducting initial conversations (<i>Nurse practitioners</i>)	YES			C		
Inquiries to registered nurses	YES			C		
Preparing everyone for what to expect	YES			C		
Establish intravenous access	YES			C		
Planning meticulously	YES			C		

Mentorship from those experienced with MAiD	NO			U		
Debriefing	NO			U		
Observation of provision	YES			C		
Best practices	NO			U		
Structured education	NO			U		
Code of ethics	YES				C	
Moral reflection	YES				C	
Ethical decision making	YES				C	
Respond to implicit and explicit requests	YES				C	
Reflect upon their own beliefs and values	YES				C	
Uncertainty about actions taken or personal beliefs	YES					C
Communication skills	YES					C
Patient (<i>and family</i>) teaching	YES					C
Patient requests	YES					C

UE = Unequivocal, C = Credible, U = Unsupported

Findings/Themes (as labeled by the author(s))	Illustrative Codes YES/NO	Ward, V., Freeman, S. & Banner, D. (2021)				
Conversations or debriefs with colleagues	YES	UE				
Care for patients undergoing MAiD in a non-provider facility	YES	UE				
Communicate with patients undergoing MAiD	YES	C				

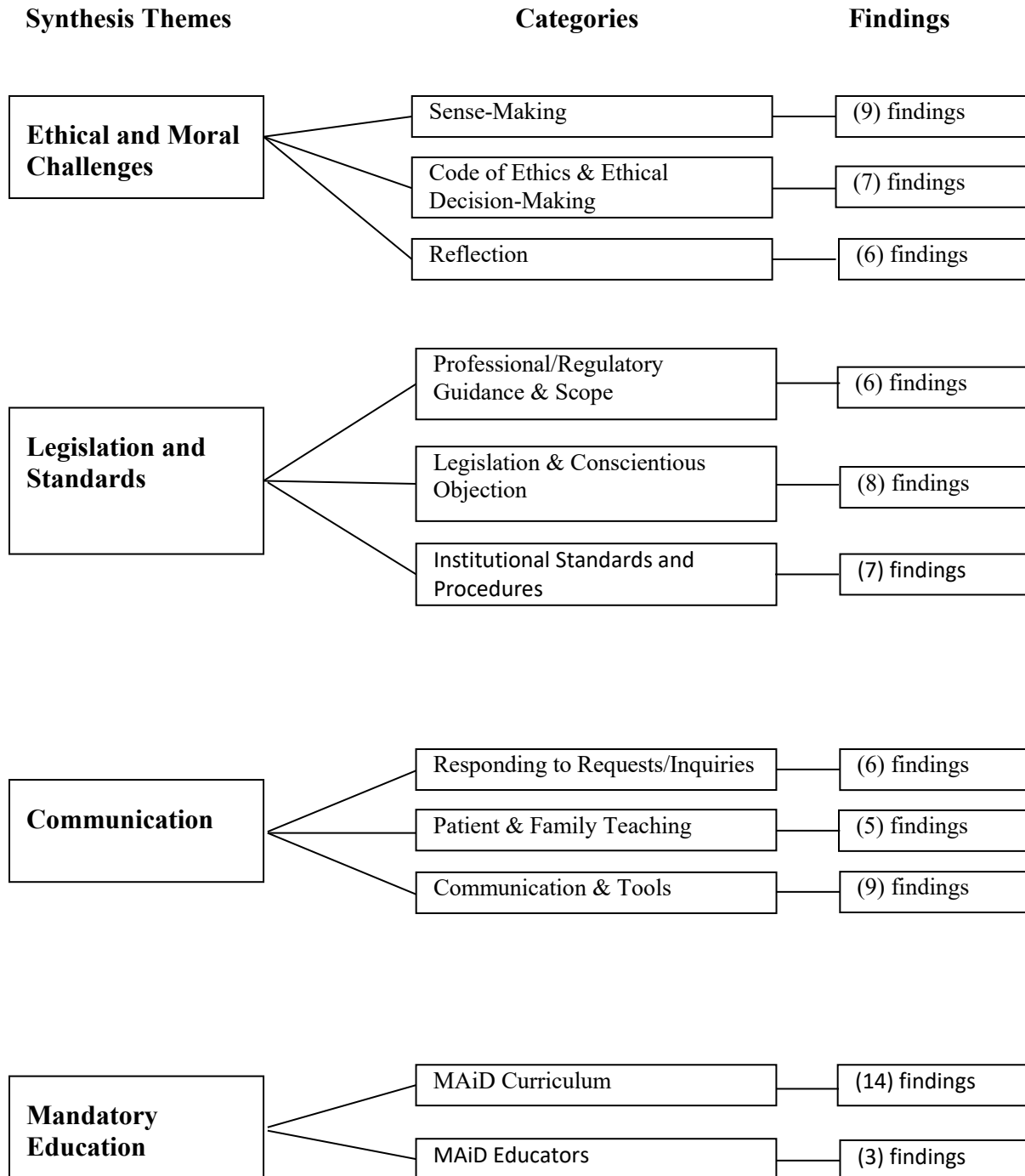
UE = Unequivocal, C = Credible, U = Unsupported

4.5 Meta-Aggregation of the Findings

Following the data collection and extraction process, data were analyzed and synthesized by the approach of meta-aggregation as per the JBI approach to qualitative synthesis (Joanna Briggs Institute, 2020). A schematic in the form of a data synthesis figure was created by consolidating the findings, categories, and synthesis topics from meta-aggregation (see Figure 2). Both reviewers assessed the table (CM & JT), discussed, and revised it to represent the meta-aggregation results adequately. There were a total of four synthesis themes: ethical and moral challenges, legislation and standards, communication, and mandatory education. The theme of *ethical and moral challenges* involved three sub-categories: (1) sense-making, (2) code of ethics and ethical decision-making, and (3) reflection. The theme of *legislation and standards* involved three sub-categories: (1) professional/regulatory guidance and scope, (2) legislation and conscientious objection, and (3) institutional standards and procedures. The theme of *communication* was divided into three sub-categories: (1) responding to requests/inquiries, (2) patient and family teaching, and (3) communication and tools. Finally, the theme of *mandatory education* involved two sub-categories: (1) MAiD curriculum and (2) MAiD educators.

Figure 2

Summary of Meta-Aggregation



4.5.1 Theme one: ethical and moral challenges

The theme of ethical and moral challenges contains a total of 22 findings from 10 separate studies and includes three sub-categories: 1) sense-making, 2) code of ethics and ethical decision-making, and 3) reflection.

4.5.1.1 Sense-making. Nurses identified a lack of understanding of the ongoing sense-making process related to MAiD (Beuthin et al., 2018; Bruce & Beuthin, 2020; Ho et al., 2021; Kopchek, 2020; Mathews et al., 2021; McMechan et al., 2019; Oczkowski et al., 2021; Volker, 2001; Ward et al., 2021). Sense-making was described as a dynamic continuum of the interplay of personal and professional values about life, death, suffering, and nursing (Beuthin et al., 2018). Specifically, nurses spoke to their ongoing sense-making process or their journey of learning and adaptation to determine their personal stance in relation to both the practice and values of MAiD and their own personal values (Beuthin et al., 2018; Mathews et al., 2021). Not a fixed state but a dynamic continuum ranging from “strongly opposed,” “in-between” or “strongly supportive,” nurses continuously reflected and re-evaluated their involvement in MAiD to identify their viewpoint (Beuthin et al., 2018). Experiences of moral uncertainty, conflict and distress were shared by nurses when they felt their values or principles were in competition with trying to address the patient’s or family’s request and uphold professional values (Volker, 2001).

I didn’t know what to say. This was the first time somebody was asking me something like that. My answer was “no.” I told them their request was going against my ethical principles. However, deep inside of me, I was in conflict. I didn’t want [the patient] to suffer, I didn’t have anything else to offer her, so I wanted to do it. But, on the other hand, my ethical values were telling me not to do it. (Volker, 2001, p. 45)

To provide opportunities to clarify and work through their feelings and sense-making process, nurses emphasized the importance of debriefing, ethical conversations, discussions, and forums (Beuthin et al., Bruce & Scaia, 2018; Bruce & Beuthin, 2020; Mathews et al., 2021). Regardless of the setting, nurses requested a safe space to check in and allow the expression of emotions and discussion of issues of moral distress (Beuthin et al., 2018). Whether it be informal sessions or third-party mediated forums, opportunities to engage in conversations and philosophical and ethical discussions involving values, death, dying, and suffering can help address some needs identified by nurses (Bruce & Beuthin, 2020; Ward et al., 2021). In the study by Ho et al. (2021), most participants identified team debriefing as a wanted and helpful platform to allow different voices to come together, engage in conversations and understand and address healthcare provider distress. Seeking more frequent debriefing (e.g., after each MAiD case), a nurse participant stated that

...debriefing is one of the most valuable and accessible [methods].

Those are so useful at reviewing cases that are highly relevant because of direct practice. They give us the opportunity to review what went well, what could have gone better and how we can do better next time. (Ho et al., 2021, p. 192)

Peer debriefing was identified as a valuable tool for quality improvement and providing a supportive community of practice for nurses (Oczkowski et al., 2019). One participant in the study by Oczkowski et al. (2021) shared,

I think debriefing is a critical component, in terms of metabolizing the story of what you've seen and heard, and hearing it from the view of other people, which for me is

always enlightening... And without doubt, without question, every single one of those when I've left the debrief I'm like "I'm glad we did that!" (p. 518)

Individual debriefing was also identified as a means for nurses to contemplate their position, perspectives, and biases toward those experiencing MAiD-related moral uncertainty or distress (Ho et al., 2021). Kopchek (2020) found that nurses identified formal and informal debriefing pre- and post- MAiD provision as imperative to address emotions, feelings, and questions related to the provision. Participant statements in the study by Kopchek (2020) included

Having a debriefing before and after MAiD is done would be helpful. Not just the individuals involved, but everyone on the floor" and that "... distress [is heard] from nurses when there is family conflict, the patient is not able to speak for themselves or the process of debriefing before or after MAiD is not done. (p. 29)

4.5.1.2 Code of ethics and ethical decision-making. Nurses expressed a need for education specific to their professional Code of Ethics, strategies for making ethical decisions and using ethical frameworks (Beuthin et al., 2018; Kopchek, 2020; Mathews et al., 2021; McMechan et al., 2019; Schwarz, 2002). In the study by Beuthin et al. (2018), nurse educators and leaders were encouraged to provide regular updates and resources to provide clarity concerning the nursing Code of Ethics as there was a lack of clarity and misinformation surrounding the Code of Ethics. Schwarz (2002) identified that most nurses were able to demonstrate familiarity with basic principles of ethics, such as the principle of double effect, respect for the individual and self-determination. Still, nurses had never received formal education in ethics and did not refer to the Code of Ethics. Focused on palliative care nurses, the study by Kopchek (2020) found that knowledge deficits related to ethics and MAiD negatively

influenced the ability of nurses to make ethical decisions, with nurses requesting more ethical training and access to an ethicist or ethical consultant. Specific topics identified for ethical training included compassion fatigue, resilience training and incorporating self-reflection (Kopchek, 2020). The need for expert resources for ethical decision-making was echoed in the study by Mathews et al. (2021).

Specific to nursing students, McMechan et al. (2019) ascertained that for students to provide safe and compassionate care, they must engage in ethical decision-making, use the principle of patient self-determination, and advocate for patient autonomy to navigate their encounters with MAiD. Through education and practical application of ethical frameworks in class and clinical settings, students can be encouraged to develop ethical decision-making (McMechan et al., 2019). Nursing students and novice nurses could also benefit from guided discussion of the Code of Ethics (including revisions to the Code of Ethics) to help them comprehend and navigate the sometimes-nuanced language within the code (Schwarz, 2002).

4.5.1.3 Reflection. Six findings in the review highlighted the importance of reflection in ethical and moral nursing practice regarding MAiD (Bruce & Beuthin, 2020; Freeman et al., 2021; Kopchek, 2020; McMechan et al., 2019; Schwarz, 2002). Greater openness and reflection and encouraging nurses to think more deeply about death and dying are strategies that can be implemented to address the “residual discomfort” that nurses may feel when they have unresolved questions or concerns regarding MAiD (Bruce & Beuthin, 2020). Similar to debriefing, a safe temporal and physical space is needed to reflect on thoughts, perspectives, understanding, and experiences regarding MAiD, independently or in discussion with others (Freeman et al., 2021). Nurses reported that, although self-reflection is a strategy needed to enhance moral and ethical practice, they may need a facilitator to engage in self-reflection

(Kopchek, 2020, p. 30). To explore ethical dilemmas, nurses suggested incorporating self-reflection both in the moment and after any ethical event but recognized: “I don’t think it’s a basic for every human to be self-reflective. You have to know where you stand and why. Where are these feelings coming from?” (Kopchek, 2020, p. 29). Nursing students also advocated for engagement in reflective activities before encountering MAiD in practice and after a MAiD provision (McMechan et al., 2019). Suggestions for facilitating moral reflection were to share “personal experiences of good and bad deaths, by presenting and discussing actual clinical cases, engaging in role-playing and small group discussions about these experiences, and describing how those experiences cause us to feel (Schwarz, 2002, p. 301)”.

4.5.2 Theme two: legislation and standards

The theme of legislation and standards has 21 findings from 10 separate studies and includes the sub-categories of 1) professional/regulatory guidance and scope, 2) legislation and conscientious objection, and 3) institutional standards and procedures.

4.5.2.1 Professional/regulatory guidance and scope. There were seven findings where nurses identified that they needed knowledge of the professional and regulatory guidelines and nursing scope related to MAiD (Brown, Goodridge, Harrison, et al., 2020; Brown, Goodridge, & Thorpe, 2020; De Bal et al., 2006; McMechan et al., 2019). As quality MAiD care requires the involvement of an interdisciplinary team, nurses brought forward concerns of confusion related to the role and scope of practice of the nurse within the interdisciplinary team, resulting in disorganized and disjointed patient care (Brown, Goodridge, Harrison, et al., 2020). The following quotes from the study by Brown, Goodridge, Harrison, et al. (2020) highlight this confusion and the feeling that professional and regulatory guidance has not provided the necessary clarity regarding role and scope:

[The patient] knew that's what she wanted and so I got the doctors, and referred, and started the process for her. And our direction isn't super clear - we, as [professional group], aren't supposed to bring it up as I'm told, but we aren't really sure what to do... is it the doctor who brings it up? Or do they learn about it from media? We don't really know (HCP. Interview 11). (p. 1474)

We're involved with the patient, but I don't know how much of it we are allowed to direct. Is it something that nurses can bring up? Or is it the doctors that should bring it up and get other teams involved with MAID, and they would give them information to follow up with? (HCP. Interview 6). (p. 1474)

Providers identified a lack of clarity and direction from professional associations regarding the role and scope of nursing students regarding MAiD as a barrier to including MAiD content into health science curricula (Brown, Goodridge, & Thorpe, 2020). Specifically, information and statements from professional associations were found to be ambiguous, fluctuating, or absent, and the information was generally shared in a disorganized manner (Brown, Goodridge, & Thorpe, 2020). Nursing faculty were hesitant in their approach to teaching MAiD due to uncertainty regarding the scope of practice for nursing students regarding MAiD and "what students 'may' but 'should' participate in (Brown, Goodridge, & Thorpe, 2020)".

Specific to nursing students, confusion and misconceptions were experienced by students about their role and scope within MAiD (McMechan et al., 2019). Nursing students were informed that it was beyond the nursing scope of practice to counsel patients about MAiD, but the ambiguity of what 'counsel' meant in practical terms left the students fearful of broaching MAiD with patients (McMechan et al., 2019). In the study by McMechan et al. (2019, p. 4), one

student commented: “The message I got [in university] was do not open your mouth if the patient talks about it. You cannot speak to patients about this.”

Nursing students also felt conflicted between trying to optimize their learning opportunities by being present during a MAiD provision and respecting the sensitive nature of a MAiD provision, feeling as though it may not be appropriate for a student to be present (McMechan et al., 2019). One student commented on this conflict by sharing

I didn't want to introduce a brand-new face and be like, hey I'm a student can I just stand in the corner? So I was really conflicted with... being presented with this learning opportunity but not being able to really take it because it just wasn't really fair.

(McMechan et al., 2019, p. 3)

The practicing nurses working on the units with student placements also encountered uncertainty regarding the student's scope of practice within MAiD (McMechan et al., 2019). As professional and regulatory organizations continue to evolve with MAiD, nursing students provided education recommendations that included clarifying the scope of the student nurse compared to licenced nurses (McMechan et al., 2019). Nurse educators and nursing students could address role confusion by working to ensure they are knowledgeable about the evolving professional guidelines, such as those from the Canadian Nurses' Association (CNA) and provincial regulatory standards (McMechan et al., 2019).

4.5.2.2 Legislation and conscientious objection. There were eight findings in the review that emphasized the essential need for nurses to be knowledgeable and educated on the current MAiD legislation and conscientious objection (Beuthin et al., 2018; Brown, Goodridge, Harrison, et al., 2020; Denier et al., 2010; Kopchek, 2020; McMechan et al., 2019). As the MAiD legislation recently underwent revisions passed by the Parliament of Canada on March 17th, 2021, it is imperative that nurses receive appropriate education on the updated legislature (Parliament of Canada, 2021). In the study by Kopchek (2020), palliative care nurses shared their identified educational needs, including the need for knowledge of legislation, legislative guidelines, and potential legal ramifications for nurses regarding MAiD. Nurses must be sufficiently educated and knowledgeable of the Act on Euthanasia (Denier et al., 2010). This legislation currently applies to Belgium but could easily be adapted for Canadian MAiD legislation to support education regarding assisted dying care.

Built into the MAiD legislation is the right for all health care providers to reflect upon their values, morals and religious beliefs and conscientiously decide whether they choose to participate in MAiD, without legal repercussions should they decline. In practice, nurses have found limited, clear information and support for those who conscientiously object (Beuthin et al., 2018; Brown, Goodridge, Harrison, et al., 2020). One experienced nurse who chose to conscientiously object for religious reasons stated:

I think that in some units [the] “duty to provide care” is being touted as “you don't have a choice” and the information isn't there [about] how to object if you don't agree with it. And that's one thing through the whole process—there is not one thing that came from [the administration] that said, “you have the right to file a contentious objection on this.” There wasn't one thing that came through the pipe. (Beuthin et al., 2018, p. 515)

Nurses who expressed a hesitancy or uncertainty about whether to engage in MAiD identified fear and confusion about legal, ethical, and professional messaging they had received, a lack of confidence in how to conduct themselves, and a lack of time to receive the required education, influenced their actions (Beuthin et al., 2018). Nursing students also identified the need for educators to be aware of the evolving MAiD legislation and the process for conscientious objection (McMechan et al., 2019).

4.5.2.3 Institutional standards and procedures. There were eight findings where nurses identified the need to be educated on institutional standards and the procedures involved in the provision of MAiD (Beuthin et al., 2018; Brown, Goodridge, Harrison, et al., 2020; Brown, Goodridge, & Thorpe, 2020; De Bal et al., 2006; McMechan et al., 2019; Oczkowski et al., 2021; Pesut, Thorne, Schiller, Greig, Roussel et al., 2020; Ward et al., 2021). In the study by De Bal et al. (2006), nurses voiced that they have an essential role in patients' overall care regarding euthanasia (the phenomenon of interest in Belgium but could easily be applied to the context of MAiD). Nurses were generally able to describe process steps in relation to the role of the nurse, such as: (a) “period before the euthanasia request” where nurses listened and spoke to patients to gain insight into the patient; (b) “confronting the request for euthanasia” and requests for information where nurses listened carefully to patients and family to determine the patient’s rationale for request and allow the patients to tell their story, and provided information on palliative care principles, care alternatives, and dying; (c) “reporting the request to other caregivers” involved the nurse always informing the physician and colleagues of the request; (d) nurses who conscientiously objected would continue to provide basic care; (e) “participating in decision-making” where nurses relayed to the healthcare team information about the patient’s needs, feelings, and suffering and participated in multidisciplinary meetings; (f) “the result of the

decision-making process” where nurses ensure patient dignity and maximize their comfort, supporting the patient’s psychosocial needs and providing nursing care up to the time of MAiD; (g) during the MAiD provision nurses would start an intravenous access and aid directly with supportive measures; and (h) “aftercare” where nurses support the patient’s family once the patient dies, help the family to grieve, debrief with the family and care team, and provide afterlife care to the patient (Beuthin et al., 2018, p. 517; De Bal et al., 2006, pp. 595-596). Nurses emphasized the need to meticulously plan for MAiD provisions to avoid disruptions in care. This includes obtaining extra supplies for specialized intravenous access, arranging the room to facilitate the family being close to the patient, and ensuring to bring items to the provision that the MAiD provider may forget, including trays for medications and death certificates (Pesut, Thorne, Schiller, Greig, Roussel et al., 2020).

Regarding clinical care realities, nurses expressed frustration and confusion regarding the actual process steps or care pathway for MAiD (Brown et al., 2020). Nurses found the care pathway to be ambiguous at times, compounded by the lack of knowledge of care processes and a perceived “air of secrecy” regarding the MAiD provision (Brown et al., 2020). For nurses caring for patients within a non-provider facility, there was substantial uncertainty around how to provide care (particularly in the imminent period prior to MAiD) when death from MAiD was expected, and the nurses wanted more direction and information from their workplace (Ward et al., 2021). Facilitating interdisciplinary education focused on program procedures and care standards was suggested in the study by Brown et al. (2020). Key informants also supported the need for clear care pathways to support MAiD content delivery in health sciences curricula (Brown, Goodridge, & Thorpe, 2020). The development of standardized assessment guides and

documentation templates were identified as helpful educational tools to navigate the care pathway (Oczkowski et al., 2021).

4.5.3 Theme three: communication

The topic of communication contains a total of 20 findings from 13 separate studies and includes sub-categories of 1) responding to requests/inquiries, 2) patient and family teaching, and 3) communication and tools.

4.5.3.1 Responding to requests/inquiries. There were six findings where nurses identified that they needed education on how to respond to requests for MAiD and inquiries for information related to MAiD (Beuthin et al., 2018; De Bal et al., 2006; Pesut, Thorne, Schiller, Greig, Roussel et al., 2020; Schwarz, 2002; Volker, 2001). Many nurses reported having conflicted feelings and a need to cope when patients implicitly or explicitly expressed a desire to die or requested assisted dying (De Bal et al., 2006; Schwarz, 2002; Volker, 2001). There was uncertainty about the registered nurse role and conversational boundaries, and many nurses described themselves as simply not knowing what they should do or say during conversations where individuals requested MAiD (Pesut, Thorne, Schiller, Greig, Roussel et al., 2020). Nurses reported that coping with being presented with a request for assisted dying was a learning process and that they were learning how to have these initial conversations (De Bal et al., 2006). The initial emotions experienced by nurses to a request included surprise, shock, or powerlessness due to perceived ignorance in that they did not know how to react, but they gradually learned how best to react to a request (De Bal et al., 2006; Pesut, Thorne, Schiller, Greig, Roussel et al., 2020). Substantial conflict also resulted when a request for assisted dying did not align with the nurse's competing values or principles (Volker, 2001).

Presented with a request for MAiD, nurse practitioners engaged in conversations with patients to evaluate their eligibility for MAiD (Pesut, Thorne, Schiller, Greig, Roussel et al., 2020). A few nurse practitioners labelled these conversations as “legacy conversations”, as it was perceived that the memory of these conversations would last with the patients (Pesut et al., 2020). These initial conversations for nurse practitioners involved meeting someone for the first time, immediately establishing intimacy and a rapport to enable the patient to share their story of suffering, and, simultaneously, being responsible for assessing whether the patient met eligibility for MAiD (Pesut et al., 2020). For these initial conversations, nurse practitioners need to learn a specific conversational skillset to prepare them to engage in these discussions and help alleviate the nurse practitioner's anxiety (Pesut et al., 2020). A large proponent of this conversational skillset involved taking a direct approach that avoided euphemisms of MAiD death, as explained by one nurse practitioner: “I take away the fluffiness of a conversation and make it really raw and real” (Pesut et al., 2020, p. 5).

When nurses respond to a request for MAiD or information regarding MAiD, nurses emphasize that information should be provided “in a compassionate listening manner” (Beuthin et al., 2018). At times, requests for assisted dying or information on assisted dying require skill at more covert communication due to more implicit or subtle exchanges of information with the patient (Volker, 2001). Stories from nurse experiences demonstrated conversations that involved innuendo, metaphors, and assumptions about what the patients were saying, which is highlighted by a nurse sharing that “requests for help with dying is not as cut and dried as legislators seem to think. Patients do not often make formal requests which you can accept or deny” (Volker, 2001, p. 45). Nurses need to actively listen to patients and families to discern what they are asking and their intent for inquiring, and not just take the statements at face value (Beuthin et al., 2018;

Pesut et al., 2020). The skill of assessing the meaning of the patient's request and whether the patient's wish to die may be the result of unspoken or unrecognized needs (such as pain and suffering that is poorly managed) is imperative for nurses, as the findings can dramatically alter the interventions that follow (Schwarz, 2002).

4.5.3.2 Patient and family teaching. There were five findings where nurses identified the need to be knowledgeable about how to provide patient and family teaching concerning MAiD (Denier et al., 2010; Kopchek, 2020; Pesut et al., 2020; Volker, 2001; Ward et al., 2021). Following a request for MAiD provision or information concerning MAiD, nurses indicated that they required more education to appropriately answer questions and engage in conversations about MAiD (Kopchek, 2020). Surrounding what is appropriate to discuss with a patient regarding MAiD, nurses were concerned that they might inadvertently say something that could be construed as coercion (Kopchek, 2020). One nurse shared:

I didn't think my opinion was important, I was there to assist the patient. Maybe I should be able to talk more about MAiD, but I just pawn off the conversation and say, ask your doctor. I don't know how to have those conversations with a patient. (Kopchek, 2020, p. 29)

The concept of covert communication also contributed to further confusion for nurses as they had to discern whether the patient and family were seeking further information and what, in particular, they wanted to know (Volker, 2001).

Patients and families also relied on education from the healthcare team and, in large part, the nurse's role to prepare everyone in terms of what to expect when planning for the moment of a MAiD death (Pesut et al., 2020). Answering questions and educating the patient and family on what to expect in preparation for a MAiD death became extremely challenging for nurses caring

for individuals in a non-provider facility (Ward et al., 2021). Nurses identified that good communication techniques in the context of the patient and family involved: active listening, asking open-ended questions, providing information, translation, consultation, providing advice, engaging in non-euthanasia-related conversation, openness and attentiveness, expressing patience, trustworthiness, gaining certainty, standing up for the patient, and creating peace (Denier et al., 2010).

4.5.3.3 Communication and tools. Within nine of the findings, nurses emphasized overall communication strategies and tools as an area requiring education and training (Beuthin et al., 2018; Denier et al., 2010; Freeman et al., 2021; Ho et al., 2021; Mathews et al., 2021; McMechan et al., 2019; Oczkowski et al., 2021; Volker, 2001). In the study by Mathews et al. (2021), participants reported not feeling confident about discussing MAiD. Nurses fear that they might introduce MAiD to patients who are not seeking information or requesting assisted dying, which may be perceived as inviting the patient to request MAiD (Mathews et al., 2021). They were concerned about inadvertently encouraging vulnerable patients to request MAiD and eroding the trust of patients and family members (Mathews et al., 2021). One participant described this concern in their statement:

I wonder if I should speak to Ethics about [bringing up MAiD with patients] because maybe they can tell me, “No, you’re allowed to say this,” or “You’re not allowed to say that,” but . . . I feel like I’m walking quite a tightrope because I don’t want to be encouraging or discouraging in any way. (Mathews et al., 2021, p. 450)

Nursing students were also hyper-aware of not engaging in discussion with patients about MAiD, demonstrated by a student stating: “The message I got [in university] was do not open your

mouth if the patient talks about it. You cannot speak to patients about this” (McMechan et al., 2019, p. 4).

Nurses described having the requisite communication skills as essential to the MAiD process and identified compassionate listening, engaging, attuning, and being comfortable with intense emotions as integral to effective communication (Beuthin et al., 2018; Volker, 2001). One health care provider in the study by Oczkowski et al. (2021, p. 518) advocated that "there needs to be more education... [for HCPs who] we anticipate seeing people with terminal diagnoses, and being equipped and educated as to sort of have a handle on those conversations when they come up."

Palliative care nurses, who have received extensive training in end-of-life discussions, also requested specialized training on MAiD communication as it was felt to be a “seismic shift” from their palliative care work (Ho et al., 2021). The development of guidelines for nursing communication throughout the MAiD process could also support nurses in developing their communicative skills in the context of MAiD (Denier et al., 2010). Nurses identified uncertainty and discomfort with the language concerning MAiD and not knowing the best approaches for such discussions. Strategies suggested to meet their educational needs include the development of communication tools to support discussion and using patient actors and experienced interdisciplinary colleagues to role play effective MAiD communication (Freeman et al., 2021; Ho et al., 2021). Communication tools, such as standardized assessment guides and documentation templates, were suggested as helpful conversation aids (Oczkowski et al., 2021). Such strategies could also assist in clarifying the boundaries of care between the patient and the healthcare provider and demonstrate how to maintain a therapeutic relationship (Freeman et al., 2021; Ho et al., 2021).

With the interdisciplinary nature of MAiD, interprofessional communication is often lacking (Denier et al., 2010). Creating a communicative culture where nurses and team members can explore and discuss concepts, actions, and procedures can facilitate interprofessional communication (Denier et al., 2010).

4.5.4 Theme four: mandatory education

The topic of mandatory education contains a total of 17 findings from seven separate studies and includes: 1) MAiD curriculum and 2) MAiD educators.

4.5.4.1 MAiD curriculum. The need for formal MAiD education and curriculum integration was highlighted in 13 findings throughout the review (Beuthin et al., 2018; Brown, Goodridge, & Thorpe, 2020; Bruce & Beuthin, 2020; De Bal et al., 2006; Kopchek, 2020; McMechan et al., 2019; Pesut, Thorne, Schiller, Greig, Roussel et al., 2020). Throughout the various studies, discussions have called forth a need for mandatory MAiD education (Beuthin et al., 2018; Bruce & Beuthin, 2020; Kopchek, 2020; McMechan et al., 2019; Pesut, Thorne, Schiller, Greig, Roussel et al., 2020). One palliative care nurse shared her experience:

No mandatory education or information was provided for the nurses. The education we were provided with, consisted of a simple checklist and we were required to just go out there and start doing it. We were not always made aware in advance that a referral was for MAiD. Often, we wouldn't be prepared when walking into a patient's house.

(Kopchek, 2020, p. 30)

Another nurse advocated that MAiD education needs further focus within nursing curriculum by sharing:

I think we're gonna do much better if we start the conversation early in our training to be more prepared to talk about these things. And often when you're 19, 20, 21, 22, 24 years

old with no life experience, unless you've lost your grandma, you might not really have a lot to say right? So I think exposure to conversation about [death and dying] and you know, at least bringing some attention to it . . . can make this process a lot more fluid for all concerned. Because it's not just the patient. (Bruce & Beuthin, 2020, p. 274)

Nurses have voiced their fear that MAiD is implemented without the appropriate initial education and continuing education (Bruce & Beuthin, 2020). Student exposure to MAiD concepts was inconsistent in nursing programs (Brown, Goodridge, & Thorpe, 2020). If MAiD was not a specific course objective, it was up to the discretion of the teaching faculty as to what and whether to include MAiD in the course content (Brown, Goodridge, & Thorpe, 2020). There was an incongruity between the theoretical content being taught in nursing programs, exposure to information in the clinical setting, and the information shared by practicing health care workers (Brown, Goodridge, & Thorpe, 2020).

Nurse practitioners felt a lack of standardized education acutely as many nurse practitioners had to rely on their own initiative to develop practice support (Pesut et al., 2020). Although many instruments were available to guide patient evaluations, it was challenging for nurse practitioners to select the appropriate instruments due to a lack of established best practices (Pesut et al., 2020). Nurse practitioners working in teams, or who had responsive and available colleagues, could seek support from their colleagues by discussing their MAiD assessments and garnering feedback (Pesut et al., 2020). The need for more robust educational support was further heightened by the requirements for more detailed reporting of MAiD cases established by Health Canada in 2018 (Pesut et al., 2020).

Resources required to inform the development of MAiD content include care pathways, accreditation standards, peer-reviewed evidence, local statistics, and the use of practice experts

(Brown, Goodridge, & Thorpe, 2020). Curriculum design should include didactic presentations, case studies, simulation, role-playing, enhanced interprofessional problem-based learning opportunities, lectures and workshops by content experts, and the creation of Communities of Practice (Beuthin et al., 2018; Brown, Goodridge, & Thorpe, 2020; McMechan et al., 2019). Nurses found including MAiD education within the context of palliative care, end-of-life care, ethics, legal issues, and professional regulation courses to be important (Brown, Goodridge, & Thorpe, 2020). Nurses have also requested the opportunity to arrange mentorship from experienced MAiD practitioners, to observe a MAiD provision before actively participating, and to engage in debriefing after provisions are enacted (Pesut et al., 2020).

Alongside the request from nurses to have an established and standardized MAiD process or care pathway, each step in the MAiD process requires corresponding supporting competencies (De Bal et al., 2006). Skills associated with these competencies include the exploration of the implicit or explicit desire to die and team skills to encourage nurses to actively participate in the discussion of patient management (De Bal et al., 2006). A specific technical skill that nurses considered paramount was the ability to initiate reliable intravenous access, as nurses were often the ones to insert the intravenous before the MAiD provision (Beuthin et al., 2018). Some nurses relayed their experiences of “lying awake the night before, worrying whether they would be able to get intravenous access quickly and painlessly” (Pesut et al., 2020, p. 7). Concerns were raised about the ability of community health nurses to develop and maintain the necessary intravenous skills to support the patients in the community throughout their MAiD provision (Beuthin et al., 2018). MAiD education should be delivered using a neutral, safe approach and in a respectful environment that allows people to explore their beliefs and values (Brown, Goodridge, & Thorpe, 2020).

Nursing students have also expressed appreciation for exposure to MAiD in clinical experiences throughout their nursing program to allow them to work through their thoughts, feelings, and values before taking full responsibility for patients as a licenced nurse (McMechan et al., 2019). Students also value the opportunity to participate in reflective activities about MAiD in their nursing school curriculum before and after they encounter patients who choose MAiD in clinical practice (McMechan et al., 2019).

4.5.4.2 MAiD educators. There were three findings where nurses identified the necessity for qualified MAiD educators to meet their knowledge and education needs (Brown, Goodridge, & Thorpe, 2020; McMechan et al., 2019). The qualities identified as essential for high-quality MAiD educators included an enhanced understanding of MAiD, being passionate about end-of-life care, being active in clinical practice, and being skilled in neutral facilitation (Brown, Goodridge, & Thorpe, 2020). Educators who were engaged in clinical practice, knowledgeable of MAiD research, and had personal end-of-life care experiences were able to include practice and clinical aspects of MAiD into their teaching (Brown, Goodridge, & Thorpe, 2020).

Nurse educators need to be better informed of evolving MAiD legislation, guidelines from professional associations, provincial regulatory standards, and policies and procedures from local institutions to avoid propagating misunderstandings and role confusion (McMechan et al., 2019). Program leadership must provide opportunities for professional development, and educators themselves should continue to seek development opportunities independently (Brown, Goodridge, & Thorpe, 2020).

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Chapter 5: Discussion

Using the approach, guidance and methodology provided by the JBI Manual of Evidence Synthesis (2020), a qualitative systematic review was completed with the goal of discovering the knowledge and education needs identified by nurses regarding medical assistance in dying based on their personal experiences. The review process produced 80 extracted findings that were included in the meta-aggregation and final synthesis of four main themes: 1) ethical and moral challenges, 2) legislation and standards, 3) communication, and 4) mandatory education. The results indicate that there is a need to examine and address the affective domain for nurses concerning MAiD, how to practically apply ethical concepts into practice, and the application of adult learning theory to the needs identified by nurses. Implications for nursing practice, research and education will also be explored below, as well as the strengths and limitations of this thesis. There is a conclusion section that finalizes this chapter.

5.1 Respect for the entity of MAiD

MAiD is a novel, complex, and ever-evolving entity that is exciting, challenging, and presents an entirely new area of nursing practice. Wonderfully captured in a quote by a nurse in the study by Pesut et al. (2020, p. 8) is “It's like living grounded theory. We're making it up as we go along”.

Throughout the 17 studies included in this review, there was a perceived underlying theme of respect and seriousness from nurses about MAiD. Whether this is in part due to the utter finality of a patient choosing MAiD and death, the associated potential legal ramifications, or the generalized uncertainty brought forward by nurses, it would be interesting to further explore this concept of respect concerning MAiD and related nursing implications (Brown et al., 2020; McMechan et al., 2019). Nurses spoke of residual discomforts about MAiD, specifically

those external factors (such as debates over provider funding), and a lack of mandatory education available to nurses, which may contribute to unintended harm by routinizing death (Bruce & Beuthin, 2020). Nurses expressed concern that MAiD may “become too clinical” and may lead to potential misuse (Bruce & Beuthin, 2020). Strategies shared by nurses to avoid medicalizing MAiD included encouraging an open and reflective culture and providing safe spaces where nurses can think more deeply about the dying process to facilitate dealing with any discomfort with death and MAiD (Bruce & Beuthin, 2020). Educators and nursing leaders encouraging and reinforcing a holistic patient- and family-centred approach to care may also help personalize MAiD provisions (Freeman et al., 2021).

There should exist strong respect for MAiD and the overall process of MAiD, as assessments, decisions regarding patient eligibility, and interventions provided carry a heavy impact. However, it is essential for nurses to question whether the weight of this respect hinders the ability to engage in conversations surrounding MAiD or the MAiD process. Although nurses identified a learning need to observe an experienced team navigating a MAiD provision before actively participating, nurses and nursing students described their hesitancy to observe as they felt it might be perceived as disrespectful (McMechan et al., 2019). A quote by a nursing student captures this impact on students and practicing clinical nurses:

“I didn’t want to introduce a brand-new face and be like, hey I’m a student can I just stand in the corner? So I was really conflicted with... being presented with this learning opportunity but not being able to really take it because it just wasn’t really fair (McMechan et al., 2019, p. 3).”

As MAiD has been legislated since 2016 as an end-of-life care option, nursing programs, institutions and healthcare organizations must work to normalize MAiD within healthcare. This

will help nurses and nursing students feel comfortable seeking learning opportunities while maintaining an appropriate level of respect. It is a fine line that the nursing profession must learn to navigate, and discussions on navigating this process can be embedded in MAiD educational initiatives.

5.2 Affective domain concerning MAiD

When nurses did not feel adequately prepared, various emotions were attributed to all aspects of MAiD, ranging from surprise, shock, anxiety, uncertainty, fear, and powerlessness (De Bal et al., 2020). Nurses reported feeling conflicted and identified the need to identify ways to cope with requests for MAiD (De Bal et al., 2020). Nurse leaders and educators should be encouraged to closely attend to the emotional nature of MAiD for nurses in various settings (Beuthin et al., 2018). It may be valuable to use guidance from the affective domain of learning described in Bloom's Taxonomy to develop education and training objectives to meet these emotional needs (The Ohio State University College of Nursing, 2015). Bloom's affective domain centres around attitudes and values, alongside the structure of cognitive and psychomotor domains (Nelson et al., 2020; The Ohio State University College of Nursing, 2015). By incorporating the values and attitudes of nurses and nursing students, the motivation and engagement of nurses can be positively influenced during the learning experience (Nelson et al., 2020). Although learning objectives for the affective domain have been notoriously difficult to create due to the sometimes unquantifiable nature of indicators for affective objectives, when educators incorporate affective domains within educational initiatives, it can lead to improved learning as positive affective influences can lead to improved cognitive performance (Nelson et al., 2020).

A multi-faceted educational approach is needed to support the effective provision of nursing care for those requesting and undergoing MAiD. First introduced within undergraduate nursing education, topics should include nursing roles and responsibilities, explore moral and ethical concerns, including the right to conscientious objection, provide opportunities for learners to clarify and work through emotions surrounding MAiD, and involve opportunities to engage in communication with patients regarding MAiD (McMehan et al., 2019). This can be facilitated through lectures, didactic learning opportunities, and workshops facilitated by nurses with active roles in MAiD and simulation-based learning experiences. Simulation offers learners the opportunity to practice real clinical experiences within a controlled and psychologically safer environment (Tyerman et al., 2021).

Resources and support for practicing nurses who are or may be exposed to patients considering MAiD are essential and must include self-care resources (Freeman et al., 2021). Educational resources identified by nurses within this systematic review emphasize the need for reflective activities and the institution of debriefing (Bruce & Beuthin, 2020; Freeman et al., 2021; Kopchek, 2020; McMechan, 2019; Schwarz, 2002). Reflective activities, performed formally or informally, could occur in a group setting or independently with self-reflection. However, consideration must be made for supporting individuals who do not find reflection intuitive, as they may require a facilitator such as an educator or a mentor (Kopchek, 2020). In a safe and open environment, accessible group debriefings sensitive to the MAiD context can facilitate learning opportunities to review recent MAiD cases and to discuss values, thoughts and feelings experienced by nurses with their colleagues (Brown, Goodridge, Harrison, et al., 2020). How to appropriately integrate and facilitate debriefing within the clinical environment should also be explored, such as timing and frequency of debriefing, identifying the most appropriate

facilitator, and who should participate in the debriefing, taking into consideration varying comfort levels with debriefing and individual personalities.

5.3 Practical application of ethics

Another theme that stood out in the systematic review findings was the general discomfort nurses felt regarding applying ethical principles and concepts to practice and the need for more training related to the ethical considerations entrenched in MAiD, which nurses termed “ethical training” (Beuthin et al., 2018; Kopchek, 2020; Mathews et al., 2021). Similar to the entire concept of MAiD, ethics cannot be easily broken down into neat little pieces and delivered to nurses so that they are completely ethically equipped.

When nurses spoke about ethical training and education specific to MAiD, they advocated that nurses require more support in applying ethics to clinical practice. Nurses requested more education to support their ethical decision-making, including using ethical frameworks. Engaging in ethical discussions with colleagues and those specially trained in ethics and moral reasoning may be beneficial (Beuthin et al., 2018; Bruce & Beuthin, 2020; McMechan et al., 2019). Opportunities to participate in debriefs, workshops and forums to review case studies and actively work through the sense-making process were all identified as modalities that nurses want to help them provide quality MAiD and end-of-life care (Beuthin et al., 2018; Bruce & Beuthin, 2020; Ho et al., 2021; Mathews et al., 2019; McMechan et al., 2019; Oczkowski et al., 2021; Volker, 2001). Nurses perceive their Code of Ethics as unclear and often vague; thus, how the Code of Ethics is applied to practice is an area of ongoing nursing research (Beuthin et al., 2018; Schwarz, 2002). Nurses have recognized the immense role ethics and moral reasoning have within MAiD and have highlighted the need for practical guidance and support to equip them to navigate the ethical complexities. The need for more ethical training

suggests the necessity to re-evaluate how ethical education is provided within nursing programs and continuing education initiatives for practicing, licensed nurses (Kopchek, 2020). It is essential that nursing leaders and educators adapt and meet the current and evolving practice needs of nurses.

5.4 Specialized communication strategies

Communication is a skill like any other nursing skill that requires proper training, resources, and support to encourage high-quality skill development and maintenance. Regardless of a nurse's experience engaging in end-of-life discussions, nurses felt that engaging in MAiD conversations with patients required a "seismic shift" in approach to communication (Ho et al., 2021). Communicative skills in the context of MAiD require specialized training (Denier et al., 2010; Ho et al., 2021). To facilitate a communicative culture, multi-disciplinary team members need to be encouraged to discuss MAiD care and specific situations, debrief on previously held conversations with patients and their family members and practice conversing in various scenarios with team member feedback (Denier et al., 2010; Ho et al., 2021). Establishing a collaborative interdisciplinary healthcare team of MAiD experts that includes ethicists, psychologists, administrators, and patient advocacy representatives may lead to developing comprehensive guidelines and resources to support communication. A focus should be placed on (1) establishing guidelines supporting the institution's MAiD care process, (2) establishment of roles and responsibilities of all healthcare providers, (3) MAiD-specific policies and procedures, (4) education ensuring a MAiD request is clearly understood by the patient and healthcare provider, and (5) ensuring the MAiD process adheres to provincial, territorial, and federal legislation (Denier et al., 2010).

Nurse educators and clinical leaders should adopt various strategies to guide continuing education resources, ensuring practicing nurses are well prepared to engage in MAiD-specific activities. As education specific to communication has been highlighted, using embedded actors for insitu simulation with skilled interdisciplinary mentors can facilitate effective therapeutic communication strategies (Ho et al., 2021). Insitu simulation should explore conversations unique to each step of the MAiD care pathway, from initial inquiries to requests to the provision of post-MAiD grief support for family members (Ho et al., 2021).

5.5 Mandatory education

With the MAiD legislation in Canada, nurses have been pioneers in establishing the care process for engaging with patients interested in MAiD. These nurses have first-hand experience of what factors facilitate or hinder care, and their input is integral for identifying unmet needs regarding MAiD knowledge and education. Based on this systematic review, the identified needs are: 1) ethical and moral challenges (Code of Ethics and ethical decision-making, sense-making, and reflection), 2) legislation and standards (professional/regulatory guidance and scope, legislation and conscientious objection, and institutional standards and procedures), 3) communication (responding to requests and inquiries, patient and family teaching, communication, and tools), and 4) mandatory MAiD education (MAiD curriculum and MAiD educators).

Educational initiatives regarding MAiD (e.g., booklets, case studies, forums, webinars, modules) are becoming increasingly available to nurses since the institution of MAiD legislation in Canada. Organizations such as the Canadian Nurses Association, the Canadian Nurses Protective Society, the Nurse Practitioner's Association of Ontario, and Dying with Dignity Canada are developing essential resources, policies and practice guidelines (Canadian Nurses

Association, 2017; Canadian Nurses Protective Society, 2016; Dying with Dignity Canada, 2021; Nurse Practitioners' Association of Ontario, 2020; Ying et al., 2018). Although information and resources have been developed, nurses throughout the review identified a need for formal MAiD education and curriculum (Beuthin et al., 2018; Brown, Goodridge, & Thorpe, 2020; Bruce & Beuthin, 2020; De Bal et al., 2006; Kopchek, 2020; McMechan et al., 2019; Pesut, Thorne, Schiller, Greig, Roussel et al., 2020). Existing educational resources are limited, and the identified need for formal MAiD education and curriculum calls to question whether the currently available resources are meeting the needs of nurses. Given the themes and findings identified within this systematic review, the conclusion is evident that current MAiD education available to Canadian nurses remains inadequate, which may negatively impact patient care.

Once high-quality, evidence-based educational resources are identified and/or created, it needs to be applied within a knowledge translation framework, such as the Knowledge-to-Action framework, to effectively move the knowledge into clinical practice (Field et al., 2014). The Knowledge-to-Action framework is a model that focuses on the dynamic and iterative processes of both knowledge creation and the translation of knowledge to practice (the action cycle) (Strauss et al., 2011). At the centre of the Knowledge-to-Action Framework is a funnel, where knowledge inquiry, synthesis and development of products/tools create a refined evidence-based knowledge that can then be applied to practice (see Appendix F) (Canadian Institutes of Health Research, 2015). The action cycle then applies the knowledge to practice through adaptation to the local context, assessing barriers, implementing interventions, monitoring the use of knowledge, evaluating outcomes, and working to sustain knowledge use (Canadian Institutes of Health Research, 2015; Strauss et al., 2011). Based on the results from the meta-aggregation within this review and the Knowledge-to-Action Framework, action to address the knowledge

and education needs of nurses regarding MAiD can be integrated into nursing education (Canadian Institutes of Health Research, 2015).

5.6 Implications for Nursing Practice, Research, and Education

5.6.1 Nursing Practice

Throughout the review process, the “diverse levels of comfort and competence of nurses are reflected in their varying levels of engagement with persons seeking MAiD” (Beuthin et al., 2018, p. 517). MAiD is a recently legislated end-of-life option in Canada that has specific but evolving eligibility criteria. As the provision of MAiD care has emotional, ethical, moral and legal implications for nurses, educators must identify and meet the diverse needs of the learner. Additionally, nursing students and practicing nurses need access to educational resources that address practice competencies (knowledge, skill, and judgment) to ensure the capacity to provide competent MAiD-related care (Canadian Nurses Association, 2017; Parliament of Canada, 2016). Nurses are guided by practice competencies specific to end-of-life, palliative, chronic illness, complex clinical skills, relational skills, and patient-centred care skills. Nurse educators and leaders are tasked with ensuring that diverse processes are in place to support nurses to meet evolving MAiD competencies (Beuthin et al., 2018). Guidance for competency development regarding MAiD can be found within the below practice recommendations based on the four themes of *ethical and moral challenges, legislation and standards, communication, and mandatory education* (see Table 6). As adult learners, nurses should be encouraged to self-identify learning needs regarding MAiD, collaborate with educators and nurse leaders in the creation of MAiD-specific educational resources, and receive ongoing continuing education opportunities to ensure safe, competent, high-quality nursing practice.

Utilizing the JBI methodology for qualitative systematic reviews, specific practice recommendations were created based on the findings of this review (Joanna Briggs Institute, 2020). The following practice recommendations (Table 5) are relevant to both nursing practice and undergraduate nursing education. As the provision of MAiD occurs in both primary and tertiary practice settings, the listed recommendations can be a valuable guide for educators in diverse settings. These findings can also be disseminated for potential applicability within an international context.

Table 5

Summary of Practice Recommendations

Theme	Sub-Themes	Practice Recommendations
Ethical and moral challenges	Sense-making	<ul style="list-style-type: none"> • Creation of safe spaces to express emotions and hold philosophical and ethical discussions. Safe spaces may include (but not limited to) informal or third-party mediated, open forums, private or group discussions. • Establish regular team debriefing (e.g. after each MAiD provision) to review cases for quality improvement and provide a supportive community. • Offer individual debriefing to encourage contemplation of position, perspectives, and biases.
	Code of ethics and ethical decision-making	<ul style="list-style-type: none"> • Provision of regular updates and resources to provide clarity concerning the Code of Ethics, including guided discussion. • Access to an ethicist or ethical consultant to support ethical training. • Specific topics for ethical training: compassion fatigue, resilience training, incorporation of self-reflection, patient self-determination, patient autonomy. • Theoretical knowledge and practical application of ethical frameworks in class and clinical settings.

	Reflection	<ul style="list-style-type: none"> • Availability of safe temporal and physical space for reflection of thoughts, perspectives, understanding, and experiences, either independently or in a group. • Encourage a culture of openness and reflection. • Incorporating self-reflection into regular practice (facilitator may be needed at times). • Facilitate moral reflection: share personal experiences of encountering death, discuss case studies, role play and small group discussion, and explore emotions/feelings associated with experiences.
Legislation and standards	Professional/regulatory guidance and scope	<ul style="list-style-type: none"> • Clarify roles within the multidisciplinary team. • Identify the nursing scope of practice within various practice settings • Clarify nursing student roles, responsibilities, and scope of practice. • Work with professional associations to develop role and scope of practice competencies for nurses. • Keep current with evolving professional/regulatory guidance.
	Legislation and conscientious objection	<ul style="list-style-type: none"> • Review and disseminate current information embedded in the MAiD legislation (e.g. through internal training). • Clarify potential legal ramifications regarding MAiD and nursing practice. • Provision of clear information and direction regarding conscientious objection. • Clear and consistent support for those who choose to conscientiously object.
	Institutional standards and procedures	<ul style="list-style-type: none"> • Facilitate interdisciplinary education on program procedures and care standards. • Develop, disseminate, and reinforce clear MAiD care pathways, both in practice and nursing curriculum. • Develop educational tools such as standardized assessment guides and documentation templates.

<p>Communication</p>	<p>Responding to requests/inquiries</p>	<ul style="list-style-type: none"> • Provide examples of implicit and explicit requests for MAiD and discuss strategies on how to respond (e.g. covert communication). • Provide coping techniques and supports for processing requests for MAiD. • Nurse practitioners: develop a conversational skill set to engage in initial conversations with those being assessed for eligibility, including taking a direct approach and avoiding euphemisms. • Encourage a compassionate, active listening manner. • Develop the skill of assessing the meaning of the patient request to determine if there is an unrecognized need to manage.
	<p>Patient and family teaching</p>	<ul style="list-style-type: none"> • Prepare nurses with training on how to answer patient and family questions and engage in conversations regarding MAiD. • Prepare patients and families for what to expect when planning for the moment of a MAiD death. • Strategies when communicating with patients and families: <ul style="list-style-type: none"> ○ Therapeutic communication strategies (active and reflective listening, open-ended questions) ○ Active patient advocacy ○ Supporting patient wishes in the context of family relationships ○ Referral for further consultation (palliative care, MAiD) ○ Maintaining an environment of psychological safety
	<p>Communication and tools</p>	<ul style="list-style-type: none"> • Address any fears nurses may have regarding discussing MAiD with patients and family members. • Develop guidelines and communication tools for nursing communication throughout the MAiD process, such as standardized assessment guides and documentation templates. • Role play conversations with patient actors and experienced interdisciplinary colleagues.

		<ul style="list-style-type: none"> • Encourage a communicative culture between interdisciplinary team members. • Strategies and communication skills regarding MAiD: compassionate listening, engaging, attuning, being comfortable with intense emotions, familiarity with MAiD language.
<p>Mandatory MAiD Education</p>	<p>MAiD curriculum</p>	<ul style="list-style-type: none"> • Development and ongoing review and revision of mandatory MAiD education in nursing program curriculum and institutional education. • Establish continuing education initiatives of MAiD concepts. • Application and alignment of theoretical content with clinical experiences. • Regulatory bodies establish competencies and skills corresponding to each step in the MAiD process, such as initiating intravenous access. • Include self-reflection activities before and after encountering a patient who chooses MAiD. • Incorporate best practices and evaluation instruments within Nurse Practitioner curriculum. • Include MAiD education in the context of palliative care, end-of-life care, ethics, legal issues, and professional regulation courses. • Arrange mentorship opportunities with experienced MAiD practitioners, develop opportunities for nurses to observe a MAiD provision before active participation, and require interprofessional debriefing for providers following MAiD related practices. • Development of resources required to inform MAiD curriculum: <ul style="list-style-type: none"> ○ care pathways ○ accreditation standards ○ peer-reviewed evidence ○ local statistics ○ engaging with practice experts. • Suggestions for curriculum design: <ul style="list-style-type: none"> ○ didactic presentations ○ case studies

		<ul style="list-style-type: none"> ○ simulation ○ role playing ○ interprofessional education ○ lectures and/or workshops led by content/practice experts ○ creation of Communities of Practice.
	MAiD educators	<ul style="list-style-type: none"> ● Qualities of high-quality MAiD educators: enhanced understanding of MAiD, passionate about end-of-life care, active in clinical practice, skilled in neutral facilitation, and informed of evolving legislation, guidelines from professional and provincial standards, and policies and procedures of local institutions. ● Provide opportunities for educators to obtain professional development opportunities.

5.6.2 Nursing Research

The findings from this qualitative systematic review demonstrate the limited number of qualitative studies that are focused on the knowledge and educational needs of nurses regarding MAiD. From the extremely broad and extensive search that was conducted throughout 11 different databases, only 16 studies met inclusion criteria. None of the articles were specifically dedicated to identifying knowledge and education needs. These findings were extracted through the exploration of nurses’ experiences, perspectives, and involvement in MAiD nursing care. Furthermore, although most of the articles were Canadian studies that specifically addressed MAiD legislation, there were only 12 Canadian studies that met inclusion criteria. The paucity of qualitative studies focusing on nurses' knowledge and educational needs regarding MAiD supports the need for more expansive nursing research into the ever-evolving MAiD legislation. Based on the four main themes discovered in this review, future qualitative studies should be designed and conducted to explore: 1) ethical and moral challenges (Code of Ethics and ethical

decision-making, sense-making, and reflection), 2) legislation and standards (professional/regulatory guidance and scope, legislation and conscientious objection, and institutional standards and procedures), 3) communication (responding to requests and inquiries, patient and family teaching, communication, and tools), and 4) mandatory MAiD education (MAiD curriculum and MAiD educators).

The intention of including all licensed nurses, nursing students and nurse practitioners within the population of interest for this systematic review was to incorporate a broad view of the knowledge and education needs of nurses and to identify the needs that pertained to all groups, especially given the paucity of applicable studies. However, given the different roles and scope of nurse practitioners involved in MAiD as assessors and providers, further research is needed that focuses on the unique educational needs of nurse practitioners. Qualitative studies focusing on individual nursing professionals, such as registered nurses, registered practical nurses, licensed practical nurses, nursing students, and nurse practitioners, should further explore potential unique educational needs within and between these nursing professionals.

5.6.3 Nursing Education

As the entirety of this systematic review focused on identifying the knowledge and education needs identified by nurses regarding MAiD, every section pertains to nursing education. The practice recommendations listed in Table 6 of the Implications for Nursing Practice section above summarize the action items from the identified knowledge and education needs from the result section of this thesis. Nurse educators and leaders should be encouraged to utilize the findings from this thesis to explore multi-modal educational approaches and strategies to appeal to the greatest range of learners and preferred learning styles.

Drawing upon the principles of Knowles' Adult Learning Theory, MAiD nursing education can be successfully applied to the characteristics of adult learners (Collins, 2004). As adult learners have accumulated life experience to draw upon as knowledge and are driven by goals, educators can engage with nurses to explore their own personal experiences with MAiD and end-of-life care and identify individual or group knowledge or education needs (Collins, 2004). Educators can also utilize the practice recommendations (Table 6) to assess how recommendations apply within their specific care context. As adult learners are self-directed and autonomous, require relevancy and practicality to learn, actively participate in the learning process, and benefit from immediate feedback, utilizing an experiential learning approach may be greatly beneficial (Collins, 2004; Grace et al., 2017). As described by John Dewey, experiential learning is learning by doing and is dependent upon creating educational experiences that allow the learner to engage in a non-threatening environment (Grace et al., 2017). Throughout this review, suggestions for educational strategies included implementing role play, simulation, and debriefing as experiential learning experiences preferred by nurses. Adhering to adult learning principles and implementing experiential learning creates an educational approach that is primed for learning.

5.7 Strengths and Limitations of the Thesis

5.7.1 Strengths

This systematic review followed the well-established methodology outlined in the JBI methodology for systematic reviews of qualitative evidence, including critical appraisal, study selection, data extraction and data synthesis (Joanna Briggs Institute, 2020). Search terms were purposefully selected to be non-specific to expand the search results, ensuring the researchers captured as many potentially applicable studies as possible. The same rationale was employed

when deciding to include 11 databases in the search process. Strategies were implemented to ensure a rigorous and comprehensive systematic review process, including maintaining complete, accurate and transparent methods and results and an auditable search strategy to allow for the review to be reproduced. The Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement was used to improve the conduct and the reporting of the systematic review process to achieve transparency, reproducibility, and comprehensiveness (Tong et al., 2012). Including a research librarian throughout the search methods helped to develop a higher quality in the search. Two reviewers (CM & JT) independently reviewed, discussed, and agreed throughout the critical appraisal, study selection, data extraction and data synthesis process. The findings from this systematic review were used to develop extensive practice recommendations, authentically representing the data from all included studies. This information and practice recommendations can support the knowledge and education needs of all nursing students and practicing nurses throughout Canada, as applicable (Joanna Briggs Institute, 2020).

5.7.2 Limitations

As MAiD is an evolving area of nursing practice within Canada, targeting nursing knowledge and education needs identified by nurses based on their current practice needs supports the development of practice recommendations to guide nursing education. However, as MAiD continues to evolve, the current practice recommendations outlined in this review may not apply to the future educational needs of nurses. It is important to periodically review the knowledge and education needs identified by nurses throughout time to ensure the current practice recommendations remain applicable.

The decision to focus on qualitative data solely was based on the need to address the often neglected nursing voice. Qualitative research stems from human experience to provide a rich, holistic overview of the phenomena yet relies on the experience of smaller sample sizes of participants compared to quantitative methods (Rahman, 2017). Quantitative data obtained through larger studies could provide data that may be more generalizable to the nursing population (Rahman, 2017). Solely utilizing qualitative data may not capture valuable findings of education and knowledge needs from quantitative or mixed methods studies. It would be important to explore further research opportunities utilizing quantitative or mixed methods studies.

All studies included in the review were published from the date that the first country internationally legalized assisted dying; from 2001 until 2021. As an amendment was made to the MAiD legislature on March 17th, 2021, with the Royal Assent of Bill C-7, this review may not capture potential knowledge, and education needs related to the changes made to the legislation (Department of Justice, 2021). With Bill C-7, the MAiD legislation retained nearly all of the original eligibility criteria from Bill C-14 but removed “reasonable foreseeability of natural death” from the list of requirements, excluded all people who are solely suffering from mental illness, and instituted a two-track safeguard system that: a) maintains and eases current safeguards for those whose natural death is reasonably foreseeable, and b) adds new safeguards and strengthens existing safeguards for those who do not have a reasonably foreseeable natural death, and allows for a waiver of final consent to the provision of MAiD based upon meeting specified criteria (Department of Justice, 2021). It would be important to re-evaluate whether all the findings from this review continue to be applicable in practice post-amendment.

There were 7/17 studies included in this review that included a sample of mixed participants, such as nurses, nurse practitioners and physicians, together in their data extraction, data synthesis and results – they did not include nurses solely. These studies were included in this review to capture valuable data that was brought forward by nurses participating in their studies, but it was difficult to distinguish which responses were specifically from nurses. Inclusion of the findings from these combined participant studies may not appropriately represent nurses if the responses were, in fact, from another healthcare professional.

5.8 Conclusion

While completing an advanced practice nursing placement with the MAiD team of the Ottawa Hospital, the primary author of this thesis (CM) encountered many nurses throughout various units within the hospital that appeared uncomfortable related to their lack of knowledge and/or experience related to MAiD. An extensive initial literature review was conducted to explore the current state of MAiD and nursing, with the findings of the review further supporting the need for enhanced nursing education. A qualitative systematic review allowed the reviewers to leverage the experiences of practicing nurses and nursing students to extract and synthesize the nurses' self-identified knowledge and education needs. Following the JBI methodology for systematic reviews of qualitative evidence (Joanna Briggs Institute, 2020), this thesis was undertaken to explore the knowledge and education needs identified by nurses regarding MAiD in an effort to provide direction and guidance for future research, nursing practice and nursing education.

The JBI methodology followed a rigorous and systematic process for performing the study search, critical appraisal, and meta-aggregation of findings (Joanna Briggs Institute, 2020). As MAiD is a relatively novel phenomenon, the reviewers (CM & JT) decided to include 11

databases and utilize broad search terms in the systematic search to identify as many eligible studies as possible. The two reviewers (CM & JT) independently reviewed all records during the initial screening and three rounds of full-text review, discussing any discrepancies in assessment and meeting a consensus without needing a third reviewer. Seventeen studies met the inclusion and critical appraisal criteria. After reviewing whether the studies applied to the MAiD context, one study was removed and a final total of 16 studies were included in the meta-aggregation process.

Following the data collection and extraction, data were analyzed and synthesized by the approach of meta-aggregation as per the JBI approach to qualitative synthesis (Joanna Briggs Institute, 2020). All findings assessed by both reviewers (CM & JT) to be credible or unequivocal were reviewed, grouped into categories based on similarities, and consolidated into themes. There were a total of 4 synthesis topics or themes: ethical and moral challenges, legislation and standards, communication, and mandatory education. Ensuring the themes were representative of the primary authors' findings, generalizable practice recommendations were created to guide future nursing practice, research, and education (Joanna Briggs Institute, 2020).

Given the themes and findings identified within this systematic review, the current MAiD education available to Canadian nurses remains inadequate, which may negatively impact patient care. Nursing educators and leaders must ensure that processes are in place to support nurses in acquiring additional MAiD competencies (Beuthin et al., 2018). Guidance for competency development can be found within the four themes of knowledge and education needs identified by nurses throughout this thesis. Adhering to adult learning principles, role play, simulation, and debriefing are experiential educational strategies that need to be included in educational strategies. Once high-quality, evidence-based educational resources are identified and/or

created, it needs to be applied within a knowledge translation framework, such as the Knowledge-to-Action framework, to effectively move the knowledge into clinical practice (Field et al., 2014). The information and practice recommendations found within this thesis can be used to support the knowledge and education needs of all nursing students and practicing nurses throughout Canada (Joanna Briggs Institute, 2020).

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Appendix A

Database Tables of Search Terms

Search terms: CINAHL

Search Step	Query	Results
1	(medical assistance in dying or physician assisted dying or assisted suicide or euthanasia) OR MAiD OR assisted death OR assisted dying OR patient directed death	14,028
2	wish to die OR right to die	2,287
3	(patient directed dying)	16
4	S1 OR S2 OR S3	15,245
5	nurs*	913,985
6	(nurs*) AND (S4 AND S5)	2,853
7	(nurs*) AND (S4 AND S5) narrow by language – English	2,748
8	(nurs*) AND (S4 AND S5) narrow by language – English and limit by published date 20010101-20211231	1,878
9	AB (nurs*) AND (S4 AND S5) narrow by language – English and limit by published date 20010101-20211231	629
10	TI (nurs*) AND (S4 AND S5) narrow by language – English and limit by published date 20010101-20211231	411

Search terms: Cochrane Library

Search Step	Query	Results
1	exp euthanasia/ or suicide, assisted/	7
2	Right to Die/	4
3	(Medical assistance in dying or MAiD).ti,ab.	23
4	(Euthanasia or (assisted adj3 (suicide or death or dying))).ti,ab.	104
5	((Right or wish) adj3 (die or dying)).ti,ab.	25
6	Patient directed dying.ti,ab.	0
7	or/1-6	156
8	exp nurses/ or exp nursing staff/	2,017
9	exp nursing/ or exp nursing, practical/	3,497
10	nurs*.ti,ab.	41,668
11	or/8-10	43,335
12	7 and 11	11
13	12	1,996
14	limit 12 to English language	9
15	Limit 13 to yr="2001-Current"	5

Search terms: Education Source

Search Step	Query	Results
1	(medical assistance in dying or physician assisted dying or assisted suicide or euthanasia) OR MAiD OR assisted death OR assisted dying OR patient directed death	2,778
2	wish to die OR right to die	451
3	(patient directed dying)	144
4	nurs*	101,398
5	S1 OR S2 OR S3	3,035
6	S4 AND S5	121
7	S4 AND S5 narrow by language – English	119
8	S4 AND S5 narrow by language – English and limit by published date 20010101-20211231	84
9	TI S4 AND S5 narrow by language – English and limit by published date 20010101-20211231	13
10	AB S4 AND S5 narrow by language – English and limit by published date 20010101-20211231	46

Search terms: EMBASE

Search Step	Query	Results
1	exp euthanasia/ or suicide, assisted/	27,104
2	Right to Die/	4,049
3	(Medical assistance in dying or MAiD).ti,ab.	678
4	(Euthanasia or (assisted adj3 (suicide or death or dying))).ti,ab.	18,437
5	((Right or wish) adj3 (die or dying)).ti,ab.	1,579
6	Patient directed dying.ti,ab.	2
7	or/1-6	34,856
8	exp nurses/ or exp nursing staff/	264,181
9	exp nursing/ or exp nursing, practical/	405,201
10	nurs*.ti,ab.	569,850
11	or/8-10	808,745
12	7 and 11	1,996
13	12	1,996
14	limit 13 to English language	1,715
15	14	1,715
16	Limit 15 to yr="2001-Current"	930

Search terms: ERIC

Search Step	Query	Results
1	exp euthanasia/ or suicide, assisted/	9,845
2	Right to Die/	0
3	(Medical assistance in dying or MAiD).ti,ab.	56
4	(Euthanasia or (assisted adj3 (suicide or death or dying))).ti,ab.	148
5	((Right or wish) adj3 (die or dying)).ti,ab.	55
6	Patient directed dying.ti,ab.	0
7	or/1-6	9,965
8	exp nurses/ or exp nursing staff/	4,642
9	exp nursing/ or exp nursing, practical/	2,176
10	nurs*.ti,ab.	16,398
11	or/8-10	16,995
12	7 and 11	279
13	limit 12 to English language	244
14	limit 13 to yr="2001-Current"	121

Search terms: Joanna Briggs Institute EBP Database

Search Step	Query	Results
1	exp euthanasia/ or suicide, assisted/	0
2	Right to Die/	0
3	(Medical assistance in dying or MAiD).ti,ab.	0
4	(Euthanasia or (assisted adj3 (suicide or death or dying))).ti,ab.	1
5	((Right or wish) adj3 (die or dying)).ti,ab.	1
6	Patient directed dying.ti,ab.	0
7	or/1-6	2
8	exp nurses/ or exp nursing staff/	54
9	exp nursing/ or exp nursing, practical/	57
10	nurs*.ti,ab.	647
11	or/8-10	673
12	7 and 11	1
13	limit 12 to yr="2001-Current"	1

Search terms: MEDLINE

Search Step	Query	Results
1	exp euthanasia/ or suicide, assisted/	18,104
2	Right to Die/	4,935
3	(Medical assistance in dying or MAiD).ti,ab.	506
4	(Euthanasia or (assisted adj3 (suicide or death or dying))).ti,ab.	14,119
5	((Right or wish) adj3 (die or dying)).ti,ab.	1,338
6	Patient directed dying.ti,ab.	2
7	or/1-6	27,481
8	exp nurses/ or exp nursing staff/	152,205
9	exp nursing/ or exp nursing, practical/	258,181
10	nurs*.ti,ab.	472,242
11	or/8-10	640,489
12	7 and 11	1,725
13	limit 12 to English language	1,507
14	13	1,507
15	limit 14 to yr="2001-Current"	772

Search terms: Psycinfo

Search Step	Query	Results
1	exp euthanasia/ or suicide, assisted/	1,679
2	Right to Die/	0
3	(Medical assistance in dying or MAiD).ti,ab.	185
4	(Euthanasia or (assisted adj3 (suicide or death or dying))).ti,ab.	3,002
5	((Right or wish) adj3 (die or dying)).ti,ab.	508
6	Patient directed dying.ti,ab.	2
7	or/1-6	3,705
8	exp nurses/ or exp nursing staff/	33,357
9	exp nursing/ or exp nursing, practical/	23,734
10	nurs*.ti,ab.	103,775
11	or/8-10	106,325
12	7 and 11	343
13	limit 12 to English language	328
14	Limit 13 to yr="2001-Current"	251

Search terms: Proquest Dissertation and Theses Abstracts

Search Step	Query	Results
1	noft((medical assistance in dying or physician assisted dying or assisted suicide or euthanasia) OR MAiD OR assisted death OR assisted dying OR patient directed death)	2,280
2	noft(wish to die OR right to die)	801
3	noft((patient directed dying))	33
4	noft(nurs*)	72,479
5	S1 OR S2 OR S3	3,004
6	S4 AND S5	248
7	S4 AND S5 Narrowed by Language: English	246
8	S7 AND S6 Narrowed by entered date: 2001-01-01 – 2021-05-30 and Language: English	152

Search terms: Web of Science

Search Step	Query	Results
1	TOPIC: ((medical assistance in dying or physician assisted dying or assisted suicide or euthanasia) OR MAiD OR assisted death OR assisted dying OR patient directed death)	60,571
2	TOPIC: (wish to die OR right to die)	44,138
3	TOPIC: (nurs*)	376,863
4	TOPIC: ((patient directed dying))	5,991
5	#4 OR #2 OR #1	106,261
6	#5 AND #3	2,904
7	#5 AND #3 Refined by: Publication years: (2001-2021)	2,590
8	#5 AND #3 Refined by: Publication years: (2001-2021) AND Languages: (English)	2,412

Search terms: Nursing and Allied Health

Search Step	Query	Results
1	noft((medical assistance in dying or physician assisted dying or assisted suicide or euthanasia) OR MAiD OR assisted death OR assisted dying OR patient directed death)	8,183
2	noft(wish to die OR right to die)	3,105
3	noft((patient directed dying))	96
4	noft(nurs*)	597,241
5	S1 OR S2 OR S3	10,528
6	S4 AND S5	2,092
7	S4 AND S5 Narrowed by entered date: 2001-01-01 – 2021-05-30	1,689
8	S4 AND S5 Narrowed by entered date: 2001-01-01 – 2021-05-30 and Language: English	1,674

Appendix B

JBI Critical Appraisal Checklist for Qualitative Research

JBI Critical Appraisal Checklist for Qualitative Research

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there congruity between the research methodology and the research question or objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there congruity between the research methodology and the methods used to collect data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there congruity between the research methodology and the representation and analysis of data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there congruity between the research methodology and the interpretation of results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a statement locating the researcher culturally or theoretically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the influence of the researcher on the research, and vice-versa, addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are participants, and their voices, adequately represented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall appraisal: Include Exclude Seek further info

Comments (Including reason for exclusion)

Appendix C

JBI QARI Data Extraction Tool for Qualitative Research

JBI QARI Data Extraction Tool for Qualitative Research

Reviewer _____ Date _____

Author _____ Year _____

Journal _____ Record Number _____

Study Description

Methodology|

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors conclusions

Comments

Complete Yes No

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(Joanna Briggs Institute, 2020)

Appendix D

Enhancing the Transparency in Reporting the Synthesis of Qualitative Research:

ENTREQ Statement

No	Item	Guide and description
1	Aim	State the research question the synthesis addresses.
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. <i>meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis</i>).
3	Approach to searching	Indicate whether the search was pre-planned (<i>comprehensive search strategies to seek all available studies</i>) or iterative (<i>to seek all available concepts until they theoretical saturation is achieved</i>).
4	Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. <i>in terms of population, language, year limits, type of publication, study type</i>).
5	Data sources	Describe the information sources used (e.g. <i>electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists</i>) and when the searches conducted; provide the rationale for using the data sources.
6	Electronic Search strategy	Describe the literature search (e.g. <i>provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits</i>).
7	Study screening methods	Describe the process of study screening and sifting (e.g. <i>title, abstract and full text review, number of independent reviewers who screened studies</i>).
8	Study characteristics	Present the characteristics of the included studies (e.g. <i>year of publication, country, population, number of participants, data collection, methodology, analysis, research questions</i>).
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. <i>for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development</i>).
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. <i>assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings</i>).
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. <i>Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting</i>).
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. <i>all text under the headings "results /conclusions" were extracted electronically and entered into a computer software</i>).
15	Software	State the computer software used, if any.
16	Number of reviewers	Identify who was involved in coding and analysis.
17	Coding	Describe the process for coding of data (e.g. <i>line by line coding to search for concepts</i>).
18	Study comparison	Describe how were comparisons made within and across studies (e.g. <i>subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary</i>).
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. <i>new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct</i>).

(Tong et al., 2012)

Appendix E

Data Extraction Tables

Title: Medical assistance in dying (MAiD): Canadian nurses' experience

Author: Beuthin, R., Bruce, A. & Scaia, M.

Year: 2018

Country: Canada

Journal: Nursing Forum, 53: 511-520.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Qualitative design of narrative inquiry and thematic analysis.</p> <p>- Aim is to understand the range of nurses' experience in providing care for someone choosing MAiD, whether directly aiding, providing supportive care, or declining to participate.</p>	<p>- 17 nurses (NPs, RNs, and LPNs,) from urban and rural areas across Vancouver Island, British Columbia, working across settings including acute care, residential care, primary care clinics, and community and palliative care.</p> <p>- No inclusion or exclusion criteria stated.</p>	<p>- Semi-structured interviews conducted in-person or by phone, audiotaped.</p>	<p>- Narrative approach informed by Riessman and thematic analysis by Braun and Clarke.</p> <p>- Researchers read each interview as it was transcribed verbatim from audio recording; with completed data set, transcripts were divided among the team to ensure close reading of transcripts.</p> <p>- Data management using Atlas-ti software.</p>
Finding Themes/ Supporting Quotes			
<p>1) Theme: Nursing practice (competencies). <i>There are no supporting quotes or illustrations for this section – only statements.</i> "Diverse levels of comfort and competence of nurses are reflected in their varying levels of engagement with persons seeking MAiD." "Chronologically, nurses may engage in some or all of the following aspects: • Responding to a request for information, • Engaging in a deeper conversation with patient and family, • Objecting to involvement but provide basic care, • Providing nursing care (up to the time of MAiD), • Starting intravenous, • Aiding directly (support through a palliative care approach), • Debriefing with family and doctor, • Providing afterlife care, and • Debriefing with team, supporting one another." "Nurses were drawing on existing competencies related to end-of- life, palliative, chronic illness, and patient-centered care approaches, as well as complex clinical skills and relational skills that foster trust and engagement."</p>			

2) Theme: Personal impact. “While not all participants were pioneers in this way, two nurses were also entering new territory of resistance as conscientious objectors. Tamara, with years of experience, would not participate in MAiD for religious reasons. She described a lack of clarity around legal and professional requirements for nurses and the absence of support for those with a conscientious objection in her hospital: “I think that in some units [the] “duty to provide care” is being touted as “you don't have a choice” and the information isn't there [about] how to object if you don't agree with it. And that's one thing through the whole process—there is not one thing that came from [the administration] that said, “you have the right to file a contentious objection on this.” There wasn't one thing that came through the pipe.” *Under the communications section:* “A better understanding of how to foster open conversations about moral distress and objection are needed to protect the integrity of everyone on the team.”

3) Theme 2: Sensemaking: taking a stand. *The associated quotes in this section lack a clear association with the findings.* “The majority of nurses shared stories of being in process, holding an in-between space of uncertainty, reflection, and active sensemaking.” “This uncertainty was not linked to religious, spiritual, or ideological reasons but arose from fear and confusion around the legal, ethical, and professional messaging they were receiving.” “Others expressed uncertainty or hesitancy to engage in MAiD for other reasons, including a lack of confidence—they just did not know what they could say or do, and the lack of time for them to take the required education.”

4) Theme 3: Technical skills. *The associated quotes in this section lack a clear association with the findings.* “While initiating a reliable intravenous access is not considered the most vital nursing responsibility in MAiD, many nurses considered this skill as paramount.” “Nurses shared concerns about community health nurses who knew their patients well and wanted to assist, however they often did not have the intravenous skills required.” “However, most of the nurses aiding with MAiD participated in all aspects including inserting the intravenous beforehand and removing afterwards, assisting the physician, writing down medications, providing afterdeath care, completing documentation, supporting the family, and transferring the body to the morgue or designated funeral home.”

5) Theme 4: Communication. *The associated quote in this section lacked a clear association with the findings.* “The combination of having excellent technical capacity with requisite communication skills was described as essential. Nurses identified compassionate listening, engaging, attuning, and being comfortable with intense emotion as key to effective communication with patients and families. Nurses emphasized the importance of providing information “in a compassionate listening manner” and discerning what patients are actually asking when seeking information.”

Statements throughout the findings section included:

- "Misinformation and lack of clarity regarding the nursing Code of Ethics and legal requirements calls for nursing leadership to ensure mechanisms to regularly update and clarify misinformation."
- "Understanding the ongoing sensemaking process calls for spaces and ways of checking in: talking, listening, hearing, and supporting nurses; providing opportunities for debriefs and ethical conversations in safe venues where emotions can surface and issues of moral distress be expressed and addressed."
- "Findings from this study have implications for clinical educators to attend closely to the emotional nature of assisted dying for nurses. Educational approaches must go beyond information sharing via didactic presentations and explore simulation, role playing, and the creation of Communities of Practice. These findings raise questions of how nurses in community and home care can develop and maintain the necessary skills of intravenous insertion to aid in assisted dying with patients they may have known for years. Findings also have implications for whether minimal education about MAiD should be mandatory."

Title: Medical Assistance in Dying: Patients’, Families’, and Health Care Providers’ Perspectives on Access and Care Delivery.

Author: Brown, J., Goodridge, D., Harrison, A., Kemp, J. Thorpe, L., & Weiler, R.

Year: 2020

Country: Canada

Journal: Journal of Palliative Medicine, 23(11).

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
- Interpretive description approach. - Goal: to explore patient, family, and HCP perspectives on MAID care access and delivery, and provide recommendations to improve a regional MAID program.	- 5 patients, 11 family members, and 14 health care providers (3 physicians, 4 social workers, and 7 nurses). Setting was in a Saskatchewan regional health authority. - Sampling considered the "inclusion of participants with diverse MAID involvement."	- Semi-structured interviews (using a guide); audio recorded and transcribed.	- Two project members reviewed transcripts. - Conventional content analysis and open-coding iterative approach used. - Textual codes were formulated, sorted, linked and thematically summarized using NVivo12.
Finding Themes/ Supporting Quotes			
1) Theme: Ambiguous Care Pathway. "Participants expressed frustration and confusion regarding the ambiguous care pathway, which significantly impacted access to care. Significant challenges were noted in obtaining accurate MAID information, referrals,			

and delivering the complexities of MAID care. This was compounded by an “air of secrecy,” HCP lack of knowledge regarding care processes, and, on occasion, HCP nonparticipation.”

2) Theme: Lack of Support for Care Choices. "Participants expressed a lack of support for HCPs who objected to MAID and for HCPs who actively choose to participate in care."

3) Theme: Uncertain Roles and Responsibilities. "Confusion regarding communication with patients and families and scopes of practice resulted in disorganized and disjointed care." *Quotes to support finding #3:* “[The patient] knew that’s what she wanted and so I got the doctors, and referred, and started the process for her. And our direction isn’t super clear - we, as [professional group], aren’t supposed to bring it up as I’m told, but we aren’t really sure what to do... is it the doctor who brings it up? Or do they learn about it from media? We don’t really know.” (HCP. Interview 11). "We’re involved with the patient, but I don’t know how much of it we are allowed to direct. Is it something that nurses can bring up? Or is it the doctors that should bring it up and get other teams involved with MAID and they would give them information to follow up with?" (HCP. Interview 6). “The [Registered] nurses weren’t sure if they were going to have to administer medications.” (HCP. Interview 4).

Statements throughout the discussion section included: 4) "Practitioners must have time to practice relational care, have administrative supports, and remuneration that reflects practitioner intensive investment. Social and emotional support through group debriefings should be easily accessible and sensitive to the MAID care context." 5) "Good clinical care must always be at the forefront, and mentorship can demonstrate and emphasize the importance of holistic assessments, understanding of a patient and family story, and utilization of interdisciplinary supports." 6) "Interdisciplinary education for HCPs should be facilitated, and knowledge must move beyond understanding legalities and into clinical care realities, including (1) the role and scope of practice of interdisciplinary team members, (2) program procedures and care standards, (3) sensitive and holistic communication with patients and families, and (4) respect for care practice choices, including those who object to and those who provide MAID." 7) "Consideration must be given to the needs of HCPs who choose to participate in MAID. This includes providing safe spaces and the opportunity to acquire skills and confidence in care provision."

Title: Medical Assistance in Dying in health sciences curricula: A qualitative exploratory study

Author: Brown, J., Goodridge, D., & Thorpe, L.

Year: 2020

Country: Canada

Journal: Canadian Medical Education Journal, 11(6).

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
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<p>- Qualitative exploratory study using Interpretive description, force field analysis and change as three steps. - Aim: "to (1) provide insight into the drivers and restrainers influencing MAID inclusion into curricula, (2) review the required resources for teaching MAID, and (3) examine the current placement of MAID concepts in relation to existing end-of-life (including palliative care [PC]) concepts."</p>	<p>- 10 key informants including "... key informant (KI) purposive sampling approach with the goal of recruiting a KI from each health sciences program in our province." "Potential KIs were either identified directly to the researcher by the Dean (or designate), or the Dean (or designate) disseminated the project information to potential KIs." KIs: pharmacy (1), social work (2), medicine (1), nursing (6). - "The undergraduate medical program and programs of nursing, social work, and pharmacy were the health sciences programs identified for project inclusion."</p>	<p>- Used a semi-structured interview guide that was provided to KIs in advance of the interview. Single interviewer conducted all interviews by means of in-person (n=4), by telephone (n=3), and via WebEx (n=3). The interviewer used a data collection checklist to record hand-written data based on the interview guide, which was then transcribed into a typed document. Typed document was sent to participants for response verification.</p>	<p>- Data collection and analysis occurred concurrently in an iterative process supported by NVivo 12. - Open and comparative coding steps outline by Boeji were applied, including code comparison within a single interview, code comparison between interviews within same profession, and code comparison between interviews from different professions. All codes underwent thematic analysis.</p>
<p>Finding Themes/ Supporting Quotes</p>			
<p>1) Theme: Profession restrainers. "A change restrainer for some was a perceived lack of clear direction from professional associations and a lack of MAID in the accreditation standards. Ambiguous, fluctuating, or absent professional association statements and a disorganized approach to information sharing restrained content inclusion."</p> <p>2) Theme: Program drivers and restrainers. "In the nursing and social work programs, student exposure to MAID concepts was less consistent. When MAID was not a specific course objective, inclusion was at the purview of teaching faculty based on the interpretation of the pre-existing course objectives. This lack of consistency was compounded when multiple sections of the same course were often taught by different faculty."</p> <p>3) Theme 3: Resource driver and restrainers. "... resource diffusion, resource overload, and risk of misinformation were identified as change restrainers. Some KIs reported referencing a single teaching resource, whereas other KIs perceived being overloaded with</p>			

resources, or noted that resources were not specific to the local practice context. Some KI's highlighted dissonance among the theoretical information presented to students, the information provided in the clinical education setting, and the information shared by practicing practitioners."

4) Theme 4: Faculty drivers and restrainers. "Faculty who were comfortable with MAID content, passionate about end-of-life care, and skilled in neutral facilitation were viewed as change drivers. They brought MAID content forward as it aligned with their personal end-of-life care experiences, their programs of research, and their teaching assignments." "Within select health sciences programs, not all members of the faculty maintain an active clinical practice, which often limited the content to the theoretical and legal aspects of MAID. In contrast, those with clinical practice more readily brought forth practical and clinical aspects of MAID. Some KIs noted that an enhanced understanding of MAID was essential for all faculty, and highlighted the need for faculty to reconcile their individual beliefs within this new care context. Some further identified that individual faculty retained the responsibility to seek professional development, whereas others identified that program leadership retained responsibility to provide professional development opportunities."

5) Theme 5: Student driver and restrainers. "KIs stated students were encountering MAID in the clinical settings, were bringing forward personal family MAID experiences, and were engaged in MAID discussions. However, some KIs also reported a paucity of student awareness that MAID was part of the current practice. Further, some KIs voiced hesitation regarding students' ethical and professional maturity within the MAID practice context, uncertainty regarding the students' scope of practice, and uncertainty regarding what students 'may' but 'should' participate in."

6) Theme 6: Required resources and MAiD placement within the curriculum. "KIs identified care pathways, education accreditation standards, enhanced interprofessional problem-based learning opportunities, case studies, the use of practice experts, peer-reviewed evidence, and local statistics as the resources required to support the MAID content delivery. Across all the health sciences programs, MAID was discussed within the context of PC and end-of-life care, and KIs discussed the importance of this. MAID was additionally situated in ethics, legal issues, and professional regulation courses. All KIs highly valued teaching about MAID in a neutral, safe manner within a respectful environment that allowed the student's opportunity to explore individual beliefs." "Some noted that faculty who were unable to teach MAID because of a conscientious objection (CO) could request an alternative teaching assignment."

Title: Medically Assisted Dying in Canada: "Beautiful Death" is Transforming Nurses' Experiences of Suffering.

Author: Bruce, A. & Beuthin, R.

Year: 2020

Country: Canada

Journal: Canadian Journal of Nursing Research, 52(4): 268-277.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Qualitative secondary analysis using narrative inquiry and thematic analysis.</p> <p>- Goal is to understand how nurses' experiences of suffering are being shaped through caring for patients and families choosing MAiD.</p>	<p>- 15 nurses (RNs, NP and licensed practical nurse); worked in diverse settings, including acute care, community-home care, and specialty areas including emergency room and palliative care.</p> <p>- Inclusion: nurses who participated directly or indirectly with MAiD.</p>	<p>- Semi-structured interviews conducted in-person and by phone, audiotaped and transcribed verbatim.</p>	<p>- Transcripts divided among researchers, listened to recordings and reflective annotations were written with transcripts.</p> <p>- Data were coded, and analysis meetings were held to inductively identify categories.</p> <p>- Stories collapsed into 3 key narratives with 7 sub-storylines.</p>
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: Residual discomforts. "Others wondered if external factors such as debates over adequate funding for prescriber medical doctors (MDs) and NPs, and lack of mandatory education might contribute to routinizing death and cause unintended harm." "In addition to concerns that MAiD may become too clinical and the potential for misuse, some participants suggested nurses must think more deeply about the process of dying in general in order to face their own discomfort with death. Greater openness and reflection were seen as integral to being able to support families and each other." "I think we're gonna do much better if we start the conversation early in our training to be more prepared to talk about these things. And often when you're 19, 20, 21, 22, 24 years old with no life experience, unless you've lost your grandma, you might not really have a lot to say right? So I think exposure to conversation about [death and dying] and you know, at least bringing some attention to it . . . can make this process a lot more fluid for all concerned. Because it's not just the patient."</p> <p><i>Statements in the discussion and implications for practice section included:</i> "Nurses expressed fears based in the unknown future including concerns that MAiD could be implemented without adequate educational support and follow-up." "Implications for nurse education and clinical nurse leaders across healthcare settings include establishing ongoing opportunities for nurses to engage in conversations and deeper philosophical and ethical discussions of values and beliefs about death, dying, and the overlapping suffering of patients and their nurses."</p>			

Title: Involvement of nurses in caring for patients requesting euthanasia in Flanders (Belgium): A qualitative study.

Author: De Bal, N., Dierckx de Casterle, B., De Beer, T., & Gastmans, C.

Year: 2006

Country: Belgium

Journal: International Journal of Nursing Studies, 43: 589-599.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Qualitative grounded theory strategy.</p> <p>- Objective: "To explore nurses' involvement in the care for patients requesting euthanasia." Aim: to provide "an in-depth understanding of the experiences of Belgian nurses who are involved in the care for patients with a euthanasia request (prior to euthanasia legalization)."</p>	<p>- 15 nurses, including 1 intensive care, 1 oncology, 8 palliative care, and 5 internal medicine nurses. Setting: two general hospitals and a palliative care setting in Flanders (Belgium).</p> <p>- Inclusion criteria: "(a) Dutch-speaking; (b) working for at least one year in hospital A or B; (c) working at least part-time (greater than or equal to 50%); and (d) ever received a euthanasia request."</p>	<p>- One-on-one semi-structured interviews, guided by open-ended questions used in the interview guide; 10 interviews were conducted in a private area of the workplace, and 5 were conducted at the participants' home. All were tape-recorded.</p>	<p>- Applied theory approach of isolating, comparing, conceptualizing, categorizing, and relating data to each other.</p> <p>- Transcripts and field notes read several times, concepts were coded and grouped into categories. Early concepts were recorded in analytic memos. Data then organized into a framework.</p> <p>- Coding supported by GRA NUD*IST N4 software program.</p>
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: The nurses' conflicted feelings about (their involvement in) euthanasia. Coping with and responding to requests. "Participants reported that coping with such requests was a learning process. At first, the request took them by surprise: the nurses were shocked and did not know how to react. Gradually, they learned how to react to such a request. Although they were no longer as shocked as they were initially, the nurses still felt a rude awakening every time they received such a request."</p> <p>2) Theme 2: Powerlessness: the central emotion experienced by participants. Coping with requests. "Besides powerlessness, all the nurses interviewed experienced anxiety, sometimes arising from their own ignorance; they did not know how to react to a euthanasia request. Although respecting the request, they were confronted with the illegality of euthanasia and with the hospital's euthanasia policy."</p> <p>3) Theme 3: Nurses' key role in caring for patients with a euthanasia request: the process model. "The interviewees stated unanimously that they had an important role in the overall care of patients requesting for euthanasia." "(a) Period before the euthanasia request: ... during this period, the nurses mainly tried to listen and to talk to the patients to gain a better idea of the</p>			

patients' mindset." "(b) Confronting the request for euthanasia: ... once nurses became aware of their patients' request to die, they made an effort to care for their patients in a compassionate way. If the nurse was the first caregiver to receive the euthanasia request, the nurse's most important task was to listen carefully to the patient, taking the request seriously. The function of listening was twofold: (1) to be present and to give patients the opportunity to tell their story and to express their feelings and concerns, and (2) to determine the reason(s) behind the euthanasia request... In addition to actively listening, nurses observed their patients' reactions to determine the root cause of the requests... At this stage, the nurses also listened to the family members, because they also experienced conflicting emotions... (certain tasks) included listening to their patients; informing them about palliative care principles, care alternatives, and dying; reassuring them that they are there for them when needed; and maximizing pain and symptom control." "(c) Reporting the request to other caregivers:... nurses always informed the physician and their colleagues of the euthanasia request, mostly during rounds." "(d) Participating in decision-making:... The nurse's role in this phase consisted of supplying information about the patient's needs, feelings, and request. One PST nurse stated the importance of team discretion when discussing the request... It was considered to be a major nursing task to communicate the significance of the patient's suffering and to relate this adequately to every team member. Besides their clarifying role, some PST nurses reported that they organized a multi- disciplinary discussion to determine which healthcare professionals should be involved in the next phase." "(e) The result of the decision-making process:... With the physician's help, nurses at times tried to enhance the terminally ill patient's dignity and to maximize their comfort by medically controlling pain and symptoms... Especially during this phase, nurses supported the psychosocial needs of their clients... Their supportive role toward the relatives primarily consisted of listening to them express their feelings, just silently being present." "(f) Aftercare: The interviewed nurses reported no cases of euthanasia actually being carried out, but they did state that they played an important role in supporting the patient's family once the patient passed away. Nurses would talk to the relatives to help them grieve."

Statements found in the discussion section include: "Our findings also indicate that each stage of this process requires that the nurses possess specific supporting competencies." "Professional guidance needs to move beyond role clarity to include skill development in exploring expressed desire to die, and team skills that empower nurses to discuss the management of these patients."

Title: Communication in nursing care for patients requesting euthanasia: a qualitative study.

Author: Denier, Y., Gastmans, C., De Bal, N, & Dierckx de Casterle, B.

Year: 2010

Country: Belgium

Journal: Journal of Clinical Nursing, 19: 3372-3380.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
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<p>- Grounded theory; qualitative interview design. - How does nurses' communication contribute to the euthanasia care process in a legal context?</p>	<p>- 18 Flemish nurses; 9 different hospitals throughout 5 provinces in Flanders; nurses working in different units. - Purposive sampling; Sampling aimed for diversity regarding characteristics of both participants and hospitals.</p>	<p>- In-depth semi-structured interviews; tape-recorded and transcribed ad verbatim. Participants were asked to think back to a specific case of a patient requesting euthanasia and the way they experienced the process as a whole. Transcripts read and discussed by all others.</p>	<p>- Transcripts repeatedly read and discussed. Dominant themes marked and coding scheme developed. - Coding supported with GSR NVivo7 software. - Independent interpretation of transcripts and codes by multidisciplinary team carried out.</p>
<p>Finding Themes/ Supporting Quotes</p>			
<p>1) Theme 1: Communication in the context of care for the patient and the family. Components included active listening; asking open questions; providing information; translation; consultation; provide advice; non-euthanasia-related conversation; openness and attentiveness; expressing patience; trustworthiness; gaining certainty; standing up for the patient; creating peace.</p> <p>2) Theme 2: Communication in the interprofessional context. Components included: providing information; discussion and consultation; active listening; providing advice; open and attentive; gaining certainty; clarity and peace; creating balance.</p> <p><i>Statements found in the discussion and relevance to clinical practice sections include:</i> "On the level of education, it is important that nurses are sufficiently trained in using their communicative skills in the context of euthanasia care, as well as in their knowledge of the Act on Euthanasia." "In the hospital context, sufficient attention should be paid to structures that facilitate and support a communicative culture, by developing an ethics policy on euthanasia, by paying attention to moral disagreement and conflict management, by organizing internal trainings on euthanasia care and by investing in effective leadership in nursing." "Guidelines for nursing communication during the euthanasia care process would contribute to supporting the nurses in providing good-quality euthanasia care." "Communication also involves explaining concepts, actions and procedures to the colleagues, making sure that a patient's euthanasia request is correctly understood by the care providers and making sure that the procedure to be followed is clearly known."</p>			

Title: Hospice care providers experiences of grappling with medical assistance in dying in a hospice setting: a qualitative descriptive study.

Author: Freeman, S., Banner, D. & Ward, V.

Year: 2021

Country: Canada

Journal: BMC Palliative Care, 20(55).

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Qualitative descriptive study with inductive and thematic analysis.</p> <p>- Aim: focus more narrowly on how the care provider experience caring for patients who chose to undergo MAiD effects their role as a hospice care provider.</p>	<p>- 8 hospice care staff. Participants were eligible to participate if they were a formal care provider (e.g., registered nurse, care aide, grief support worker, and care manager) or facility-affiliated informal care providers (e.g., trained hospice volunteer or program coordinator)</p> <p>- Convenience and purposive sampling used. "... geographically-isolated medium sized city (population < 100,000) in western Canada." "In this study, care providers at the hospice care facility were not involved in the assessment nor in the provision of MAiD. Instead, if a patient inquires about MAiD, the hospice care providers would refer the patient to a physician or nurse practitioner for further information and assessment if requested. As per facility policies, if a patient requests MAiD they may be cared for until the time</p>	<p>- In-depth semi-structured interviews; conducted in a confidential room on-site. Audio recorded and field notes were taken.</p>	<p>- Qualitative description approach.</p> <p>- Inductive and thematic analyses undertaken.</p> <p>- Transcripts cleaned and reviewed. Read closely by team to identify important concepts.</p> <p>- Transcripts uploaded into NVIVO 12, coded, and organized thematically.</p> <p>- Labelled and grouped data was reviewed by 2 researchers independently, areas of convergence discussed until consensus achieved.</p> <p>- As codes refined, the team mapped the emerging patterns and themes.</p>

	<p>immediately prior to the procedure at which time they must be transferred off-site to receive the procedure."</p> <p>- Inclusion: "Participants were eligible to participate if they were a formal care provider (e.g., registered nurse, care aide, grief support worker, and care manager) or facility-affiliated informal care providers (e.g., trained hospice volunteer or program coordinator)."</p>		
Finding Themes/ Supporting Quotes			
<p><i>Statements found in the discussion section include:</i> "For some, a lack of certainty around language made interactions with patients and those around them difficult." "Care providers require a multi-faceted range of resources, including clinical, legal, and logistical supports at the practice, organizational, and health system levels, to facilitate the delivery of high-quality care to those requesting and undergoing MAiD and to promote the delivery of coordinated and holistic patient-centered care. Resource development should focus not only on equipping care providers with tools specifically tailored to providing quality support for persons requesting MAiD, but also to provide support to the care providers themselves through education and self-care resources. Communication tools to support discussion, which also clarify the boundaries of the care provider-patient relationship in regards to MAiD, may help bridge some of the disconnect in the patient-provider communication." "Care providers need a safe temporal and physical space to reflect on and connect with others about their thoughts, perspectives, and experiences as related to their understanding and experiences with MAiD. Safe environments that support discussion of polarizing topics, including moral distress, religious beliefs, and conscientious objection, are necessary."</p>			

Title: The Seismic Shift in End-of-Life Care: Palliative Care Challenges in the Era of Medical Assistance in Dying.

Author: Ho, A., Joolae, S., Jameson, K., & Ng, C.

Year: 2021

Country: Canada

Journal: Journal of Palliative Medicine, 24(2).

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Qualitative interview study with thematic analysis.</p> <p>- Aim: examined palliative and hospice care providers' (PHCP) experiences and perspectives in providing EOL care after the legalization of MAiD. "It explored challenges PHCPs face and resources that can support clinicians' work in providing person-centered EOL care."</p>	<p>- 26 PHCP participants, including 7 physicians, 12 nurse, 5 social workers, and 2 spiritual health practitioners. Purposive and maximal variation sampling techniques were used. Participants worked in community, hospice, hospital palliative care, or multiple site settings in Vancouver, Canada.</p> <p>- No inclusion or exclusion criteria stated.</p>	<p>- Semi-structured interviews (using a guide) conducted in person or by phone/Skype; audio recorded and transcribed verbatim. "Field notes documented the recruitment and interview contexts as well as participants' speech and nonverbal behavior."</p>	<p>- Inductive analysis comparing indicators, concepts, and categories.</p> <p>- Constant comparative approach utilized to systematically organize, compare, and understand differences and similarities.</p> <p>- Multi-step coding process with 1-4 independent researchers, supported with NVivo 12 software.</p> <p>- Analytic memos recorded of researcher's self-reflections and critical analysis of emerging ideas.</p> <p>- Adherence to the Consolidated Criteria for Reporting Qualitative Research checklist.</p>
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: Education and training. "Participants recommended expanding MAiD education for PHCPs to clarify the complexities in the MAiD legislation (e.g., eligibility criteria, waiting period), institutional policies, and professional colleges' and health authorities' procedural requirements. They also proposed specialized training on MAiD communication." "Participants noted that despite their extensive training in EOL care discussions, MAiD requests felt like a "seismic shift" from their palliative care work. As a sensitive topic, MAiD can dramatically affect the patient-provider therapeutic alliance. Engagement in MAiD conversations requires guidance on what language or approaches can best support patients in the care pathway, from exploration of patients' initial inquiries to grief support for families' post-MAiD procedures. Suggested strategies included using patient actors and skilled interdisciplinary mentors to demonstrate effective MAiD discussions."</p>			

2) Theme 2: Team and individual debrief. "Most participants reported that team debriefs were helpful in supporting staff by encouraging a welcoming space for different voices to come together and providing a platform for more conversations to understand and address provider distress. Participants recommended more frequent debriefs than currently offered (e.g., debriefs following all MAiD events): "Debriefing is one of the most valuable and accessible. Those are so useful at reviewing cases that are highly relevant because of direct practice. They give us the opportunity to review what went well, what could have gone better and how we can do better next time." (Participant #6, Nurse)." "Individual debriefing for PHCPs to contemplate their own position, perspectives, and biases was deemed especially valuable for clinicians experiencing MAiD-related moral uncertainty or distress."

Title: How do Palliative Care Registered Nurses Apply Concepts of Ethical Decision-Making When Caring for Patients who Request Medical Assistance in Dying? An Interpretive Descriptive Qualitative Study.

Author: Kopchek, L.

Year: 2020

Country: Canada

Journal: Proquest, Ann Arbor, MI

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
- Qualitative interpretive description. - Purpose: "The primary purpose of this qualitative study was to understand how palliative care RNs apply the concepts of ethical decision-making when caring for patients who request MAiD." "The research was also proposed to support policies and practices related to ethics and MAiD for palliative care RNs who work within settings that provide MAiD as a health care service." Research questions: 1) How do palliative	- 10 palliative care nurses, including 3 acute care, 4 hospice care, 1 long-term care, and 2 community care. 9 worked in an urban setting and 1 worked in a rural area. 1 palliative care nurse identified as disagreeing with MAiD. All participants work in Ontario, Canada. Purposive sampling and maximum variation approach was used. - Inclusion: "palliative care nurses who work in Ontario, Canada and have experiences related to MAiD that can inform the research questions."	- Semi-structured interviews were conducted by telephone and were digitally recorded.	- Data analysis performed concurrently with data collection. - Iterative reasoning approach used to sort data. Data sorted using broad-based coding, grouping themes. Transcripts carefully reviewed. - Ideas written down during and after interviews, and when reviewing transcribed audiotapes. - Microsoft Word used to organize themes; separate file used to collect important quotes.

<p>care RNs apply concepts of ethical decision-making when caring for patients who request MAiD?, and 2) What are the educational needs of RNs related to ethical decision-making and MAiD?</p>	<p>"...lived in rural or urban communities and if they worked in hospital, community or long care facilities to maximize the diversity of participant's experiences." "if they had firsthand experience with MAiD or exposure to MAiD in some clinical context."</p>		<p>- Constant comparative analysis used.</p>
<p>Finding Themes/ Supporting Quotes</p>			
<p>"Knowledge deficits related to MAiD and ethics in general negatively influenced palliative care nurses' overall ability to make ethical decisions. Participants shared many educational needs, such as legislation rules and/or guidelines, legal ramifications for nurses, and ethical training." "Participants reflected on needing more education about ethical decision-making, the process of MAiD, roles, competencies specific to nurses, documentation, and having conversations with patients and/or families."</p> <p>1) Theme 1: Education and Support. "We need more ethical training. Everyone is focused on skills and not the real conversations." "One participant reflected on incorporating self-reflection in the moment and after an ethical event to explore and talk about ethical dilemmas: "I don't think it's a basic for every human to be self-reflective. You have to know where you stand and why. Where are these feelings coming from?" "the palliative care nurses who worked in acute care settings shared that access to an ethicist or ethical consultant would be helpful." "The ability to answer questions and have conversations related to MAiD was emphasized by nurses. Nurses didn't know what they can or can't say to patients without feeling like they are coercing the patient to make a decision regarding MAiD. "I didn't think my opinion was important, I was there to assist the patient. Maybe I should be able to talk more about MAiD, but I just pawn off the conversation and say, ask your doctor. I don't know how to have those conversations with a patient"." "Participants indicated that having formal and informal debriefing before and after the provision of MAiD is imperative to ensure any emotions, feelings, and questions are addressed: "I hear distress from nurses when there is family conflict, the patient is not able to speak for themselves or the process of debriefing before or after MAiD is not done (P5)". "Having a debriefing before and after MAiD is done would be helpful. Not just the individuals involved, but everyone on the floor" (P7)." "Nurses felt rushed and stressed when not provided adequate time, education and/or support when deciding whether or not to participate in MAiD. The community palliative care nurses reported that access to online education, pamphlets and/or support from management would be helpful when participating in MAiD. Participant Eight reviewed a scenario that occurred amongst nurses: "The care providers didn't prepare the organizations to go ahead and start doing MAiD. No mandatory education or information was provided for the nurses. The education we were provided with, consisted of a simple checklist and we were required to just go out there and start doing it.</p>			

We were not always made aware in advance that a referral was for MAiD. Often, we wouldn't be prepared when walking into a patient's house." "One participant requested topics related to compassion fatigue, resilience training, and incorporating self-reflection when educating nurses regarding MAiD." Statements from in the discussion section, subsection education and emotional supports included: "Debriefing allows nurses to discuss feelings, emotions, review cases, which results in better patient care (Harvath et al., 2006). Formal versus informal debriefing is a necessary means of support that was validated in this study and throughout the literature (Harvath et al., 2006; Smith et al., 2011). Nine participants revealed that debriefing is not always done and that it is essential to nurse well-being."

Title: Impact of Medical Assistance in Dying on palliative care: A qualitative study.

Author: Mathews, J.J., Hausner, D., Avery, J., Hannon, B., Zimmermann, C., & al-Awamer, A.

Year: 2021

Country: Canada

Journal: Palliative Medicine, 35(2): 447-454.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<ul style="list-style-type: none"> - Qualitative descriptive design with thematic analysis. - Research question: How has Medical Assistance in Dying impacted palliative care practice for physicians and nurses in Canada? - Purpose: to understand how Medical Assistance in Dying has impacted palliative care practice for physicians and nurses. 	<ul style="list-style-type: none"> - 23 palliative care providers from Southern Ontario, Canada. 13 physicians and 10 nurses who worked in various settings, including inpatient consult services, inpatient palliative care units, outpatient clinics, home-based palliative care, and residential hospices, with several participants working in more than one setting. - Purposive and snowball sampling used. - "We invited palliative care leaders and frontline providers with publicly known opinions, either published or articulated, 	<ul style="list-style-type: none"> - Semi-structured interviews using a predefined interview guide. - Interviews conducted and audio-recorded by 3 investigators. - Interviews conducted in person or over the phone and a professional transcription service was used to transcribe recordings verbatim. 	<ul style="list-style-type: none"> - Transcripts analyzed by 2 investigators using Braun and Clarke's version of thematic analysis. - 4 interviews analyzed independently, then discussed to develop an agreed coding framework. - Remaining transcripts divided and reviewed, with weekly meetings to review and discuss.

	<p>about Medical Assistance in Dying. We also asked participants to recommend potential interviewees with known and diverse opinions about Medical Assistance in Dying."</p>		
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: Medical Assistance in Dying creates new "difficult conversations". "Many participants did not feel confident about discussing Medical Assistance in Dying. They described ethical and moral dilemmas regarding the appropriateness of certain discussions, such as introducing Medical Assistance in Dying to patients who did not initiate these requests. Participants were concerned that introducing the topic of Medical Assistance in Dying might be misinterpreted as an invitation to request for it, and may add to the burden of vulnerable patients and erode families' trust. It is important to mention that there is no mandatory or standard training related to responding to requests for Medical Assistance in Dying in Canada at this time." N4 said: "I wonder if I should speak to Ethics about [bringing up MAID with patients] because maybe they can tell me, "No, you're allowed to say this," or "You're not allowed to say that," but . . . I feel like I'm walking quite a tightrope because I don't want to be encouraging or discouraging in any way."</p> <p>Statements found in the discussion section include: "Participants in our study described ethical and professional dilemmas around communication, especially around broaching the topic of Medical Assistance in Dying and determining the optimal timing of assisted death." "Enhanced communication teaching with specific emphasis on conversations around Medical Assistance in Dying for palliative care providers may help to address these challenges." "Participants in our study, including those with moral and religious objections, described a journey of learning and adaptation to Medical Assistance in Dying. This active process of sense-making overtime was described in another study exploring provider experiences around assisted death." Statement found in the conclusion section: "Communication training with access to expert resources for ethical decision-making and a review of eligibility criteria for Medical Assistance in Dying may help to address new challenges related to communication and symptom control, respectively. "</p>			

Title: Canadian Nursing Students' Experiences with Medical Assistance in Dying.

Author: McMechan, C., Bruce, A. & Beuthin, R.

Year: 2019

Country: Canada

Journal: Quality Advancement in Nursing Education, 5(1).

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Qualitative design drawing on narrative inquiry and thematic analysis. - Purpose is to "explore the experiences of senior nursing students in caring for patients who choose a medically assisted death." Another aim is to "understand students' perceptions of their educational preparation regarding MAiD and to identify potential gaps in existing knowledge and skills."</p>	<p>- 9 fourth-year students in a Bachelor of Science in Nursing program in a Canadian university. 2 students were practicing licensed practical nurses at the time of interviews. 7 participants had some level of experience caring for a patient receiving MAiD (under the supervision of a preceptor RN); 1 participant was present during the MAiD procedure and death. 3 identified as currently religious, 1 had no current affiliation, but a "strong religious upbringing" and 1 was spiritual but not religious. - No inclusion or exclusion criteria stated.</p>	<p>- Audiotaped, semi-structured interviews conducted in-person or by phone. All interviews conducted by 1 researcher (also a fourth-year student).</p>	<p>- Thematic analysis guided by Braun and Clarke. - Interviews transcribed verbatim, then divided and read by research team. - Members presented a summary of their transcript findings, then a group discussion held to discuss emerging themes. - Main codes identified and transcripts were coded. - Final themes and subthemes identified using inductive reasoning.</p>
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: Role Confusion. Subthemes: where do (student) nurses fit? and fear of saying the wrong thing. "Students expressed confusion and misconceptions about their role as nursing students and those of nurses more broadly in MAiD. They shared anecdotes of witnessing RNs and LPNs in practice who lacked knowledge of this practice." "Participants had a desire to be present during MAiD for the educational value of this exposure, but also remained dedicated to respecting patient and family privacy. Students described this tension as a dilemma between wanting to be present for learning purposes, but not feeling their presence was appropriate given the sensitive nature of dying." "I didn't want to introduce a brand-new face and be like, hey I'm a student can I just stand in the corner? So I was really conflicted with... being presented with this learning opportunity but not being able to really take it because it just wasn't really fair." "As evidenced by participant's anecdotes, students' perspectives were also mirrored in the uncertainty demonstrated by nurses on their clinical placement units. Participants felt that many nurses are "still in the dark" on the subject of MAiD." "I think there was a lot of misinformation; things that we didn't know like starting the IV, or who could care for</p>			

whom." "Many stated that they understood it was beyond the scope of the nurse or nursing student to counsel patients about MAiD; however, few were certain about what this constraint meant in practice. Many participants expressed fear of broaching the subject of MAiD at all with their patients." "Participants referred to how their awareness of not being allowed to speak with patients about MAiD was founded in their BSN education: 'The message I got [in university] was do not open your mouth if the patient talks about it. You cannot speak to patients about this.'"

2) Theme 2: Honouring Patient Autonomy. Subthemes: the nurse as advocate, not judge and MAiD as "normal nursing". "MAiD presents yet another situation where students must engage their ethical decision making in order to provide compassionate and safe care. Findings from this study demonstrate how abiding by the principle of patient self-determination helped participants to navigate their encounters with MAiD, particularly in the face of their own feelings and moral conflict." "This suggests that nursing students can effectively utilize ethical frameworks presented to them through education and benefit from opportunities to continue practical application of these skills in class and clinical settings."

3) Theme 3: Students' Recommendations for Education. *Suggestions made by participants for educational preparation in made included:* "Incorporate lectures and workshops facilitated by nurses and health professionals who have first-hand experience with MAiD"; "provide clear instruction on the roles and responsibilities of student nurses, RNs, and LPNs in MAiD"; "provide opportunities to clarify and work through feelings about MAiD and understand conscientious objection"; and "use clinical simulation to role play speaking with a patient about MAiD and carrying out the role of the nurse during a MAiD death". "...findings point to participants' expressed appreciation for having exposure to MAiD in their nursing program, as this allowed them to work through their unease before taking full responsibility for patients." "...our study support students' valuing of both opportunities to work with dying patients who choose MAiD and engaging in reflective activities about MAiD prior to and after encountering it in practice." "Several participants expressed the need to take the initiative in learning about MAiD, suggesting the importance of implementing more formalized MAiD curricula for BSN students. Findings suggest both students and educators can be better informed about the evolving legislation and guidelines about MAiD. Specifically, students suggested simulation (including conversations with patients), guest lecturers, and reflective practices..." "... seminars with nurses or physicians who have directly participated in MAiD provide insight for students into the logistics of the procedure, as well as the emotional depth of assisting in an individual's death. Ensuring students and educators are knowledgeable about their professional organizations' guidelines such as the Canadian Nurses' Association (CNA) (2017), provincial regulatory standards, and institutional policies, will help clarify misunderstandings and role confusion."

Title: How We Can Improve the Quality of Care for Patients Requesting Medical Assistance in Dying: A Qualitative Study of Health Care Providers.

Author: Oczkowski, S.J.W., Crawshaw, D., Austin, P., Versluis, D., Kalles-Chan, G., Kekewich, M., Curran, D., Miller, P.Q., Kelly, M., Wiebe, E., Dees, M., & Frolic, A.

Year: 2021

Country: Canada

Journal: Journal of Pain and Symptom Management, 61(3): 513-521.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Qualitative descriptive approach.</p> <p>- Objective: To describe MAID clinicians’ perspectives on quality of care in MAID, including challenges, successes, and clinical practice suggestions. "In this article, we report a subset of interviews from this first phase: HCPs descriptions of quality MAID, focusing on the barriers and facilitators to providing high-quality clinical care to patients requesting MAID."</p>	<p>- 20 healthcare providers from four Canadian centers (Hamilton, Niagara, Ottawa and Vancouver). 3 centers had hospital-based MAiD teams, and the fourth was an outpatient clinic. "Participants were primarily physicians (70%) although NPs, registered nurses, social workers, and clinical managers were also represented."</p> <p>- Participants included physicians (n=14), NP (n=3), Social worker (n=1), Clinical manager (n=1), and nurse (n=1).</p> <p>- "The HCPs were preferentially the patient’s MAID assessor or provider; however, we also interviewed allied health (nurses, social workers, and managers) who were directly involved in the patient’s MAID experience if the patient’s assessor/provider</p>	<p>- A semi-structured interview guide, organized according to chronological steps of the MAiD process, was used by investigators at each center to conduct and audio record in person or phone interviews. The recordings were transcribed, deidentified, and uploaded to a cloud-based qualitative management system.</p>	<p>- Qualitative descriptive analysis.</p> <p>- Open coding on first 3 interviews helped develop an initial set of codes and codebook.</p> <p>- Meetings held to discuss and update the codebook.</p> <p>- Iterative process of thematic analysis, codes were organized and grouped into primary and secondary themes.</p>

	was unable or unwilling to participate in the study."		
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: Supporting Providers and Sustainability. "Another key area noted for support was the need for continuing education and feedback. Participants described MAID as an area of clinical practice in evolution, where observation, feedback, and education could increase an individual’s ability to provide high-quality care. Peer debriefing was seen as having particular value as it could identify opportunities for quality improvement and also provide personal/emotional support for clinicians within a community of practice: I think debriefing is a critical component, in terms of metabolizing the story of what you’ve seen and heard, and hearing it from the view of other people, which for me is always enlightening .. And without doubt, without question, every single one of those when I’ve left the debrief I’m like “I’m glad we did that!”." <i>From the table for themes/subthemes, under continuing education and feedback it lists the suggested practices of:</i> "Connect or develop clinician peer support groups & community of practice; Identify local clinician experts for consultation regarding cases where MAID eligibility is unclear; Standardize documentation process to ensure transparency and protection of patients, families, and clinicians; Identify experienced mentors for new MAID clinicians; Encourage and support clinician participation in continuing education (e.g., conferences, research); Include non-MAID clinicians in some debriefing and feedback sessions (e.g., bedside nurse) to gain new insights into care practice; and Organize regular feedback sessions with the goal of improving local practice; can be combined with debriefing and peer support."</p> <p>2) Theme 2: Institutional Supports. "MAID was recognized as a new and unique conversation to have with patients, requiring careful listening and exploration of their MAID request and their personal journey with illness. The use of standardized assessment guides and documentation templates was described as helpful conversation aids and as education tools." "There needs to be more education.. [for HCPs who] we anticipate seeing people with terminal diagnoses, and being equipped and educated as to sort of have a handle on those conversations when they come up." "Participants described concerns about the increasing number of MAID requests, in light of the small number of clinicians providing MAID and a high rate of turnover of MAID practitioners. Early identification and training of new MAID assessors and providers was described as a strategy to mitigate this effect and ensure a sustainable workload for practitioners." <i>From the table for themes/subthemes, under communication tools and training it lists the suggested practices of:</i> "Organize mentorship opportunities during MAID assessment and provision; Practice challenging conversations and active listening skills using simulated patients/role-play; Develop a structured conversation guide/assessment form to ensure comprehensive assessments and to act as an educational resource; and Develop a toolkit of clinician MAID communication resources."</p>			

Title: Constructing Good Nursing Practice for Medical Assistance in Dying in Canada: An Interpretive Descriptive Study.
Author: Pesut, B., Thorne, S., Schiller, C., Greig, M., Roussel, J., & Tishelman, C.
Year: 2020

Country: Canada

Journal: Global Qualitative Nursing Research, 7: 1-11.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<p>- Interpretive description; qualitative interview study. - Goal is to better understand the policy, practice, and ethical implications of MAiD for nursing. To describe how nurses construct good nursing practice within the context of this new end-of-life option.</p>	<p>- 59 nurses; purposive and snowball sampling of nurses recruited through health regions, the Canadian Nurses' Association, and the Canadian Association of MAiD Assessors and Providers; targeted recruiting to seek geographical variability. - Inclusion: registered nurses or nurse practitioners who had experience with participating, or choosing not to participate, in MAiD.</p>	<p>- Telephone or in-person interviews using a semi-structured interview guide. All invited for a second interview if they had more to add - 1 participant did complete a second interview. Digitally recorded and transcribed verbatim.</p>	<p>- Open codes were derived inductively and agree upon by 2 research team members after reviewing 6 transcripts. - Transcripts downloaded into NVivo for analysis. - Refined codes were used to code remaining transcripts. - Data analyzed using constant comparative analysis. - From the codes, a thematic account was constructed. - Field notes, reflective memos, investigator triangulation, and audit trail also used.</p>
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: A Familiar Conversation with New Options. Subthemes: Nurse practitioner legacy conversations, inquiries to registered nurses, and reflecting on biases. "Nurses in this study were learning how to have initial conversations about a MAiD request." "...nurses needed to adapt in their patterns of response to requests for assisted death. These conversations happened in different ways depending upon whether the nurse was a nurse practitioner trying to evaluate a patient's eligibility for MAiD or a registered nurse trying to discern the nature and intent of the request." Nurse practitioner: "These conversations entailed meeting strangers for the first time and rapidly establishing rapport and intimacy so that they could hear the patient's story of suffering, while at the same time taking on the responsibility of determining whether someone was eligible, or not, for MAiD." "...learned a conversational skillset that eased their anxiety." "...nurses learned to take a direct approach, avoiding all language that would euphemize the MAiD death: I 'take away the fluffiness of a conversation and make it really raw and really real'..."registered nurses were often uncertain about their role and boundaries in (the) conversations." "Many nurses described themselves as not knowing what they should do."</p>			

2) Theme 2: Artful Practice. Subthemes: establishing the relational context, planning meticulously, orchestrating the act, and supporting the family after death. "Participants told stories of lying awake the night before, worrying whether they would be able to get intravenous access quickly and painlessly." "Nurses also learned of the problems that could arise during the MAiD death and prepared themselves accordingly. This included bringing things that the MAiD provider was likely to forget (e.g., trays for medications, death certificates), obtaining extra medications and needles for specialized access (e.g., Huber needles), and arranging the room so that the family could be close to the patient..."

3) Theme 3: Competence and confidence. Subtheme: Competence and competence. "Trying to create best practices with little guidance." "'It's like living grounded theory. We're making it up as we go along'. The practice supports available to these nurses varied across the country." "Even after the legislation had been in place for some time, and there were many independent learning opportunities available, nurses suggested that learning modules were not enough. To be confident and competent, nurses required mentorship from individuals who had become experienced with MAiD and they required debriefing after the event with those who knew what it was like to be involved in these impactful provision. Some nurses suggested that, ideally, they should be able to observe before they performed a role in a MAiD death. Timeliness of this education was also important. Some nurses noted that they had not been interested in education about MAiD until they were actually confronted with the possibility of a MAiD death: 'There isn't an appetite for information until there is an appetite'." "...nurse practitioners often felt the lack of supportive education most acutely..." "A number of nurse practitioners had simply taken the initiative to create their own practice supports and to share them with their colleagues." "Nurse practitioners also indicated that although there were many patient assessment instruments available to guide their evaluations (e.g., frailty scale), the lack of agreed-upon best practices in MAiD made it difficult to choose the most appropriate ones. This was less of an issue for those nurse practitioners working within teams where they had the opportunity to discuss their MAiD assessments than for those working alone." "This need for further education and support was exacerbated by the more detailed reporting requirements introduced in November of 2018 by Health Canada.." "Overall, among both registered nurses and nurse practitioners, there was agreement that confidence and competence required structured education, mentored experiences, and supportive debriefing."

Title: Assistance in Dying: The Nurse's Experience.

Author: Schwarz, J.K.K.

Year: 2002

Country: United States.

Journal: Proquest Information and Learning Company, Ann Arbor, MI.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
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<p>- Phenomenological approach (hermeneutic) with thematic analysis. - Aim: to explore nurses' experiences and responses to patient requests for AID. Research question: how do professional nurses experience and respond to a request for AID from a decisionally capable person?</p>	<p>- 10 nurses, including 4 in home hospice care, 2 in critical care, 1 a family nurse practitioner and expert AIDS nurse. All were Caucasian, middle-aged, well-educated, and had many years of nursing experience. - "The only entrance requirement for this study was a nurse's belief that she or he had been asked for AID by a decisionally capable adult and a willingness to discuss what that experience was like."</p>	<p>- Most interviews occurred in participant's home; the other interviews occurred in the participant's workplace office, the researcher's home, the participant's hotel room, or over the phone. Tape-recording of multiple conversations with participants as they told their stories of experiencing patient requests for AID. Transcribed verbatim and treated as textual data.</p>	<p>- Reflexive process that began as soon as texts were created. - Initial overview or gestalt about what the experience was like for each participant. Then a focused reflection, followed by preliminary coding of the data. - Emerging themes were then identified and written summaries were provided to the participants so they could determine accuracy of grasping the essence of their experience.</p>
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Finding Themes/ Supporting Quotes

The findings are from the Implications for Education section and not within the themes. "Nurse in this study had not received any formal educational preparation in ethics, and they did not appeal to any of the profession's written guides in ethical decision-making." "Although most nurses in this study demonstrated some familiarity with basic ethical principles considered important in EOL care - such as the principle of double effect, and the central role of respect for persons and their right of self-determination, they did not refer to the code of ethics or the profession's position statements on AID. Student nurses and nurse clinicians without experience in palliative care would benefit from information and guided discussion of the revised code of ethics and its use of nuanced language that stipulates that nurses "may not act with the sole intent of ending a patient's life". "I discussed how participants used, and in some cases "misused," the principle of double effect as a means to justify certain EOL interventions thought to hasten dying. These findings suggest that too much is expected of the principle of double effect if it is expected to function as a practical guide for complex EOL nursing decisions." "The question of how best to educationally prepare novice nurses to engage in thoughtful moral reflection and to develop skills in reaching ethically justifiable clinical decisions remains a challenge."

"Learning how to engage in moral reflection about good EOL care is enhanced by doing - by sharing personal experiences of good and bad deaths, by presenting and discussing actual clinical cases, engaging in role playing and small group discussions about these experiences, and describing how those experiences cause us to feel - are measures that will facilitate learning and providing good EOL palliative care."

"Nurses who provide care to patients who live with life-threatening or chronic incurable illnesses must be better prepared to respond to implicit and explicit requests for AID made by patients and/or their families. Nurses must be encouraged to reflect upon and identify their own beliefs and strongly held values, and to recognize how conflicts in values can impede effective communication about the patient's EOL wishes. As these findings make clear, in order to effectively respond to vulnerable patients who request AID, nurses must be skilled in assessing the meaning of such requests, and in recognizing that a wish to die often masks such unspoken and unrecognized needs as poorly managed symptoms of pain and suffering."

Title: Oncology Nurses' Experiences with Requests for Assisted Dying from Terminally Ill Patients with Cancer.

Author: Volker, D.L.

Year: 2001

Country: United States

Journal: ONF, 28(1): 39-49.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
<ul style="list-style-type: none"> - Descriptive, naturalistic study; interpretive interactionism. - Purpose: explore oncology nurses' experiences with receiving requests from terminally ill patients with cancer for assisted dying. 	<ul style="list-style-type: none"> - 40 nurses; randomized, sequential direct mailing to "ONS members who were most likely to have received requests for assisted dying." "The clinical nurse specialist group was purposively heavily sampled because the first 10 stories submitted revealed that master's-prepared nurses provided much more detailed, thick descriptions of their experiences." - No inclusion or exclusion criteria were stated. 	<ul style="list-style-type: none"> - Anonymously submitted written stories, transcribed verbatim into a word processing program; analyzed using Denzin's process for interpretive interactionism. 	<ul style="list-style-type: none"> - Stories analyzed using Denzin's interpretive process for data analysis. - First-level coding of isolated key elements and structures. Text reviewed multiple times for key words, phrases, or statements (labelled and underlined). - Recurring themes were assembled by "construction".
Finding Themes/ Supporting Quotes			
<p>1) Theme 1: Conflict - Uncertainty about either actions taken or personal beliefs about assisted dying. Subthemes: collision of values and distress. "Many stories reflected an experience of tension wanting to meet the patient's or family's request versus upholding professional values. For some, the experience of receiving a request for assisted dying was rife with conflict between</p>			

competing values, principles, or interests." "I didn't know what to say. This was the first time somebody was asking me something like that. My answer was "no." I told them their request was going against my ethical principles. However, deep inside of me, I was in conflict. I didn't want [the patient] to suffer, I didn't have anything else to offer her, so I wanted to do it. But, on the other hand, my ethical values were telling me not to do it."

2) Theme 2: Covert Communication. Subthemes: the dialogue around the request and the silent knowing. "As nurses responded to the study question, they typically described how the request was stated or implied or how they came to know that a patient or family member desired an action or information about assisted dying. The theme of covert communication refers to the implicit or subtle nature of the exchange of information and understandings about assisted dying among patient, family, and nurse. A few of the communications described were overt in nature, but an examination of the communications described also revealed some perplexing, more covert patterns of communication." "One nurse shared that 'requests for help with dying is not as cut and dried as legislators seem to think. Patients do not often make formal requests which you can then accept or deny.' "Their stories were laced with innuendo, metaphors, and assumptions about the nature of what patients and family members wanted." "Improved education for development of communication skills within the context of end-of-life care is warranted".

Statements found in the discussion and implications section included: "Although some study participants expressed a sense of certainty about the situations they experienced and the actions they took, many others described experiences of receiving requests for assisted dying as rife with conflict. Values collided as stories unfolded about wanting to meet a person's request while feeling a sense of distress with the uncertainty. Often, expressions of personal feelings about suffering at end of life and religious beliefs provided additional contextual elements to the dilemmas described." "Theoretical models of moral reasoning proposed for nurses prescribe ethical decision-making processes that should result in decisions or actions that are consistent with ethical principles, professional nursing codes and positions, and core nursing constructs such as caring and advocacy. Yet, the disconnect between making ethically or legally appropriate decisions and the resulting affective response was apparent in this study."

Title: Hospice Care Provider Perspectives of Medical Assistance in Dying in a Canadian Hospice That Does Not Provide Medical Assistance in Dying.

Author: Ward, V., Freeman, S. & Banner, D.

Year: 2021

Country: Canada

Journal: Canadian Journal of Nursing Research, 0(0): 1-12.

Study Design; Aim/Objective	Sample Strategy/ Population	Data Collection	Data Analysis
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<p>- Qualitative descriptive approach. - Objective: describe hospice care provider perceptions off MAiD in an in-patient hospice facility that does not provide MAiD.</p>	<p>- 8 participants including grief support workers, hospice volunteers, registered nurses, care aides, unit clerks, and administrators from an independent hospice facility that does not provide MAiD on site; convenience and purposive sampling; smaller community setting within a western region of Canada. - No inclusion or exclusion criteria were stated.</p>	<p>- In-person semi-structured interviews.</p>	<p>- Data analyzed inductively and organized thematically. - Transcripts read closely and coded, identifying commonalities and emerging patterns. - Key words and phrases identified; coding became more focused and refined. Codes grouped over time and merged into themes. - Coding facilitated with NVIVO 11 and codes grouped into a codebook. - Team worked together to map the data, identify relationships, and generate themes.</p>
<p>Finding Themes/ Supporting Quotes</p>			
<p>1) Theme 1: Caring for patients undergoing MAiD within a non-provider facility. "This uncertainty and appropriateness around providing regular care when death from MAiD was expected greatly challenged some caregivers and many were unsure on how best to care for, and communicate with, the patient during the imminent period prior to MAiD." "One participant recognized that their feelings about this issue may relate to the relative newness of MAiD in Canada and hypothesized that their experience may change as they learn through more experiences of engaging with patients requesting to undergo MAiD."</p> <p>2) Theme 2: Balancing interpersonal dynamics in an interdisciplinary team environment. "Interpersonal dynamics and team cohesion arose as important topics in the analysis of the study data. One of the challenges with discussions of MAiD observed by several hospice care providers, regardless of their stance towards MAiD, was that conversations around MAiD tend to become highly emotional which can give rise to interpersonal tension, especially when those involved in the conversation had different or opposing views on MAiD. Several hospice caregivers in this study commented that an important source of support was having conversations or debriefs with their colleagues and being able to speak openly about one’s experiences and feelings. Most hospice caregivers reported that “having staff around that understood, that you could share with and [that could] relate to what was going on” (Participant 5) made the experience of any death, whether MAiD or non-MAiD, easier to handle." "...several participants</p>			

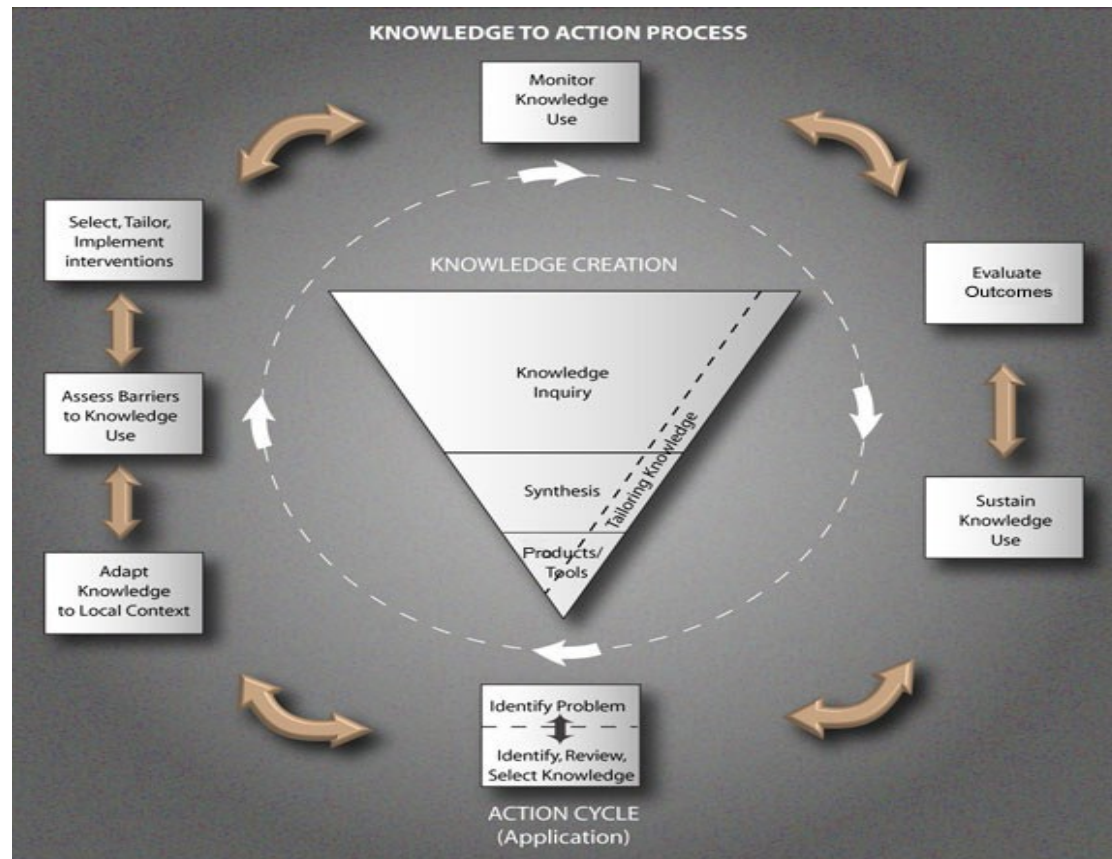
indicated that debriefing and support for hospice staff is needed, particularly with respect to the care of the patient undergoing MAiD. Participants recognized that this could come in the form of education, information, as well as supported conversations. One participant stated: 'because it is such a taboo topic that we need to get it out there. [We] need more education, more information [so that others] know that it is not as big and bad and scary as people think . . . third party to try and mediate our conversations and debriefing so neither of us feel that we are wrong, or what we feel is wrong, but to know that our feelings are ok even if everybody around us doesn't agree with them'."

Statements found in the discussion section included: "Participants in this study recognized the need for further practice supports for the whole care team, including how best to communicate with patients undergoing MAiD. For example, many participants in this study described a feeling of awkwardness when interacting with patients undergoing MAiD, particularly during the imminent period before MAiD." "Participants in this study wanted more information and direction from their workplace and professional bodies regarding how to navigate these uncertainties."

Modified from JBI template source of evidence details, characteristics, and results extraction instrument (Joanna Briggs Institute, 2020).

Appendix F

Knowledge to Action Framework



(Canadian Institutes of Health Research, 2015)