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GAPS IN NURSING PRACTICE SUPPORT FOR MEDICAL ASSISTANCE IN DYING

BY

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Dedication

To my son Mason: proof that we can do hard things. Keep reaching for the challenging goals, and the heights that you achieve will know no bounds.

Acknowledgement

To say that I have been well-supported along my journey would be a grave underestimation of the fantastic people that I have in my life. I am so fortunate to be surrounded by a wonderful circle of support. First and foremost, I would like to thank my supervisors, Dr. Jennifer Stephens, and Dr. Lorraine Thirsk, for their unwavering support and dedication to this project. Without their knowledge, expertise, and insights, I would still be floundering out in the weeds. Both Dr. Stephens and Dr. Thirsk have pushed me beyond my comfort zone to explore new goals and reach new heights. This truly would not be possible without them cheering me on at each step of the way.

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Abstract

The inception of Medical Assistance in Dying (MAiD) in 2016 has altered the landscape of end-of-life healthcare planning across Canada. However, the frameworks guiding nursing practice related to MAiD are subject to variability across Canada. This leads to role ambiguity and barriers in relational nursing practice. Using Critical Incident Technique, this Masters' level qualitative research study explores the experiences of seven Canadian nurses engaging with patients seeking MAiD. Semi-structured interviews were conducted to identify gaps in current nursing practice supports; 19 significant incidents were analyzed. Findings demonstrate that gaps in practice support exist related to nursing role clarity, educational support to enrich therapeutic communication skills, and staff-focused resources, such as debriefing and improved communication networks. Understanding nursing experiences within this context offers the opportunity for more consistent nursing practice frameworks and practice supports, leading to improved therapeutic relationships and patient care.

Keywords: Medical Assistance in Dying; Nursing; Therapeutic Relationships; Nursing Practice Support; Critical Incident Technique; Qualitative Research

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List of Symbols, Nomenclature, or Abbreviations

EoL: End-of-Life

MAiD: Medical Assistance in Dying

CIT: Critical Incident Technique

RN: Registered Nurse

NP: Nurse Practitioner

PN: Practical Nurse

Chapter 1. Introduction

Introduction

The inception of medical assistance in dying (MAiD) into law in Canada in 2016 has changed the landscape of end-of-life (EoL) planning and decision making for patients and healthcare providers alike. Currently, patients deemed eligible for MAiD may choose to end their life by self-administering medications prescribed by an authorized clinician, or by receiving clinician-administered medications by the healthcare provider to end their life (physician assisted death) (Health Canada, 2021). Prior to its legalization in Canada, MAiD was a highly contentious issue; advocates on both sides of the issue raise several ethical and moral considerations in MAiD (Pesut et al., 2020a). MAiD continues to be a topic of much discussion and ongoing debate; issues including equitable access to palliative care, conscientious objections, and the right to patient autonomy in end-of life (EoL) decision making, lead to conflicting opinions about the use MAiD (Pesut et al., 2020b). As further amendments are made to the Canadian federal MAiD law, concern is growing for inequitable access to healthcare services, as well as misuse of MAiD services (Wright et al., 2020).

The MAiD delivery process continues to be refined across Cananda, with variable delivery models enacted depending upon the availability of MAiD resources locally, and the MAiD delivery framework endorsed by the agency or organizations involved in MAiD. MAiD may include a multidisciplinary approach whereby patients receive care from their physician or nurse practitioner (NP), as well as nursing care throughout the MAiD journey. Depending upon the patient's health status and extent of their care needs, nurses may have a significant role in patient care leading up to the moment of the patient’s death. Nurses may be involved in day-to-day care of the patient and assist in navigating challenges in the healthcare system. Current MAiD legislative frameworks and inconsistent MAiD delivery structures lead to challenges providing supportive nursing care during the MAiD journey (Pesut et al., 2019b). The lack of defined nursing roles in MAiD has been perceived as a critical aspect that is missing from meaningful relational practice in patient and family centered EoL care planning (Beuthin et al., 2018; Pesut et al., 2020b).

Background

The idea for this study arose from my experience working as a direct care nurse in a palliative care unit at an urban hospital. It was here that I identified a gap in nursing care specifically related to MAiD. Although many peers were supportive of MAiD, there was a palpable discomfort and reluctance to discuss or acknowledge MAiD with patients who were pursuing this option. Furthermore, it was unclear what role, if any, nurses were legally permitted to fulfil with patients expressing the desire for assisted death. I noted that this resulted in a missed opportunity to engage patients in a deep and meaningful relational way. Additionally, I observed gaps in education and practice support available to empower nurses to talk about MAiD with their patients. Limited direction from professional nursing regulatory bodies and healthcare organizations leads to a significant amount of confusion regarding how nurses should engage with patients seeking MAiD. Poor clarity about nurse roles in discussions concerning assisted death with patients was observed. The lack of power to engage with patients about their MAiD journey created substantial emotional and moral distress within my own nursing practice, and nursing colleagues shared similar emotions.

Current legal frameworks and ambiguous professional practice guidelines for nursing practice related to MAiD are stifling the capacity of nurses to engage in meaningful relational practice with patients seeking information about MAiD and seeking care throughout the MAiD journey (Pesut et al., 2020b). While the Canadian federal legal framework includes clearly defined roles for Nurse Practitioners in MAiD, this legal framework leaves out considerations for Registered Nurses (RN) and Practical Nurses (PN) (Pesut et al., 2019a; Pesut et al., 2019b). RN and PN are not legally involved in the administration of medications for the MAiD event, however, they may be engaged in patient care right up to the time of the MAiD event, and perhaps family care after the event. Each province and territory are responsible for creating their own nursing scope of practice, and practice guidelines with respect to MAiD, working within the established Federal guidelines. Variability in clarity and depth across the provincial frameworks leads to confusion and ambiguity in the RN and PN role (Pesut et al., 2019b).

The legislative framework defining MAiD practice and eligibility requirements includes stipulations that patients must not be coerced or persuaded into the choice to pursue MAiD (Health Canada, 2021). While this is an important safeguard intended to promote safe and appropriate use of MAiD, the ambiguity of this statement in addition to limited practice supports from nursing regulatory bodies has evolved into fear and hesitancy from nurses wanting to support their patients but are cautious of impacting patient eligibility for the MAiD process (Pesut et al., 2019a; Pesut et al., 2020a). Together, the uncertainty that stems from each of these factors may be impacting nurses' capacity to engage in deep, meaningful conversations and relational practice with their patients. It seems that there may be a risk that nurses could miss opportunities to engage and support patients during their MAiD journey because of limited direction and nursing practice support. Exploration of nursing experiences navigating conversations about MAiD, EoL planning, and MAiD journeys with patients will assist in clarifying how nurses can be supported to engage in meaningful relational practice with patients pursuing MAiD.

Research Question

The purpose of this research is to identify the gaps in nursing practice support related to MAiD. The research question that has guided this study is *What are the gaps in nursing practice supports related to MAiD?* The perspectives and experiences of nurses who have provided care to patients seeking assisted death were explored to identify gaps in nursing practice supports related to MAiD. Understanding nurses' experiences assists in identifying the gaps in relational practice relative to MAiD that exist, and understanding how the gaps can be addressed to support nurses to engage relationally with patients. The findings from this inquiry have implications for the development of robust, clearly defined nursing roles and practice supports to assist clinical nursing practices, as well as future research.

Definition of Terms

Throughout this project, the term *life-limiting* refers to any medical condition that reduces the projected lifespan of the patient. This term is used to identify patients who are eligible for MAiD, under current legislative guidelines. In referring to *end-of-life conversations* or *end-of-life care planning*, these terms are used to identify conversations that nurses may have with their patients where patients share their wishes, desires, thoughts, and goals about their own end-of-life. These conversations are not aimed at nurses telling patients which treatment options that the patients should choose, as this is not within the nursing scope of practice, but rather they are the conversations in which patients are able to share their experiences and their care wishes with the nurse.

Care planning conversations will be used to describe nurse-patient conversations that explore topics such as EoL care planning, MAiD as a treatment option or expressions of desire to die. These are notably intense conversations for patients to broach, but also difficult for nurses to skillfully navigate to ensure that the patient feels that their concerns and wishes have been heard. When these conversations focus on MAiD specifically, the conversation can be challenging for nurses to navigate to ensure that they are not perceived to be coercing the patient, nor allowing personal biases to influence patient decision making.

Further, the term *relational practice* is used to describe the approach that nurses may use to develop deeper caring connections with patients and their families. Consideration of the contextual aspects of the patient's positioning, including interpersonal and social constructs, allows nurses to understand patient care needs to a greater depth. Relational nursing practice allows for a more holistic approach to care.

Finally, *autonomy in nursing practice* is the capacity to critically assess the patient's care needs and act independently, within the nursing scope of practice, to ensure that the patient's care needs are met.

Summary

MAiD has expanded the EoL care planning options for patients in Canada. In turn, this has impacted nursing practice, with little guidance supporting nurses to fulfil their roles within this context. This may lead to missed opportunities for meaningful connection with patients and their families, as well as more superficial relational practice. Relational practice is necessary for nurses to fully understand patient care needs and goals, and to be able to advocate for those needs. The capacity for deeper connection leads to improved nursing role fulfilment, and improved nurse-patient relationships (Peplau, 1997). Role ambiguity and limited practice supports lead to hesitancy to connect with patients exploring MAiD as part of their EoL care planning (Pesut et al., 2020a; Pesut et al., 2020b). Therefore, further exploration of nursing experiences is required to identify ways to support nurses to engage in meaningful relational practice with their patients as they navigate EoL decision making.

Chapter 2. Review of the Literature

Introduction

A search of the literature was conducted using EBSCO's unified database search engine. Results were refined to include peer-reviewed, published articles dated from 2016 onwards. Search terms used in literature collection included: *medical assistance in dying; physician assisted death; nursing practice; patient experience; therapeutic communication and nursing communication.* The patient and family perspective, in addition to the nursing perspective, was sought intentionally to inform this research. Understanding the patient and family perceptions of nursing care during the MAiD experience provides information about how the nurses can be supported to address nursing care concerns raised by patients and families. The search was limited to articles published in Canada and that had a Canadian context. These search terms led to a very small number of results, as there are few studies to date that explore the patient and family experiences accessing MAiD, particularly in Canada where MAiD is a relatively new legal option. The search was then expanded to include international studies where assisted dying is legal, such as the United States, Belgium, Luxembourg, Switzerland, and the Netherlands. Slightly more results were returned, but overall limited research related to patients' and families' lived experiences was found. The expanded search resulted 57 articles. The final literature review included a total of 14 articles: 12 Canadian articles and two European articles. Table 1 summarizes the literature review inclusion and exclusion criteria.

Table 1

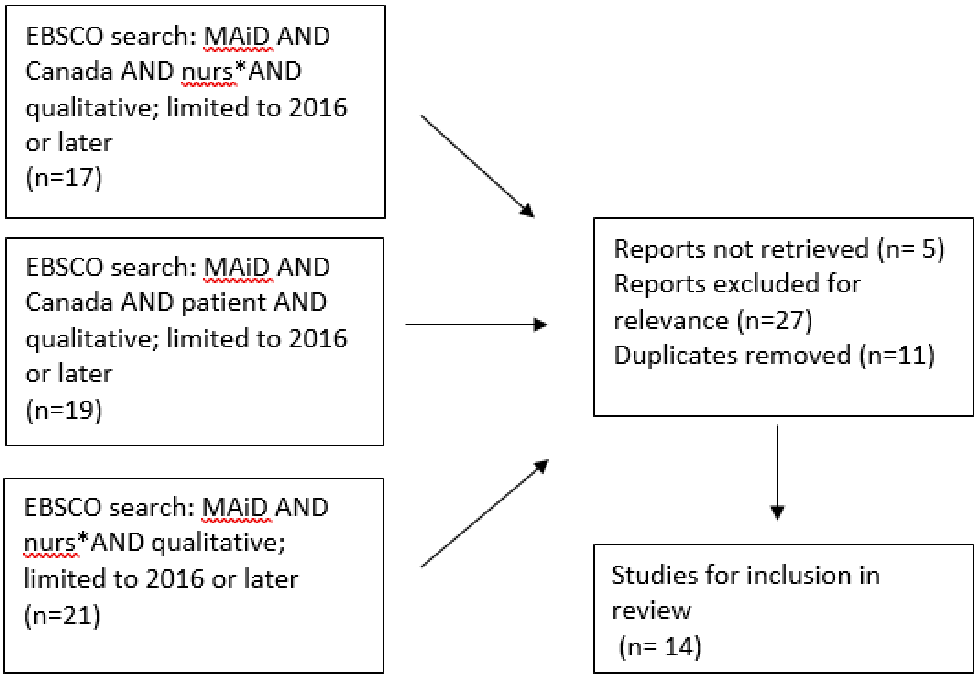
Literature Review Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Population: Nurses; patients seeking MAiD	Nurse* OR Registered Nurse OR patient AND MAiD OR assisted death	NOT Registered Nurse
Concept: Therapeutic Nursing Communication in MAiD	Qualitative AND lived experience with MAiD AND Registered Nurse* OR patient* OR patient's family	NOT qualitative literature OR nursing focused
Context: Canadian	Peer-reviewed, scholarly articles published in English language AND provides Canadian context	Articles do not provide Canadian context OR article dated prior to 2016

Five articles examined the patient and family perceptions of MAiD specifically, four of which were based in Canadian context. Nine studies that were included reported findings from a nursing perspective; this included eight articles from Canada, and one article exploring Belgian nursing experiences. The Belgian article was included as the procedures assisted dying procedures outlined in the article, reflected procedures in place here in Canada. The review included 11 articles founded in empirical data, and 3 literature review articles. Figure 1 illustrates the literature selection process. Thematic analysis of the final collection of articles included findings from the patient and family perspective, as well as the nursing perspective.

Figure 1

Summarized Literature Search Process



Patient and Family Perspective

Patients and their family members report significant barriers and changes in care when pursuing MAiD. Barriers in accessing information about MAiD, concerns about time constraints and capacity to consent, along with perceived changes in healthcare provider care are among the most prominent, and distressing findings.

Difficulty Accessing Information About MAiD

Lack of clarity in the MAiD process and difficulty accessing information to initiate conversations about MAiD with caregivers is a recurring theme from the patient and family perspective (Brown et al., 2020a; Brown et al., 2020b.; Oczkowski et al., 2021). Patients and families expressed confusion about how to initiate MAiD requests, or where to find pertinent information about assisted death. A study by Brown et al. (2020b) discusses the frustrations expressed by patients and families in trying to get accurate information about MAiD and appropriate referrals in a timely manner. Brown et al. (2020b) also report that patients and families reported a sense of secrecy among healthcare providers which was equated to a general lack of knowledge about how to access MAiD resources. This led to further barriers and frustrations in accessing the required referrals and care for MAiD.

Likewise, Oczkowski et al. (2021) found in their interview-based study, that patients and families expressed a lack of exposure to MAiD information, or initial awareness that it is a treatment option. Patients suggested that increased visibility of MAiD as a care option would dispel confusion and uncertainty related to MAiD access (Oczkowski et al., 2021).

Furthermore, once the initial MAiD request was submitted, patients and families expressed that ongoing lack of clarity throughout the process led to increased stress, particularly on the day of the MAiD event (Brown et al., 2020a, Brown et al., 2020b, Hales et al., 2019; Ockowski et al. ,2021). Confusion about how long the referral process would take, the availability of healthcare providers and scheduling challenges added to the emotional stress of the process for patients and families alike (Hales et al., 2019). Families also reported that increased information explicitly about how the event would go would be helpful in preparing family members (Brown et al., 2020b). When timing is of the essence, ambiguous pathways and difficult access to the required healthcare providers is a significant cause of stress and frustration for patients and their families.

Difficulty Navigating Legal Constraints and Eligibility Process

Patients and families also reported barriers related to legal safeguards and provisions included in the Canadian legal framework for MAiD (Brown et al., 2020b; Hales et al., 2019). The requirements of capacity for consent at time of assisted death and the 10-day reflective period are sources of considerable stress. Fear of loss of capacity during this reflective period, and the emotional distress of waiting for the loss of a loved one can create significant emotional distress for patients and families (Brown et al., 2020b; Hales et al., 2019). Brown et al. (2020a) identified the need for anticipatory grief guidance from the healthcare team to navigate the challenges created by these uncertainties.

Perceived Changes in Care After MAiD Request

Patients and families reported perceiving changes to care once a MAiD request has been made or granted (Brown et al., 2020a; Brown et al., 2020b). The change in care is not perceived as a positive shift, as patients and families reported perceived disproval or disappointment from care providers that identify as conscientious objectors to MAiD (Brown et al., 2020b). This adds further strain to the nurse-patient relationship, and emotional duress for patients concerned about the quality of their care. Further exploration into these concerns is required to determine the nature of this care shift.

Nursing Perspective

Nurses have also identified gaps in care and barriers in care provision. The findings related to nursing experience are reported across three themes: experiences providing care, moral and ethical concerns, and perceived gaps in care.

Nursing Lived Experiences

It is reported that nurses are often the first person that a patient shared their desire for death with (Pesut et al., 2019; Wright et al., 2017). This places significant responsibility on the nurse to engage in meaningful relational practice to explore the meaning behind wishes to die and the appropriate use of MAiD referrals. Nurses reported a significant barrier to engaging in a meaningful and fulsome manner is the time required to sit and be present in a wish to die conversation (Pesut et al., 2019; Pesut et al., 2020a). Given that nurses typically carry a patient load of more than one patient in most care areas, finding the balance between tending to other patient needs while making time to actively listen to the patient's meaning in wish to die comments is very challenging (Pesut et al., 2020a).

Further to time constraints, nurses reported challenges navigating communication silos between healthcare teams and services. Confusion regarding access points to MAiD providers, eligibility procedures and accessibility of services creates challenges for nurses assisting patients to access MAiD support (Pesut et al., 2019; Pesut et al., 2020a). Uncertainty of who and how to connect creates frustration and distress for nurses as they experience a sense of urgency to connect patients with the required resources.

Moral, Ethical and Emotional Impacts

Beuthin et al. (2018) explored the impact of nursing participation in MAiD in their narrative inquiry-based study. The authors reported that, for nurses in support of MAiD, there is the belief that enabling MAiD equates to the provision of holistic care, and of a good death in line with the patient's values (Beuthin et al., 2018). Furthermore, Beuthin et al. (2018) found that this perspective adds positively to the nurse's perception of quality of care provided and role fulfillment. Being able to advocate for patients' final wishes is considered to reflect the values of patient centered care in nursing.

Important information regarding the impact that conscientious objection to MAiD has on nurses also emerged in the literature. Although Bill C-14 includes provisions for conscientious objection to participating in MAiD events, objecting to MAiD for moral or ethical values remains a complex stance for nurses (Panchuk & Thirsk, 2020). Nurses who identify as conscientious objectors reported feelings of segregation and exclusion from care when a patient's care trajectory shifts from a palliative focus towards MAiD (Beuthin et al., 2018). This transition is painful for nurses as they find themselves excluded from the circle of care where a meaningful nurse-patient connection was once made. Additionally, when members of the care team ask nurses who object to MAiD to act as witnesses in documents related to the provision of MAiD, it puts conscientious objectors on the spot, eliciting fear of reprisal or judgement from other members of the care team (Beuthin et al., 2018). Further to this, nurses in support of MAiD reported a disconnect or tension with nurses who are conscientious objectors, as they feel that those objecting are no longer part of the circle of care but acknowledge the challenge of being excluded from care (Pesut et al., 2020b).

Finally, nurses reported that supporting patients through a MAiD event is different than navigating other end-of-life trajectories, creating a profound emotional impact on nurses (Pesut et al., 2020b). Remarks shared with Pesut et al. (2020b) during their research elucidate the emotional impact of caring for a patient who is alert and talking one minute and who has died just seconds later; the experience is reported as emotionally impactful and not to be taken lightly.

Bellens et al. (2020) conducted a study in Belgium, where euthanasia has been a legal process for approximately 15 years. Interestingly, the nurses interviewed for that study identify that euthanasia remains an emotionally charged process, where nurses continue to feel ethical distress at times (Bellens et al., 2020). It is interesting to note that compared to the newer MAiD program nurses are engaged with in Canada, nurses in Belgium continue to navigate the same challenges related to moral and ethical distress 15 years after the inception of assisted death in that country. Nurses identified the need for more robust preparation for such experiences, such as the use of team debriefs, to navigate the heavy emotional toll (Pesut et al., 2020b). Nurses also acknowledged the benefit of being adequately prepared emotionally to better support patients and families at the time of the MAiD event (Beuthin et al., 2018; Pesut et al., 2020b).

Discomfort in End-of-life Discussions

Although nurses are often the first healthcare provider that patients confide their wish to die with (Health Canada, 2021; Pesut et al., 2020a), nurses reported the need for increased practice supports to prepare them to engage in appropriate and meaningful conversations addressing EoL decision making and wishes to die (Beuthin et al., 2018; Pesut et al., 2020b).

Most notably, the literature reiterated that lack of clearly defined practice supports and roles impact nursing confidence in the provision care in MAiD cases. As noted by Pesut et al., (2020a); Pesut et al., (2020b); and Wright et al., (2017), there is significant discrepancy in the practice supports that are available to nurses across care settings, provinces, and nationally. Nurses reported confusion and role ambiguity as a significant barrier to exploring patient wishes to die (Pesut et al., 2020a). Nurses reported discomfort engaging in conversations with patients expressing a desire to die or requesting assistance accessing MAiD. Fear of saying the wrong thing, and fear of overstepping legal boundaries are cited as significant barriers in communication by nurses (Pesut et al., 2020b).

Process and Role Clarity

Pesut et al. (2020a) examined the impact of the inconsistencies in practice support related to MAiD, citing lack of resources from professional governing bodies and workplaces alike. Through their review of legislated constraints on nursing roles, the authors argued that the nursing role in MAiD is highly complex, and capacity to perform patient-centered care in disorganized systems is limited (Pesut et al., 2020a). The authors reported vast discrepancies in practice framework set forth by the regulatory provincial and territorial nursing bodies, whereby some provinces have as little as 3 pages of guiding documents related to nursing practice in MAiD, while others have up to 15 pages of guiding framework (Pesut et al., 2020a). This supports the nursing voices calling for improved direction and role clarity.

Nurses reported uncertainty about legal implications for their role when patients express the wish to die (Pesut et al., 2020a). Nurses understand that in line with eligibility requirements, patients must request MAiD without coercion, and fear of being perceived as influencing a MAiD decision is creating hesitancy to explore initial wish to die conversations (Pesut et al., 2020a; Wright et al., 2017). This is creating delays in the referral process and increasing time to access MAiD resources and assessments. Nurses desire further education and practice resources to assist in navigating wishing to die conversations to be better able to determine if a referral to MAiD resources is appropriate, or if improved symptom management is required for the patient.

Summary

Overall, the impact of these findings on nursing practice and patient experience in MAiD is the limitation on relational practice that evolves from minimal practice supports and logistical stifling of nursing roles. Under the current climate of MAiD in Canada, nurses are not able to fully engage in meaningful relational practice as they fear overstepping legislative boundaries. Patients and families feel the impact of stunted relational practice as well. Patient and family perceptions of quality in nurse-patient interactions are negatively impacted when information about MAiD is not shared in a timely manner by nurses, creating barriers for patients wishing to access MAiD. The development of clearly defined communication strategies and practice frameworks would allow nurses to lean into these difficult conversations feeling equipped to navigate the emotionally charged terrain of end-of-life planning.

Valuable comparisons between nursing and patient perspectives have been made to determine key factors leading to shortcomings in nursing practice in the care of patients seeking MAiD. The implications of this review relate directly to nursing practice. By identifying areas for improvement, more rigorous supportive frameworks can be developed to inform nursing practice related to MAiD. This will allow for improved satisfaction in nursing practice, both from the nursing perspective as well as from a patient and family perspective.

Further exploration of how to support nurses in the provision of relational practice in MAiD cases is needed. Canada has made positive strides to deliver MAiD in its early stages, but with continued revision, support and streamlining of processes, nurse will be enabled to deliver great care in support of MAiD events.

Chapter 3. Theoretical Framework

Research Philosophical Positioning

The philosophical assumptions made in this inquiry align with the constructivist paradigm. Constructivism describes knowledge as a social construct that results from the interactions that occur between individuals and their environments (Creswell & Poth, 2018). As a researcher, I acknowledge that I hold my own perceptions of reality, and the participants hold their own understanding and meaning of the experiences they share. Together, these perceptions construct meaning within the experience of supporting patients through EoL planning. My positionality within the research is strongly influenced by my own experiences working with patients navigating EoL decisions and planning. While effort was made to limit the influence upon respondents during the data collection process, I acknowledge that my biases bear impact upon the data analysis. As a nurse, I strongly value deep relational connection with patients, and this is a motivation fueling this line of inquiry.

Epistemological Stance

The epistemological positioning of this inquiry is founded in a subjective stance. The subjective position acknowledges that the individual has their own perspective of knowledge and truth that is founded in their experiences and social constructs (Creswell & Poth, 2018). This positioning acknowledges that the participants hold their own beliefs, values and perceptions of the incidents that will be explored in the interview process, and that I as a researcher, also hold my own beliefs, values, and perceptions. Working collectively with these subjective perceptions, understanding, and meaning emerges from the data.

Nursing Theory and Assisted Death

MAiD and palliative care are differentiated through one key fundamental approach to patient care. Using a multidisciplinary approach, palliative care is focused on maintaining quality of life and symptom management throughout the final stage of life incorporating patient and family-centered care, without hastening death (Dobrina et al., 2014). MAiD also uses a multidisciplinary approach focused on supporting patient wishes in navigating complicated, life-limiting conditions, with the intent to hasten death (Cambell & Cox, 2010). Despite the different approaches to patient death specifically, similarities in the theoretical underpinnings of nursing practice exist across MAiD and palliative care. This is captured in theories such Kolcaba's Comfort Theory (Kolcaba, 1994), humanistic nursing theory (Wu & Volker, 2011) and Peplau's Theory of Interpersonal Relations (Peplau, 1997) specifically. The common theme amongst these nursing theories is the emphasis on the nurse-patient relationship to support patients in maintaining quality of life during the final stages of life. In practice, nurses caring for patients planning for MAiD have the opportunity to focus on developing rich relational connections with the patient and their families. These therapeutic relationships support the goal of providing patient-centered care, meeting care needs to preserve quality of life as much as possible throughout the MAiD journey. However, this relationship can be negatively impacted when nurses are not certain of their roles within the assisted death context or are prevented from engaging in conversations because of regulatory or policy constraints.

Despite the fundamentally different approaches to patient death that MAiD and palliative care take (i.e., a hastened death in MAiD versus symptom management until natural death occurs in palliative care), the nursing care that is provided prior to death focuses on patient-centered interventions supporting quality of life in both contexts. Therefore, this inquiry is guided by nursing theories that are often applied in the palliative setting, specifically Peplau's Theory of Interpersonal Relations.

Peplau's Theory of Interpersonal Relations

Peplau's Theory of Interpersonal Relations (Peplau, 1997) explores six key nursing roles that nurses encompass throughout the nurse-patient relationship. Fulfillment of these roles supports the nurse to provide robust meaningful relational practice that meets the patients care needs. The significance of this theoretical framework within the context of this inquiry relates to the impact of reduced role fulfillment that nurses report in caring for patients pursuing MAiD. The nursing roles described by Peplau (1997) include the stranger, the teacher, the resource person, the counsellor, the surrogate, and the leader. In her the paper, Peplau states:

> They [patients] want respect and regard for personal dignity. They seek interest in them as persons. They want to express and have details of their health problems heard. They want a non-binding beneficial connection with nurses. (Peplau, 1997, p. 166)

This quote captures the essence of developing patient focused care in end-of-life planning and supporting the request for MAiD. In pursuit of making meaningful connections with patients, this is the underpinning principle for developing robust relational practice. Assisted death is sought by patients for a multitude of reasons; many of these reasons appear to be founded in the desire for dignity in dying and death on the patient's terms (Brown et al., 2020a; Hales et al., 2019). When examining the barriers to care related to MAiD identified in the literature, it becomes evident that the nursing roles posited by Peplau are difficult to fulfill within the current MAiD delivery structure and practice frameworks. This impedes the capacity of the nurse to develop a robust relationship with the patient, impacting the patient experience at EoL. Understanding of these practice gaps will allow for further development of practice supports to deepen relational nursing practice in the context of MAiD care.

Nursing Therapeutic Relationships and MAiD

The therapeutic nurse-patient relationship is categorized into three main phases: the orientation phase, the working phase, and the termination phase (Registered Nurses' Association Ontario, 2006). Each of these phases represents important nurse-patient transactions that contribute to the overall success of the nurse-patient relationship. The orientation phase is the space where nurses and patients get to know each other, where strangers become allies in the shared goal of meaningful, effective patient care. The working phase often occupies the bulk of the relationship, as care is provided in line with treatment goals to support the patient's wellness journey. While therapeutic communication patterns and needs change across each phase of the relationship, the working phase require frequent check-ins with the patient to ensure that care needs are being met and that adjustments in care needs can be communicated effectively with the care team. Finally, the termination phase creates a space for nurses and patients to close their relationship and move forward in their respective directions. The phases may occur across a short span of one interaction, or may occur across days, weeks, months, or years. Regardless of time spent with the patient, or the nature of the patient's care needs, these phases occur and open the opportunity for robust therapeutic relationships. This concept of time is important within the MAiD context, as patients may not have the luxury of time before the looming window of capacity closes. This creates a sense of urgency, as nurses strive to provide a positive, caring experience throughout the MAiD journey, making extra effort for this final leg of the life journey to be special for the patient and their loved ones. An article by Pesut and Thorne (2023) describes the increased pressure that is perceived by nurses to demonstrate exceptional caring leading up to the MAiD provision. In their longitudinal study of nurses' experiences caring for patients seeking assistance in dying, the authors discuss the significant emotional strain that nurses experience while supporting patients through the MAiD process (Pesut & Thorne, 2023). The authors further highlight that when supporting a patient through the assisted death process, the values in care shift from a biomedical stance on dying, to a more sociological construct whereby the depth of the nursing relationship, and capacity to support patient wishes during this time are of utmost importance (Pesut & Thorne, 2023). The development of a robust therapeutic nursing relationship is central to supporting this process.

Summary

Nursing care in EoL planning and treatment is focused on supporting the patient through biomedical processes such as symptom management, however, also highlights the significance of patient and family-focuses care that maximizes quality of life and actualization of care goals. Within the current context of MAiD, the ambiguous care roles outlined in the regulatory frameworks create a disruption in the capacity for nursing relational practice and nurse role fulfillment. Guided by palliative nursing theories, such as Comfort Theory, Humanistic Nursing Theory and Theory of Interpersonal Relations, this study will continue to elucidate practice supports to enhance nurse-patient relationships and nursing role fulfilment in assisted dying care.

Chapter 4. Study Design

Introduction

This study applied Critical Incident Technique (CIT) methodology. As a qualitative method, CIT has been used across many fields and sectors, particularly the healthcare sector (Byrne, 2001; Keatinge, 2002; Kemppainen, 2000; Viergever, 2019). A formal description of CIT methodology was published in the seminal work by Flanagan in 1954 (Flanagan, 1954). Flanagan (1954) sought quality improvement opportunities in aviation training initially, however this methodology has been applied to many different sectors since (Byrne, 2001; Keatinge, 2002; Kemppainen, 2000; Viergever, 2019). In Flanagan's work (1954), data was collected from participants using semi-structured interviews, and direct observation of the training processes. The term *critical indent* was used to identify significant events that occurred during the training process. The critical incidents were analyzed to determine the helping and hindering aspects of the incident, and to develop suggestions for improved training methods (Flanagan, 1954). This forms the basis of the CIT methodological approach and is why CIT is often used in quality or practice improvement-type research studies (Byrne, 2001; Keatinge, 2002; Norman et al., 1992).

Since Flanagan's account of CIT was offered, CIT has emerged from the literature as a malleable and accessible approach that elicits succinct information to reveal meaningful insights into practice improvements (Viergever, 2019). CIT may be employed in healthcare research seeking to identify potential action for quality improvement, or to examine the perception of quality of care. Within a nursing context, CIT may be used to explore patient perceptions of the quality of healthcare received, or nurses' perspectives of the quality of care provided (Butterfield et al., 2009; Sharoff, 2008; Viergever, 2019). Additionally, CIT is used in nursing research to examine the complexities of the nurse-patient relationship, as these interactions have been identified as significant determinants in perceptions of quality of care received (Kemppainen, 2000; Rubin, 1993). Exploration of these aspects of nursing practice using CIT offers the opportunity to gain insight into nurse and patient experiences, while providing solutions to improve the clinical issues that are identified in the process.

Furthermore, Kemppainen (2000) discusses how the CIT style of interviewing facilitates data collection in unwell patients, as the interviews may be short in duration and the design of the questioning elicits the required information without tremendous response burden or fatigue in acute or gravely ill participants. This would be a practical consideration for future studies within the MAiD context, to examine perceptions of care from the patient or family member perspectives, while minimizing fatigue and strain. Within the current study, CIT was used to explore nurses' perceptions of nursing practice supports currently in place, as they relate to the quality of the nurse-patient relationship while caring for patients seeking assisted death. The purpose is to identify the gaps in nursing practice supports that exist within the MAiD context, and to illuminate barriers to meaningful relational nursing practice.

CIT methodological paradigm

Flanagan's (1954) original work was written in a heavily positivist era, and his description of the researcher's role captures this: "The extent to which a reported observation can be accepted as fact depends primarily on the objectivity of this observation" (p. 335). However, in striving for objectivity from the observer, Flanagan

(1954) also acknowledges that achieving objectivity in this research is difficult given the reliance upon participant recollections, which are heavily influenced by the biases and perceptions of the individual.

More contemporary approaches to qualitative research hold increasingly post-positivist and constructivist positioning, acknowledging that participants will each have different ways of knowing and meaning associated with an incident, and that the observer will also carry their own set of beliefs (Butterfield, et al., 2009; Cresswell & Poth, 2018; McDaniel et al., 2020). Therefore, to apply CIT in contemporary nursing research, traditional CIT philosophy blends with more pragmatic epistemological paradigms to acknowledge that there are multiple ways of perceiving an incident, but that conclusions and recommendations can be drawn from these inherently subjective perceptions (Viergever, 2019).

The use of CIT in this inquiry was grounded in a constructivist perspective. Further to the post-positivist acknowledgment of the individual biases of the researcher and participants, the constructivist perspective acknowledges that knowledge is created, rather than discovered, and that new knowledge is constructed by reworking concepts that have already been created to make sense of our reality (Cresswell & Poth, 2018; McDaniel et al., 2020). The constructivist paradigm in research acknowledges the individual realities that exist, and the significance of the individual experiences that participants share within the research (Cresswell & Poth, 2018). Insights from the researcher and the participants are woven together to construct new meaning and understanding from the data.

Research Design

This study was designed to explore the gaps that exist in nursing practice support related to MAiD. Guided by the research question: *What are the gaps in nursing practice supports related to MAiD?*, this inquiry examined these gaps from the nurses' perspective to determine how nurses understand the current practice supports and identify additional supports that may be helpful in fostering robust relational practice throughout the assisted death journey.

Sampling

Purposeful sampling was used to promote the collection of rich data, from mindfully selected participants. Purposeful sampling is a strategy that procures selection of participants that are most likely to generate desired information to increase the depth of understanding of the phenomenon under investigation (Campbell et al., 2020). This approach assumes that individuals meeting specific criteria hold specific knowledge about the topic in question, therefore are important to include (Campbell et al., 2020; Robinson, 2014)

This study concentrated on nurses who have had experience caring for or supporting patients during their MAiD journey. Participants were Registered Nurses (RN) specifically. Nurse Practitioners (NP) were excluded from this research as the NP role in MAiD is clearly defined in the legal MAiD framework, as well as in the regulatory nursing frameworks, while the description of RN and PN roles is limited. Practical Nurses (PN) were excluded from this study as there is more variability across Canada in the legislated PN roles. Therefore, inclusion of the RN exclusively allows for examination of the gaps in practice supports that exist for this specific, consistently defined nursing designation.

Participants were recruited using email posters as primary methods to disseminate the participation opportunity. Potential participants were sought from the Athabasca University (AU) Master of Nursing current student lists, and further distribution of the posters on the AU research opportunity portal. This strategy was chosen to access individuals from a broad geographical area and engage with nurses across the country; and, to reduce the complexity of recruiting from a multitude of agencies nationally. Snowball sampling was encouraged to reach larger numbers of potential participants. Snowballing consisted of asking individuals who have demonstrated interest in the research to share the opportunity with peers and colleagues that they believe would be interested in participating to broaden the participant pool.

For inclusion in this study, participants were not required to be actively providing direct nursing care in any capacity, however, were required to have provided care within the past 5 years. This aligns closely with the timing of the inception of MAiD in Canada. Additionally, nurses were included if they self-identified as having experienced one or more of the following criteria:

- Have cared for a patient who has been deemed eligible for MAiD
- Have cared for a patient who has inquired about MAiD
- Have cared for a patient who has been deemed ineligible for MAiD
- Have engaged in end-of-life care planning conversations with a patient

The use of this sampling strategy ensured that nurses had relevant experiences to share, enabling collection of more rich, unique data capturing nursing experiences related to MAiD. A large sample size is not required for CIT methodology, as the focus is on the robust data that is collected through exploration of even only a few participants (Flanagan, 1954; Schluter et al., 2007). The target number of participants for this study was eight to ten participants, hoping to glean a minimum of eight to ten incidents for analysis.

Data Collection

Individual, semi-structured interviews were conducted virtually with each participant. The interviews varied in length between 40 to 60 minutes. Interviews were guided by semi-structured questions (Appendix A). Each participant was asked these questions, or slight variations, however further probing questions were also used when any opportunity arose to encourage the participant to elaborate upon a concept further, to gather a richer description of the event. Examples of these probing questions include encouraging participants to share their perceptions of the event, more details or context for the described experiences, and exploration of personal reflections about the experiences.

The interviews were recorded on the virtual platform for verbatim transcription following the interview. The primary researcher transcribed each interview using the transcription summary document provided by Microsoft Teams, which were compared against the recorded video of the interview. Each interview was anonymized, and member checking occurred as each participant was emailed a copy of their transcript for approval. A copy of each interview was stored securely, in a password protected, encrypted format on the researcher's computer.

Additionally, the use of a contact summary sheet is suggested by Schluter et al. (2007) as an added tool to use immediately following the interview. The contact summary sheet provides the observer with the opportunity to document initial impressions and starting point for data analysis (Schluter et al., 2007). Immediately following the conclusion of each interview, the researcher created a contact summary sheet to capture the impressions and points for analysis from that conversation.

Data Analysis

The unit of analysis in CIT is the specific incident(s) described by the participants. In this study, the critical incident was defined as a specific, detailed interaction between a nurse and patient seeking MAiD. Examples for inclusion are conversations where patients express the desire for assisted death to the nurse; a conversation between the nurse and patient while the nurse is providing care at any time during the MAiD journey; or a patient asking the nurse for information about MAiD. These are not exhaustive examples; however, these examples highlight the focus of the interaction between nurse and patient related to MAiD. Once all interviews were complete, and the transcripts were anonymized and verified, data analysis began with an initial reading of the transcripts to re-orient the researcher to the context of the interview.

While reading through the transcripts initially, significant events were evaluated for their connection to nurse-patient interactions and MAiD, as well as depth of information provided by the participant to determine inclusion in the data set. Generalized statements not connected to a specific incident, or vague responses lacking detailed descriptions were not included in the data analysis process. A total of 19 significant events were described in the interviews. However, 18 events were included in the final data analysis process, as one event was not included due to the vague description provided by the participant. Each event was identified as either a positive or a negative experience from the participant's perspective.

A second reading of the transcripts re-oriented the researcher to the content of the experiences and allowed for central themes in the nurses' experiences to emerge. Themes, as discussed by Ganapathy (2016) are described as an outcome that arises from the categorization and analytic reflection upon the identified codes within the data. The central themes in experiences that emerge reflected the shared lived experiences that nurses described across the significant events that were disclosed. The central themes were then further coded and analyzed according to CIT methodology.

Coding is an inductive content analysis process used to extract key points from the data, for further analysis (Vaismoradi & Snelgrove, 2019). Using the central experience themes identified in the data, a third reading of each transcript included a list of pre-formulated codes to identify the helping elements, the hindering aspects and the desired supports described in each significant event. The pre-formulated codes included *helping supports*, *hindering aspects*, and *wish list supports* codes as key components of CIT data analysis (Schluter et al., 2007).

Finally, comparison of the practice support codes across each central theme, and within each practice support category determined similarities and differences amongst the helping, hindering and desired nursing practice supports in the data. This process elucidated the gaps in the nursing practice supports related to MAiD.

Reliability and Trustworthiness of the Research

Trustworthiness is supported in qualitative research through credibility, confirmability, and transferability (Grossoehme, 2014). Further, Flanagan (1954) posits that in CIT methodology, pre-understanding of the phenomena of study is important to strengthen credibility of the research. In this inquiry, credibility and reliability are enhanced through several measures. Throughout the research process, ongoing reflective journaling supported self-awareness of researcher positioning within the study. With a clinical background caring for patients seeking MAiD, awareness of personal biases is essential for acknowledging the impact these biases exert throughout data collection and analysis.

At the outset of the inquiry, the use of purposeful sampling ensured that participants had meaningful experiences to share within the phenomenon of interest. Participants were chosen to share their experiences based on a set of well-defined criteria to enhance the collection of rich data. A letter of invitation to participate, which outlines the requirements to participate in the research is included in Appendix B.

The interview process in CIT is a relational transaction between the researcher and the participant. Therefore, it is important to mindfully develop a semi-structured interview guide that includes space for initial rapport building between observer and participant (Butterfield et al., 2009). A semi-structured interview approach also aids in maintaining consistency and fidelity in data collection (McDaniel et al., 2020). The phenomenological interview strategies incorporated into the prepared interview questions were mindfully curated to encourage participants to provide more detailed, relevant information.

CIT relies upon the recollection of the participants to share their experiences, therefore, creation of rapport with participants can increase participant comfort in storytelling and space for probing questions (McDaniel et al., 2020). As the validity and reliability of the participant's memory is difficult to ascertain, the information gathered from participants is generally considered to be more reliable if the participant can provide robust details and insight into the experience they have described (Kemppainen, 2000). Preparation for the interviews included peer-review of the proposed interview questions, as well as a trial usage of the interview guide to ensure that the structure of the questions is well curated to elicit the desired information. Appendix B provides a copy of the interview outline.

Data were analyzed for content and was considered more reliable as the details provided in the interview evolved, whereas more vague statements of thoughts and emotions related to the event were considered less reliable data. Insufficient detail led to the exclusion of one significant event during the data analysis process. During the interview process, if more depth in the participant responses was needed, gentle probing and clarifying questions were used to encourage participants to share more details of the experience. Triangulation of the transcripts with the participants further supports rigor of the data and ensures that the observers have captured the essence of participant response accurately, and the true impact of the factors present in the critical incident are identified and addressed (Keatinge, 2002; Kemppainen, 2000). Member checking was used; each participant was sent a copy of the transcript from their interview to provide the opportunity for feedback and clarification of the data.

The credibility of the data was enhanced by using audio and visual recordings during the interview process. The use of recordings ensured that participant responses were captured as accurately as possible, and the video component lends itself to a more fulsome understanding of the interaction by observing participant body language (Butterfield et al., 2009; McDaniel et al., 2020). The use of contact summary sheets and multiple readings of each transcript supported reorientation of the researcher to the interaction, for a deeper understanding of the conversation for analysis. The use of direct quotes in data analysis supported the integrity and accountability of the research, while also respecting the experiences of the participants through accurate representation of their stories.

Further, credibility was enhanced through appraisal of the incidents described by the participants. The greater the detail included in the participant's account of the event is considered to lend more credibility to the information shared (McDaniel et al., 2020). As the nurse-patient interactions were the unit of analysis in the data analysis process, it was important for the incidents to consistently provide adequate detail and context. As suggested by Bradbury-Jones and Tranter (2008) and by Viergever (2019), clear definition of what information is required to meet the criteria for an experience to be deemed relevant to the data was developed at the outset of data collection to ensure that these details are met during the data collection process. In this research, considerations for inclusion criteria included the context of the incident; the depth of details of the incident, including pertinent information about thoughts, feelings, and observations from the participants; and the significance that the participant assigns to this incident.

Ethical Considerations

Core ethical considerations in research include respect for the person, concern for welfare and justice (Lee, 2018). Precautions included in this study design address these considerations and reduce the risk of harm to the participants. The topic of this study creates potential for harm to participants due to the risk of emotional distress that the interviews may create. The sensitive nature of the conversations, along with reliving past nursing experiences, creates potential for emotional strain and distress. Further to this point, the specific terminology used in the interviewing process was carefully chosen to limit the potential distress that participants may experience. For example, it has been noted that the use of CIT methodology in healthcare has deviated away from the term *critical incident*, in favour of terms such as *significant event* (Schluter et al., 2007; Viergever, 2019). This is due in large part to the healthcare association of the term *critical* with very specific, urgent contexts, when, for the purposes of research, the reference to critical does not necessarily equate to the same sense of urgency (Bradbury-Jones & Tranter, 2008; Viergever, 2019). The discussion of *critical incidents* may elicit memories of stressful or distressing events, which may be difficult for some participants. To address this risk to participant welfare, careful consideration for the words chosen in the interview process was made; the term *significant* or *meaningful interaction* was used to refer to the specific events discussed in the interview process.

Pilbeam et al. (2022) suggest that the impact of research participation is often minimized in healthcare providers, and that healthcare providers are often perceived as impervious to the negative impacts of sharing their experiences. However, the potential for psychological harm and trauma exists when individuals recount difficult experiences.

To address this potential harm and provide support to participants through this potentially difficult experience, a curated list of accessible mental health support was emailed to the participants at the conclusion of the interview.

Additional safety considerations for participants included the provision of a safe and inclusive interview environment. MAiD is a highly divisive issue and politically charged issue in Canada. Furthermore, there is concern regarding litigation over incorrect interpretation of MAiD laws, or misuse of MAiD (Pesut et al., 2019a). In some interviews, discussion of the participant's beliefs and values relating to MAiD occurred as part of the retelling of the participant's experience. It is noted that the focus of the research is not contingent upon any beliefs or values related to MAiD, and this information, when shared, was noted solely to gain insight into the participant positioning within the inquiry context. Participants were reassured at the outset of the interview that their personal beliefs regarding MAiD would not be coerced or persuaded to change their beliefs and values, nor would investigator beliefs and values be shared with participants to avoid influence over participants. Participant values were respected throughout the interview process, and personal beliefs were not included in data analysis nor project findings.

Approval from the Athabasca University Research Ethics Board (REB) was obtained prior to participant recruitment. Informed consent was obtained from each participant prior to engaging participants in the interview process. Appendix C demonstrates the informed consent document that was shared with participants. Appendix D provides the certificate of ethical approval from Athabasca University. Data collection and storage practices were shared with the participants at the time of consent and included plans to store data for potential use in future projects. The researcher does not hold a position of power or supervisory role over any of the participants. There are no conflicts of interest to report with this research.

Budget

This project received funding from the Athabasca University Graduate Student Research Fund (GSFR). This funding was used to cover the costs for the research project in its entirety. The remaining funds will be used to towards costs associated with the dissemination of research results.

Summary

This inquiry uses CIT methodology to explore the experiences of nurses who currently, or have previously, cared for patients seeking MAiD. The one-on-one interviews with participants allowed the investigator to engage with the participant directly, document their experiences and provide opportunity to clarify the perceived meaning and values that the participant associates with their experiences. Purposeful sampling through targeted channels recruited individuals with nursing experiences from a multitude of settings and geographic locations, eliciting meaningful insights into nursing relational practice within the context of MAiD. Attention to detail in analysis of the critical incidents has highlighted the gaps in practice support related to MAiD. Identification of these gaps will illuminate how nurses can be further supported to engage relationally with patients seeking an assisted death.

Chapter 5. Results

Introduction

The experiences of the participating nurses were captured, providing insight into how nurses are impacted while providing care to patients seeking MAiD. Listening to the stories told, it became evident that nurses providing care within the context are highly motivated to create the best care experience possible for their patients. The nurses spoke of the importance of patient-focused care, patient advocacy and therapeutic connections as meaningful ways to demonstrate caring for their patients during EoL decision-making. These aspects of nursing were the common threads woven within the lived experiences shared and form the foundation of the ensuing data analysis.

Sample Characteristics

Seven RN participants were included in the study sample. Participants joined from across Canada, representing five different provinces, and one territory. Table 2 provides an overview of participants by geographic location.

Table 2

Participant Demographics: Geographic Location

Geographic Location	Number of participants
BC	1
AB	1
MB	1
ON	2
NS	1
NT	1

The participants represented a variety of experience levels, with years of experience as an RN ranging from less than one year, to over 38 years of experience. The participants also shared varied experiences across a variety of care settings. Several participants had worked or were currently working as Nurse Navigators or Coordinator for MAiD, while others worked in palliative care, or acute care settings. Table 3 provides a breakdown of the nursing care areas represented by the participants.

Table 3

Patient Demographics: Nursing Care Area

Nursing Care Area Experience	Number of participants
MAiD Navigator or Coordinator	3
Palliative Care Nurse	2
Acute Medical Nurse	1
Subacute Medical Nurse	1

**Note:* The care areas represented in this table are the care areas that the participants reported working in at the time of the significant events reported.

Thematic Analysis

Across the seven participants, there were 19 significant events identified. Guided by the question, *what are the gaps in nursing practice supports related to MAiD?* Data analysis in this study revealed two central experience themes shared by the nurses. These themes are *the impacted therapeutic nursing relationship* and *autonomy in nursing practice* within the context of MAiD. Further, analysis of the significant events revealed that nurses feel supported in caring for patients seeking MAiD through a variety of different practice supports. Comparison of the helping element against the hindering aspects and the desired supports illuminated the gaps in nursing practice supports that exist. These gaps include *defined nursing roles within MAiD, nursing education relevant to MAiD, resiliency support, interprofessional collaboration,* and *systemic* *communication.* These gaps are identified in the data as important issues to nurses, as they bear impact on how nurses act, think and feel when caring for patients seeking MAiD.

Theme 1: The Impacted Therapeutic Nursing Relationship in MAiD

The stories shared by nurses in this study elucidate the impact that nursing practice supports have upon the therapeutic nursing relationship. In the data, nurses discussed the importance of creating meaningful relationships with their patients as a fulfilling experience. This nurse, P03, described:

> I was unsure if he wanted any of the nurses in the room during, so I had went to say good-bye before the event and he grabbed my hand, and he said you were probably the best nurse that I had here and then he wanted me to stay.

Another nurse, P02, identified the positive impact that a robust therapeutic connection had on the overall experience of supporting that patient through MAiD in these terms, "building that therapeutic rapport and taking the time to actually get to know that person …build that connection and, you know, be a support for her was helpful."

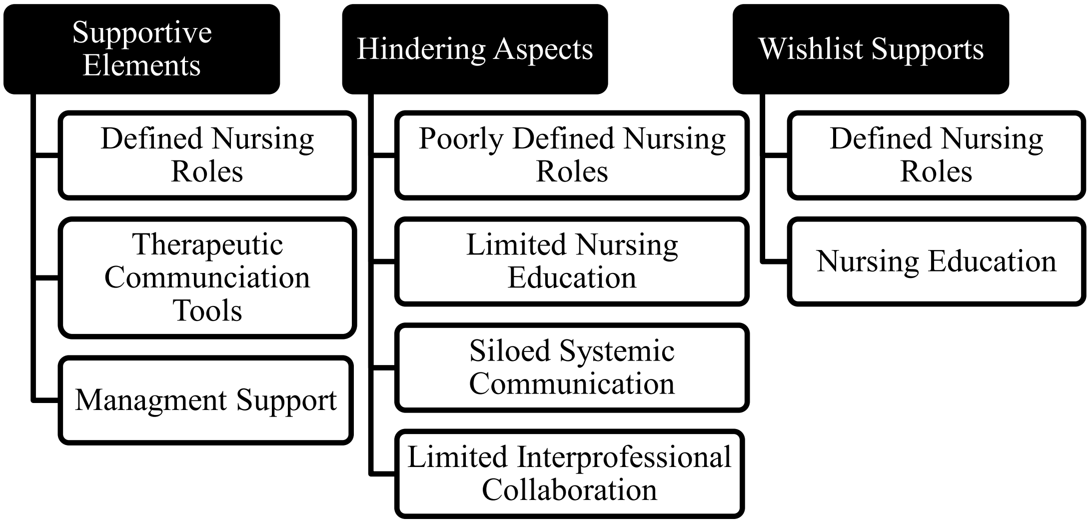
Nurses shared how rich, meaningful therapeutic connections allow them to understand the needs and care goals that are important to their patients, assisting them to demonstrate caring and support to patients while navigating the complexities of the MAiD system. P03 described the importance of therapeutic relationships in this way:

> Time felt different. And…there was more of a pressure to make sure that it was a really good experience… I felt, I still do feel, when I have when I know people are scheduled for MAiD that I need to, I mean I always try to do my best, but I need to try and do 150% for, to make sure that this goes smoothly.

Through discussion of available supporting elements, hindering factors and wish list supports, nurses described the context of how supporting and hindering factors impacted their capacity to develop robust caring relationships with patients navigating MAiD. Figure 2 summarizes the key practice supports, hindering factors and wish list items that emerged from the data related to therapeutic nursing relationships. It is important to note that in some cases, nursing interactions with patients were not identified as negative experiences overall, despite the presence of one or more hindering factors, but the hindering factors influenced the depth of the therapeutic nursing relationship that was established within the interaction.

Figure 2

Practice Supports Relevant to Therapeutic Patient Relationships



Defined Nursing Roles. Well-defined nursing roles, such as a nurse navigator role, are identified by the participants as a supportive element within the MAiD context. P01 described, “I think, because I was a MAiD coordinator by then, I knew more than enough about MAiD to be able to navigate that situation.” Having a clearly defined nursing role supported this nurse in understanding how to navigate MAiD with the patient and how to develop a strong relationship with them. P01 also reported that role clarity also supported the provision of appropriate nursing care throughout the nursing interaction with this patient, ending in a positive and meaningful therapeutic nurse-patient relationship.

Additionally, another nurse, P05, noted that their understanding of nursing roles in MAiD has evolved over time, since the initial enactment of MAiD stating, “things have changed a little bit though. Like before, when somebody would bring up that they wanted the shot and before everybody was like a little taboo about it. I'm finding now that there is that conversation.” The evolution of nursing roles, and improved clarity that nurses have described are identified as supportive elements in developing therapeutic nursing relationships.

However, the variability of defined nursing roles related to MAiD, and the lack of clear nursing policy is highlighted in the data as a hindering factor in therapeutic relationship development. Nurses shared that lack of understanding of nursing roles in MAiD leads to missed opportunities for connection and disrupts the development of strong therapeutic relationships. As P05 explained, “as an RN, and through our college, we're not really allowed to necessarily bring it up unless the client brings it up and there's lots of rules.” Moreover, the data demonstrates that disruption to therapeutic communication may stem from fear of overstepping legal boundaries and jeopardizing nursing licenses. This nurse, P07, described what that uncertainty feels like, saying, “you don't wanna say the wrong thing either, right? Because, you know, we have licenses too.”

Further, the data also demonstrated that imposed role constraints by way of intersecting care providers also hinders the therapeutic nurse-patient relationship. P07 offered:

> Once somebody applies to MAiD and the MAiD navigator calls them, I feel like we don't necessarily have much of a role anymore, which can be super challenging because we've been with some of these patients for a long time…We have, you know, this connection.

Overall, nurses perceived that nursing roles are not well defined within the context of MAiD, creating a disruption to the therapeutic communication channels with patients. The data demonstrated that lack of defined nursing roles in MAiD hinders effective therapeutic communication and nursing relationships with patients. Further, nurses noted that the poorly defined nursing roles in MAiD must be addressed. As this nurse, P06, stated, "we need more firm guidance and policy." Nurses identified the need for robust practice guidelines and nursing role definition to support security in developing therapeutic relationships with patients.

Therapeutic Communication Tools. Knowing what to say to a patient seeking information about MAiD, or a patient desiring an assisted death is reported in this data as a challenging aspect for nurses. When patients ask about MAiD, this presents an opportunity for meaningful dialogue with the patient to explore thoughts, feelings, and perceptions of care, to ensure that patient needs are being met. In this study, nurses described a lack of guidance and resources supporting therapeutic communication within the MAiD context. As P07 reported, "we kind of just have to fly by the seat of our pants to try to figure out the best approach for that patient."

Moreover, the data revealed that within the context of MAiD, nurses report challenges to the termination of the nurse-patient relationship, particularly at a time when the patient is receiving their MAiD provision. Knowing what to say to demonstrate support and caring as a patient chooses to end their life is described as difficult without adequate communication tools prepared. As P06, offered:

> One of the things that I found is I didn't have… I felt that I didn't have anything appropriate to say. What do you say? Good luck? What is that phrase in your nursing pocket, that you say as somebody is leaving?

Limited therapeutic communication tools also emerged from the data as a concern when nurses are working outside of palliative care settings. Nurses reported feeling unprepared for MAiD conversations in curative care settings and challenged to quickly pivot from an active curative approach to a relenting, palliative approach, with few therapeutic communication tools at their disposal. As P05 described:

> I think what happens on active medical or surgical floors, is treatment is active… Trying to transition those nurses into, “that's okay”, right? You know, you've done what you can, and you've got them here, and there, he's capable and he wants to do this. And then, kind of letting go of that active nursing.

Overall, limited knowledge of how to communicate effectively with patients seeking MAiD was evident in the data as hinderances to meaningful therapeutic communication. The desire for increased education for nurses surrounding MAiD emerged in the data, as P06 pleads, “we've got to get a curriculum for nurses for- and it doesn't have to be for navigators, it can be for our floor staff who is part of or experiencing provision.” Nurses suggested that having prepared communication strategies is a helpful tool to guide nursing practice, as P05 provided this tip, “I have a phone number that you can call if you're really interested, and you can ask whatever questions you'd like to ask.” This concept was further reinforced by P04:

> What we do need to say is: this is what I do know about the legislation, is you have to do a consent, two assessments and you have to be eligible. And that kind of thing and give them the basic information. They [nurses] also feel, then, that they have that power of that conversation to be able to talk about it [MAiD].

Further, the closing, or termination phase, of the nurse-patient therapeutic relationship appeared in the data as an important component of the relationship. Nurses noted that a distinct ending allows space for closure for both nurses and patients. Nurses desire educational support that equips them with pearls of therapeutic communication, particularly when closing a relationship with a patient moving towards their MAiD provision, so that they are ready to demonstrate support and caring for their patients. Nurses seek nursing-specific education to support therapeutic communication throughout the MAiD process.

Management Support and Siloed Systemic Communication. Communication from management is reported in the data as an important element to support nurses in their practice; nurses perceive that managers have the potential to be a pivotal component in the quality of the nurse-patient relationship. P02 shared how their manager proactively approached staff to discuss MAiD, “she [manager] gave us the opportunity to confide with her, and if our… kind of opinion of where we were and our comfort level with MAiD.” Additionally, nurses reported that proactive communication and input from the manager has supported them in their therapeutic nurse-patient relationship. P02 discusses how provision planning and staffing support from the manager supported the unit, “she [manager] ensured that there was at least one person on shift that would be able to take that group, if needed.”

Moreover, when provision planning is not well communicated within the healthcare team, nurses reported that this bears impact upon the ability to demonstrate caring for the patient and family and affects the nursing therapeutic relationship. The influence of systemic communication upon nursing therapeutic relationships is highlighted in this example from a nurse who described the negative experience encountered when no provision planning communication occurred across the systems involved in the provision. P03 explained:

> Immediately went to the manager and I said what happened here because this was wildly inappropriate. We were able to kind of reconcile it for the patient and the family in the end, thankfully, but…that preparatory work was not there for that patient… it made it look like because as a nurse, a direct care nurse, it looks like we don't care. Like, in that instance, it looked like we didn't care. And I found that was the most… hurtful part of it, for me.

This experience demonstrates the impact on the therapeutic relationship that the nurse was able to establish, P03 reported a negative perception of the care provided by following up with this statement, “I would have really appreciated the opportunity to make this more of a therapeutic environment for this family and this patient walking in. Which wasn't afforded to us, unfortunately, because of a breakdown of communication somewhere.”

Limited communication about upcoming provisions also impedes the termination phase of the nurse-patient relationship. P06 commented:

> It didn't allow us to, you know, terminate our nursing relationship or you know or to say goodbye to the clients…instead of knowing the evening before where we could provide, you know, somebody a special last meal, a special last bath or, you know, some compassionate care, and then able to provide a termination of the nursing relationship.

Moreover, when information is not communicated from the MAiD team that the provision is complete, this impacts the nurse's relationship with the patient and their family:

> I think it's really challenging to not know if somebody has had the provision or not. You know, sometimes when we cautiously call, I call it, because you don't know…Like, what if…Because they can decide at that very moment that they don't have the provision, that's their choice. And so, it is really challenging sometimes.

Overall, the data reflected that nurses perceive open, engaged management as a supportive element to their nursing practice by supporting nurses through staffing considerations, proactive communication and the care considerations that strengthen the therapeutic relationship. Lack of systemic communication clearly impacts how nurses close their therapeutic relationships with patients and families alike. Without knowing if a patient has received their MAiD provision, the nurse is not able to adequately terminate the therapeutic relationship and is also put into a difficult position of asking family members about the patient’s status, rather than receiving this information from the care team.

Interproessional Collaboration. In the data, nurses discussed the importance of interprofessional collaboration within MAiD programs. Nurses noted that barriers in interprofessional collaboration hinder the therapeutic patient relationship. For example, nurses shared that in some experiences, the use of the MAiD team disrupts continuity of care and therapeutic rapport. The experience of immediately handing the conversation over to the MAiD team when a patient mentions MAiD impacts the nurse-patient relationship and capacity to demonstrate caring. As P07 described:

> Once somebody applies to MAiD and the MAiD navigator calls them, I feel like we don't necessarily have much of a role anymore, which can be super challenging because we've been with some of these patients for a long time…We have, you know, this connection.

The data demonstrated that removing the nurse’s ability to terminate the caring relationship effectively impacts how nurses perceive their experiences caring for patients with MAiD. In this case, the interruption of the nursing relationship created a negative perception of the event, as this nurse, P07, felt it was not in the patient’s best interest to disrupt the continuity of care, “we [nurses] should be able to hand them a pamphlet, you know, because they're obviously confiding in us because they trust us.” The abrupt disconnection from the patient is identified in the data as a source of disappointment and distress for the nurse. Nurses seek support from interprofessional collaboration and proactive healthcare systems to support a more cohesive MAiD experience, underpinned by strong therapeutic connection.

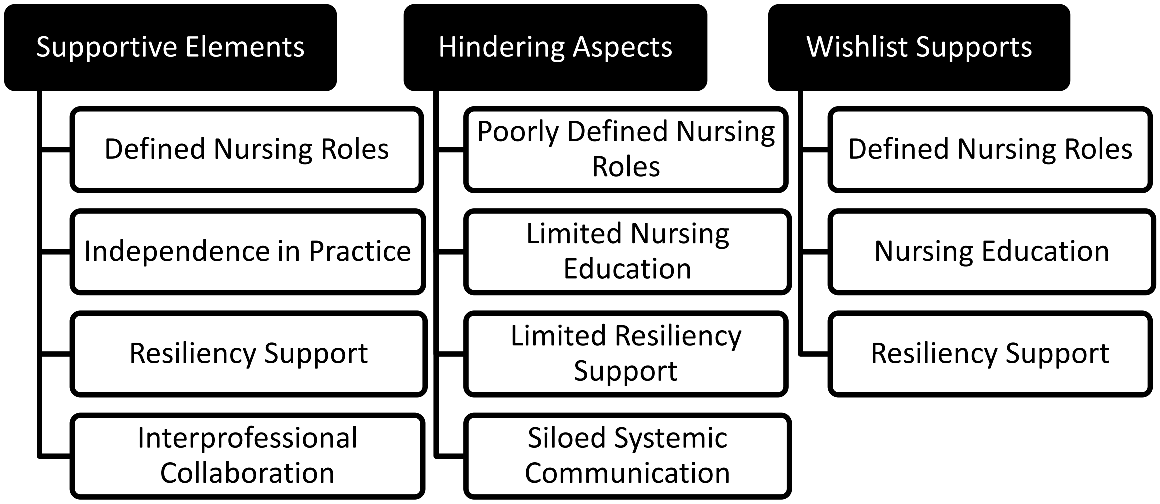
Theme 2: Autonomy in Nursing Practice

The concept of autonomy in practice emerged in the data when nurses share how they were able to navigate MAiD with their patients through advocacy, therapeutic communication, and their own resiliency in practice. Nurses described how having confidence in their practice enables them to advocate for patients, where others may shy away. As P01 described, “I was able to take a situation that I think, had it been in the hands of some other nurses who didn't feel as… autonomous in their practice, I think that they would have stayed away from that conversation.” Moreover, P01 illustrated the challenges that nurses overcome with autonomy in their practice, “my nursing body and my workplace has not given me a lot of information, but I'm going to get you whatever information it is.”

Nurses noted that the presence of supportive elements created space for nursing autonomy, leading to positive communication with patients and colleagues, capacity for patient advocacy and patient teaching to support patients navigating MAiD. Figure 3 summarizes the identified helping elements, hindering factors and wish list items that emerge from the data related to autonomy in nursing practice.

Figure 3

Practice Supports Relevant to Autonomy in Nursing Practice



Defined Nursing Roles. Nurses noted that the nursing role guidelines within the MAiD context, particularly when MAiD was first enacted, were quite limited and unclear. However, some improvement was noted in the data. P03 described:

> In the beginning we weren't even allowed to kind of approach the topic, it had to be explicitly set by the patient for us to even discuss it… So, as time went on, that got a little bit better... And I do feel more comfortable explaining the process to people now.

A lack of nursing role clarity emerged in the data as a hinderance to nursing autonomy within the MAiD context. Nurses identified that their provincial or territorial governing bodies do not provide adequate direction regarding the nursing role in MAiD. As P04 describes:

> I think the nursing role in the MAiD world, in the legislation, the way nursing is written up, is that we are very task driven for MAiD…We have to understand that nursing role is totally different than that, right? We have psychosocial skills. We have the ability to do therapy. Yet in the MAiD world, it becomes very narrow. That's why in in some hospitals, the social work role is actually a bigger role than the nursing role, because they don't, I'm gonna use, honor it [nursing] as much.

Further, nurses identified that the need for robust nursing practice frameworks is elevated in rural settings. As discussed by this rural participant, P06, fewer resources in rural areas have made the development of hardy nursing practice guidelines challenging:

> Our licensing body here…because of where we're located, a lot of times our nursing documents reflect- advise you to go to then the nurse like you know, to go to the [CPNS]…it tells you to go to another document, so we don't have the anything really written specifically by this jurisdiction.

Nurses identified poor role clarity and imposed roles constraints as hindering factors to achieving autonomy in practice. The data revealed that familiarity with the nursing roles within MAiD is perceived as a supportive element for autonomy in practice, as this develops confidence in nursing practice. Further, it was observed that increased experience with navigating MAiD lends itself to perceived improved patient advocacy by nurses. Consistency in practice frameworks is sought from nurses to provide clear boundaries for nursing care.

Limited Education and Independence in Practice. In situations where nurses struggle to identify supportive elements that assisted them to navigate situations with their patients, the importance of nursing autonomy emerged in the data. Nurses described relying upon their own information retrieval skills and their self-sufficiency in their practice to seek out answers and support for their patients, when it appears that resources are otherwise limited. P01 explains:

> His [the manager] messaging was “No, we don't support MAiD. That's just that.” And I was like, OK, so you don't support me, but I am my own professional. And so, I'm going to get my patients whatever information it is that they want, and my college will support me in that… I was able to take a situation that I think, had it been in the hands of some other nurses who didn't feel as oh…um… autonomous in their practice, I think that they would have stayed away from that conversation.

Further, another nurse, P05, reinforces the helpful impact of confidence and autonomy in practice saying, “I think the biggest thing for me is like if I don't know an answer to a question like a for a client, I'll find it out.” The capacity to be self-directed, autonomous in nursing practice and seek out the information needed in the moment emerged as a supportive nursing quality.

Nurses reported receiving limited educational opportunities related to MAiD, and in some cases, reported relying upon their own research and interest in the topic to inform themselves about the intricacies of MAiD. P01 offered, “my learning was really just sort of studying the law and then working through it, case by case.” Another nurse, P02, described relying upon their own knowledge base, rather than formal education pertaining to MAiD, to support their patient interaction, “my knowledge about palliative care, that was really able to support that conversation really well.” Further, P07 described their experience of education relevant to MAiD as “there was no education, no training, no anything.” In smaller or rural care agencies, where dedicated palliative spaces are not available, lack of education was cited as an important hinderance in practice. This nurse, P06, shared, “we don't have a palliative unit. We don't have Hospice beds. So, we are often relying on our medicine nurses to be [prepared]…And so, without specialty training, it's a lot to ask.” In the absence of nursing education related to MAiD, nurses reported relying upon themselves for ways to inform themselves about how they can interact with patients seeking MAiD, as well as where to glean additional MAiD resources.

Mentorship from nursing peers is also identified as an important source of knowledge and skill development, to grow autonomy and confidence in practice. This nurse, P05, credits the mentorship that she has received to her confidence in her current role with MAiD, “It's so incredible. Yeah, the mentorship is huge.” Moreover, mentorship is noted in the data as a resource that nurses feel would benefit novice nurses to develop confidence and autonomy in their practice. As P06 pointed out, “We need to be mentoring though the next generation of nurses as well, you know, which is really important.” Further, P05 credits the mentorship that she has received to her confidence in her current role with MAiD, “It's so incredible. Yeah, the mentorship is huge.” Mentorship is noted in the data as a resource that nurses feel would benefit novice nurses to develop confidence and autonomy in their practice.

The desire for nursing education emerged in the data as a wish list item to support nursing confidence and autonomy. P02 explained that education about MAiD would have made a significant impact on their practice:

> If we had had some in-servicing about you know what MAiD was, and how the process works…and then get into the nuances of what we how can and can't talk with patients about MAiD certainly would have made my life a lot easier.

Nurses expressed the desire for additional education about MAiD to support autonomy and advocacy, as it is difficult for nurses to direct their patients to the appropriate resources when the MAiD process is poorly understood. P04 stated:

> We would certainly like more education for nursing as a whole in our organization…we're hoping to do that because then that helps all nurses to be able to understand the process, so that if you're looking after a patient, you at least have some knowledge of the process, right?

Moreover, P07 posited, “we also need a curriculum for navigators, for people who are supporting the process”. Education supporting nurses in knowing where and how to access MAiD resources and services, along with further clarity in what to expect from the healthcare system while supporting patients along the MAiD journey is an important support that emerged in the data.

Emotional Resiliency Support. Emotional resiliency support is identified in the data as nurses reflected upon difficult emotions that may arise while providing care for patients accessing MAiD. When nurses are provided with the opportunity for reflection and debrief, this type of post-provision support supports nurses’ autonomy and emotional wellness in practice. P06 explains, “we do at my work do some bereavement support for us once a month...and we do definitely some things that are needed to… for our own mental health.” Additionally, another nurse, P02, describes the helpful experience of having formal routine check-ins with staff, led by management, “after the fact, we had a brief debriefing session and went (discussed) how it went and if there were any…any difficulties or any suggestions for the future. We went through that with the MAiD team."

When emotional support resources are not available to nurses, this was perceived as a hindering aspect by nurses. The lack of debrief practices creates a missed opportunity for an emotional check-in and closure that is needed to resolve feelings connected to caring for a patient accessing MAiD. P07 stated, "there's never been a debrief and there's never been anything really for the staff, which is a negative in my opinion"

Nurses described how the loss of a patient, even when planned, can be a difficult experience to navigate. The data reflected that when nurses are not supported to process difficult emotions, they experience moral distress, emotional fatigue, and burnout. As this nurse, P06, pointed out:

> You can't connect with somebody unless you're willing to give a piece of yourself. To be able to give a piece of yourself, you have to be in a peaceful place. You have to be supported in your work and you have to have the opportunity yourself to debrief so that if you are feeling moral residue, moral distress, that you have somebody to talk about that with.

Nurses identified the lack of emotional resiliency support and debriefing opportunities following MAiD provision are a hinderance to autonomy and confidence in practice. Resources like routine mental health assessments, a formal debrief and a scheduled break off-unit following MAiD provision are some of the suggestions brought forward in the data. As P07 stated, "I think that after every MAiD provision there should be a formal debrief.” Even during a positive patient interaction, the value of debrief is noted. This nurse highlights that one piece that was missing from an encounter was a formal debrief, as well as some time off unit to process the emotions following the MAiD provision. The nurse offers, “there's never been a debrief and there's never been anything really for the staff, which is a negative in my opinion.” Similarly, another nurse, P07, discusses the desire for a debrief:

> Any other type of nursing, you know like if a big trauma comes into the ER, they always debrief about it. If there's a code they debrief about it, but like if there's MAiD, we don't debrief. It's just the end of the patient’s life and you wheel them to the morgue.

A scheduled break, or brief time away from the unit following a MAiD provision was identified in the data as another opportunity for support from management. P02 suggested “a scheduled break maybe… or you know, additional supports would have been a bit more…advantageous.” The findings of this study indicate that formal debrief, supported by management, would be a helpful tool to support resiliency and mental health in nurses and a resource that is sought by nurses.

Interprofessional Collaboration and Systemic Communication. Data in this inquiry demonstrated that nurses perceive that the cohesiveness and transparency of communication within the interdisciplinary care team impacts the nursing practice within the MAiD context. Nurses reported relying upon interprofessional colleagues as resources for information and support in practice to provide patients with requested information to support wholistic patient care. Specific professional groups that the nurses identified in the data include the MAiD team, physicians, and social workers.

Interestingly, the MAiD team is identified as both a supportive element and a hindering factor in the data. Nurses expressed gratitude for the support of the MAiD team; the team is perceived as both an educational resource for nurses supporting confidence in nursing practice, and as a modality to support overall quality in the patient experience. A nurse, P07, described their perspective of the MAiD team, “a helpful thing is that we always have the [MAiD] team on. We can always reach out to patient relations. We can always, you know, they're always just a phone call away.” While another nurse, P05, offers, “Contacting MAiD [team] via email is so important to me.”

Physicians and allied health professionals, namely Social Workers (SW), were also identified in this study as interprofessional collaborators with nurses. Nurses identified complex relationships with both groups. Moreover, nurses indicated that the quality of communication and clarity in roles determine the impact of interprofessional collaboration. Physicians are a central component to MAiD access for patients. Nurses reported that their relationship with the physician, as well as the physician’s perspective of MAiD have impacted the nurses’ capacity to navigate MAiD with their patients. Physicians are perceived as a valuable tool and resource for information about MAiD. P01 described how support from the physician furthered the nurse’s knowledge and understanding of MAID, “working here, having long conversations with the assessors and the providers about their assessments to understand how they interpreted the law.”

Further, social workers were identified by nurses as a helpful resource to support patients and their families as they navigate the assisted death trajectory. P01 shared the supportive role that SW played in their understanding of MAID, “I had to become really good friends with the social worker for the palliative program…she was able to provide me with some resources." P01 attributed the support that they received from SW to their confidence in navigating MAiD with their patient. The findings in the study indicate that the quality of interprofessional collaboration correlates to nursing confidence and autonomy in practice.

Ineffective communication across the different healthcare systems and care providers involved in MAiD emerged as a hindering factor in the data. Nurses noted that poor communication regarding provision planning, along with limited status updates related to the MAiD provision are hinderances to nursing autonomy. P07 discussed how poor systemic communication impacts the termination phase of the nurse patient relationship. In this case, the termination phase was negatively impacted, as communication did not occur across the care team. The nurse shared:

> I felt at that time, when that patient was on our floor, that all of a sudden, they one day just took him upstairs and we never heard anything again…why didn't we get to care for them till the end? I feel like there was like a big gap in communication.

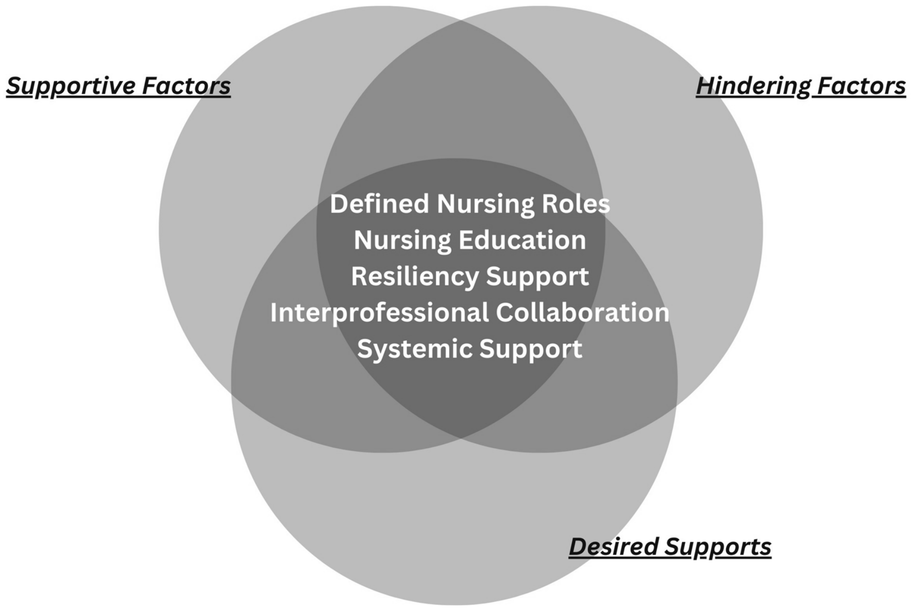
Nurses described limited systemic communication as a hinderance to nursing autonomy, by imposing further role constraints upon nurses when provision planning is not adequately shared with the nursing staff. The data demonstrated that are not able to work to their full scope, nor enact advocacy when nursing relationships are impacted by limited systemic communication.

Gaps in Nursing Practice Support

After listening to nurses describe their experiences navigating MAiD with patients, and examining the data for supportive and hindering aspects, along with wish list items, the gaps in nursing practice support emerged from the data. Across the two central themes, therapeutic nursing relationships and autonomy in nursing practice, there were five elements that recur and stood out in the data as gaps in nursing practice support. These elements include *defined nursing roles within MAiD*, *nursing education relevant to MAiD, systemic support, resiliency support* and *interprofessional collaboration*. While some of the practice supports, such as defined nursing roles, emerged as supportive elements in the data, they are identified as a gap in practice support because they do not appear to be consistently present across nurses' experiences. For example, despite being noted as a supportive element, the lack of well-defined nursing roles in MAiD emerged as a hinderance to nursing autonomy, and as a wish list item. Therefore, the gaps in nursing practice support were identified through listening to the stories told by the nurses and hearing how the hindering aspects shared in the data impacted nursing practice. These findings were compared with the helpful outcomes associated with the supportive elements identified in the data to validate the identified gaps. Finally, the wish list items were considered and cross-referenced with the supportive and hindering elements to confirm the results. Figure 4 illustrates how analysis of the key themes from the *helping factors, hindering aspects* and *desired supports* relate to each other to validate the relevancy of each theme.

Figure 4

Gaps in Nursing Practice Support Identified by Thematic Data Analysis



Summary

The findings from this study illustrated two central themes that emerged from the data: Nursing Therapeutic Relationships and Autonomy in Nursing Practice. Analysis of data revealed practice supports and hinderances, along with wish list items to support each of these themes. Inconsistent application of these practices supports, and wish list items highlight the gaps in nursing practice supports that exist within the context of MAiD. The identified gaps include *nursing role clarity related to MAiD; nursing education related to MAiD; nursing resiliency support; interprofessional collaboration* and *systemic support*. The nurses' responses provided rich insight into each of these gaps by demonstrating the value of the support (as a helping factor), the barrier that the absence of the support creates (as hindering factors), and the desired supports needed to address each gap.

Data from this inquiry demonstrated that a gap in nursing education related to therapeutic communication tools to connect with patients seeking MAiD exists. Nurses who are uncertain about how to communicate effectively with patients expressed the desire for education related to how MAiD can be discussed. Additionally, a clear definition of what should or should not be discussed is also sought. Increased nursing education focused on how to communicate therapeutically and safely with patients seeking MAiD is sought to address the gap in education related to therapeutic communication supporting MAiD exist.

Chapter 6. Discussion

Introduction

The enactment of MAiD in Canada as a health care option has had significant impact on nursing practice (Hales et al., 2019; Pesut et al., 2020a; Pesut et al., 2020b; Pesut & Thorne, 2023). Nurses rely upon clear direction and established guidelines to direct safe and comprehensive patient care across all phases of the life cycle. The limited consideration for nurses within the MAiD context also emerged in the experiences shared in the data of this study. Further, it is evident that despite the gaps in nursing practice support that exist within the context of MAiD, nurses continue to carry a significant responsibility of creating a positive EoL and MAiD experience for the patient. Nurses are being asked to fold into imposed role constraints, while simultaneously stretching to meet practice demands beyond their comfort and expertise with little direction or consideration.

The Impacted Nurse-Patient Relationship in MAiD

Therapeutic nursing relationships are central tenets in nursing care that allow nurses to connect with patients to explore the patient's care needs and elevate the quality of the nursing care the patient receives (RNAO, 2006). The importance that nurses place upon providing an outstanding level of patient care leading up to a MAiD provision is evident in the data of this study. Nurses value providing high quality, patient-centered care, particularly in the often-intricate experiences navigating MAiD. Moreover, the value of robust therapeutic connection is also exemplified in the data along the MAiD journey. Therapeutic communication skills have the potential to influence the depth of relational connection achieved with the patient and their family; in turn, shaping the quality of care that patients receive. Possessing the knowledge of how to connect with patients seeking an assisted death, and engaging patients in rich conversations about their experiences throughout their MAiD journey is essential to ensure that patient care needs are met. Further, patients must feel supported exercising autonomy over their healthcare decisions, independent of what their decision may be. Patient autonomy is supported when nurses demonstrate caring through meaningful therapeutic communication (Beuthin et al., 2018).

The data in this study indicates that therapeutic nursing communication is supported by well-defined nursing roles within MAiD, adequate therapeutic communication tools or resources and nursing management support. Unfortunately, the nursing experiences shared in the data suggest that, due to the absence of relevant nursing practice support, meaningful therapeutic relationships are often disrupted within this context. This is supported in research by (Pesut et al., 2020b), who posit that challenges in therapeutic communication, and uncertainty in nursing role boundaries influences the depth of the nurse-patient relationship. Further, Pesut et al. (2020a) also discuss the importance of the therapeutic nurse-patient relationship, and how limited direction for nursing roles within MAiD strains the development of these relationships. Nurses have previously shared frustration and moral distress when imposed role constraints limit the capacity for therapeutic communication (Beuthin et al., 2018). The impact of nursing practice supports upon therapeutic relationships in the present study is further elucidated through exploration of the phases of the therapeutic nurse-patient relationship.

The Working Phase

The working phase of the nurse-patient relationship is the portion of the nurse-patient relationship that strives to achieve identified patient care goals (RNAO, 2006), and it is a recurrent point of interest in the data of this study. Markedly, nurses described the challenges in communication experienced during this phase. Specifically, knowing what to say when patients express interest in MAiD or how to connect patients with MAiD resources was routinely shared by the participants. Nurses cited a lack of educational tools related to therapeutic communication in MAiD, along with poorly defined nursing roles, limited systemic communication and inhibited interprofessional collaboration as hinderances to the development of robust therapeutic relationships. Further, the current findings reflect previous literature that reported the challenges and uncertainties that nurses experience when responding to inquiries about MAiD (Pesut et al., 2019a; Pesut et al., 2020a).

The implications of stunted therapeutic nursing communication in the working phase of the relationship resonate with the offerings of Chochinov (2023). Chochinov (2023) discusses the concept of intensive caring as an important tool for ensuring that patients feel that they matter, as a key principle of hospice and palliative care. While MAiD and palliative care take different approaches to patient death, there are notable similarities in patient considerations across each treatment pathway. Quality of life and supporting patient autonomy are reported as priorities in care throughout the MAiD journey (Beuthin et al., 2018).

Further, MAiD may be sought by patients who receive high-quality palliative care and should be acknowledged as treatment option supporting patient autonomy and informed consent throughout their illness journey. A report released by Health Canada indicates that 82.8% of individuals who accessed MAiD, also accessed palliative care services, suggesting that patient autonomy in healthcare decisions is a significant reason for accessing MAiD (Health Canada, 2021). When nurses are not supported to provide intensive caring, the opportunity for meaningful connection is lost. This missed opportunity for connection influences the nurse's understanding of the individual patient care needs, and ultimately shapes the capacity to provide intensive caring for the patient (Chochinov, 2023). When nurses don't know how to ask patients about their experiences and care needs, nurses are missing the opportunity to understand symptom management and suffering from the patient's perspective, hindering the functioning of the working phase of the nurse-patient relationship. Moreover, as nurses spend significant time with patients each day, particularly in in-patient settings, when nurses are not engaging relationally in this depth with patients, the healthcare team may be missing valuable insights into patient care needs.

Moreover, throughout the working phase with a patient, the richness of a nurse's connection to the care team also shapes the strength of the nurse-patient relationship and the quality of care provided to the patient. The data reflects this in the nurses' perceptions of support by the members of the interdisciplinary care team, stating that they feel better equipped to tackle difficult conversations with patients during the working phase of their journey when interprofessional collaboration is more cohesive. This echoes findings from (Pesut et al., 2019a; Pesut et al., 2020a), interprofessional collaboration elevates nursing capacity to navigate MAiD with patients. Notably, the data of the current study demonstrated that the gap in interprofessional collaboration impedes information exchange within the care team. Therefore, the presence of effective communication channels and well-identified MAiD resources is essential to support nurses to seek out information for patients, but also to share pertinent information back to the care team, elevating the opportunity for holistic, patient-focused care. This is an important consideration in the development of robust practice supports and holds vital implications for nursing practice and high-quality patient care.

The Termination Phase

While each of the nursing relationship phases may be impacted throughout the MAiD journey, the termination phase is the phase that nurses repeatedly identify in the data as a phase that is heavily influenced by the challenges faced when navigating MAiD with their patients. This correlates with previous descriptions of nursing concerns related to MAiD found in the literature, where nurses express challenges closing relationships with patients accessing MAiD due to discomfort with limited therapeutic communication tools (Beuthin et al., 2018; Pesut et al., 2020a).

Further, the knowledge gaps in therapeutic communication and truncated nursing roles throughout the MAiD journey reported in the data of this study, leave little room for meaningful dialogue with patients. This creates missed opportunities for meaningful connection with patients and their families and closing of the relationship at the end of the journey. Nurses identified how a lack of closure during the termination phase of the nurse-patient relationship is a source of moral distress and how this negatively impacts the nurses' perceptions of how well they demonstrated caring for their patients. These concerns also arise in the literature and have implications for the incidence of emotional fatigue and burnout in nurses (Beuthin et al., 2018, Pesut et al., 2020b). Nurses seek the opportunity to appropriately close relationships within MAiD to resolve their own emotions within the caring relationship, and as a way of demonstrating support and caring for their patient and the family. The capacity to terminate the nurse-patient relationship is impacted by gaps in the communication and interprofessional collaboration identified within the data.

The emotional burden identified in these poorly closed interactions carries more weight in the absence of post-provision nursing supports. Post-provision supports such as formal debriefs with the care team, routine mental health check-ins and the creation of safe, reflective spaces for nurses are identified in the data as meaningful ways to support nurses navigating the emotional burden of disrupted nursing relationships. These supportive elements identified in the data are described by nurses as important interventions to improve nursing resiliency and reduce the likelihood of nurses experiencing further role strain and burnout. This reflects findings from Pesut et al. (2020b), who discuss the emotional toll of supporting patients, and their families, in MAiD as a different emotional experience than palliative EoL care. The authors also suggest the use of healthcare team debriefs following a MAiD provision, to support the emotional well-being of nurses, following provision (Pesut et al., 2020b)

It is notable that patients who are eligible for MAiD do not always choose to follow through with a MAiD provision; patients have the option to decline, right up until the time of medication administration. Therefore, it is vital for nurses to be able to offer support for the patient and let them know that they are supported regardless of the decision that is made in the end (CNA, 2017). The current data reflects how difficult it may be for nurses to know what say to patients prior to their MAiD provisions, acknowledging the need for further nursing education to support meaningful supportive dialogue as the relationship is seemingly ending, while leaving space for last minute changes in provision planning.

Nurse-Patient Relationships Outside of the End-of-Life Care Settings

Strain on the nurse-patient relationship is further noted in care areas outside of the palliative or EoL realm. MAiD requests are occurring across all types of care settings, and nurses outside of the palliative context may be even less prepared for these conversations. In this study, nurses identified that the demands placed on nurses in rural areas or in spaces without designated palliative care beds are forced to quickly pivot their care from curative approach to care into a palliative care approach, with little to no practice support. This is also discussed by Panchuk & Thirsk (2020), where the physical resources of bedspaces and staffing capacity in rural spaces is overlayed with the ethical complexities experienced by conscientious MAiD objectors. This is further explored by Brown et al., (2020b), who also point out that this leads to inequitable access to MAiD services.

Moreover, the results in this study suggested that a shift away from a curative approach towards MAiD in acute care settings may be perceived as a medical failure, rather than supporting a patient to exercise autonomy in healthcare decisions. The present study illuminated the challenge that exists in this pivot, leaving nurses feeling as though they have failed their patient, rather than supporting them well enough to maintain a level capacity to choose how to proceed in their illness journey. It is evident that the experiences in these types of care settings are increasingly complex, adding further strain to the nurse-patient relationship.

Nursing Autonomy and MAiD

Autonomy is a central tenet in nursing practice; it acknowledges the nurses' capacity to assess a patient's care needs and act independently to address the needs, within the nursing scope of practice (Rouhi-Balasi et al., 2020). The nursing scope of practice is broad and includes skills beyond physical care actions and includes nursing interventions such as psychosocial counselling and patient teaching. Autonomy is also a quality that continues to evolve with knowledge and experience (Rouhi-Balasi et al., 2020). As nurses hone their craft in the area where they work, they develop a greater depth of understanding of the intricacies in that care area and the confidence to advocate for patient needs. In the data of this study, nurses identified confidence and experience with MAiD as important supportive elements to elevate their capacity to care for patients seeking MAiD. Moreover, autonomy in practice appears to fuel nurses to support patients to gain access to important MAiD resources, particularly when other supportive practice elements are absent. Therefore, nursing autonomy appears in the data of this study as a crucial aspect of navigating the MAiD process.

The data in this study illuminated the infringement upon nursing autonomy and subsequent imposed role constraints that occur within the context of MAiD. Nurses report uncertainty of nursing roles and boundaries for advocacy in MAiD, citing repercussions against nursing licenses or impacts on patient eligibility as sources of fear while navigating MAiD with a patient. This is supported by findings from Pesut et al., (2019b) and Pesut et al., (2020a), who discuss nurses' experiences of hesitation and discomfort when providing care for patients seeking MAiD, when the nurses do not understand fully if or how it my impact their legal obligations enacted by their nursing license. While the NP role has a clearly defined scope in MAiD legislation, the RN role does not, leading to inconsistent, variable implementation of RN roles within MAiD across the institutions and regions across Canada (Hales et al., 2019). In this study, it is identified that nurses feel that they can provide higher quality patient care when they have confidence in their knowledge about MAiD and feel comfortable sharing information about MAiD highlight valuable considerations for quality care in the EoL journey. Nurses have noted that in the absence of easily accessible MAiD resources, they are relying upon their own resourcefulness to secure MAiD resources. Improved ease of access to MAiD resources would further support nursing autonomy, creating improved quality of care for patients.

Nurses in this study recognize the importance of defined nursing roles within the MAiD context as valuable and desired practices supports. Nurses receive practice guidance from their provincial or territorial regulatory bodies, and as identified in the literature, there is stark variability in the direction received from the provincial or territorial level to support nurses in navigating MAiD with their patients (Pesut et al., 2020a; Pesut et al., 2020b; Wright et al., 2017). Securing well defined nursing roles within the MAiD context supports nursing autonomy by providing nurses with clear direction of how to provide fulsome care while advocating for patients needs when requesting an assisted death. Further, having well-defined nursing roles fosters confidence in nurses, as they know the distinct limitations of their scope of practice, and how to work within that scope. Maximizing the use of the nurse’s full scope of practice allows nurses to provide a higher level of quality in care, using a broader range of nursing skills. As suggested in the data of this study, nurses have the skills and capacity to connect with patients beyond physical caring skills, but with psychosocial and counselling skills as well. Lack of clearly defined nursing roles leaves nurses uncertain how deeply they can connect with patients using these skills, reducing autonomy and confidence in practice.

Autonomy in nursing practice is further complicated within the context of MAiD when nurses are conscientious objectors to MAiD, or they are working in faith-based organizations that do not support MAiD. In this study, nurses share that communication barriers in faith-based organizations challenge nurses to work autonomously and advocate for their patients. Nurses share experiences of fear regarding the impacts to quality of care that patients may experience when pursuing MAiD in faith-based spaces, leading to emotional distress in nurses.

Implications for Nursing Practice

Palliative and EoL care are guided by a variety of patient-focused theories which underpin nursing practice, including Peplau's Interpersonal Relations Theory (1997). While MAiD is not always provided to patients who have already been receiving palliative care, many of the concepts outlined within the principles of palliative care apply within the MAiD context as well. When considering the practice implications that the gaps in nursing practice support and the lived experiences that the impact on nursing role fulfillment must also be considered.

In Peplau's Interpersonal Relations Theory (Peplau, 1997), Peplau describes six nursing roles that nurses may enact while caring for a patient. These roles include *teacher, resource, counsellor, stranger, surrogate,* and *leader*. Each of these roles provides a unique caring aspect as the nurse engages with the patient in a therapeutic way. When nurses do not have the therapeutic communication skills required to connect relationally with their patients, or when they are uncertain of their nursing role expectations within the MAiD context, this impedes the nurse's capacity to fulfill meaningful roles when caring for patients. For example, when nurses are not certain how to communicate with patients relationally, the capacity to share information in a teaching and a resource role is disrupted. Further, roles such as counsellor and leader are stunted when nurses do not have the autonomy to share resources about MAiD with their patients, or to explore unmet care needs.

Moreover, nurses express that robust therapeutic connection is difficult to attain due to limited understanding of their own nursing role, paired with the disconnect from interprofessional colleagues who may not acknowledge the full scope of care that nurses can provide in this context. Further, ambiguity in nursing roles creates tension in the therapeutic communication when nurses receive little, or conflicting, direction of how to acknowledge MAiD requests. When nursing roles related to MAiD are stifled through thin practice guidelines, nurses are uncertain about how they should connect patients, creating a gap in interprofessional collaboration when other disciplines do not include nurses in these important conversations. Nurses are identified in the literature as a trusted source of information and counseling for patients and their families (Pesut et al., 2019a; Wright et al., 2017), however current MAiD practice guidelines do not recognize this essential nursing role.

The exclusion of nurses from policy and role development conversations further stifles nursing roles in MAiD. Nurses need to be involved in developing defined nursing roles to ensure the full scope of practice is considered in MAiD. Decisions about nursing roles are being made by non-nursing professionals, and the result is blurred interprofessional boundaries and imposed nursing role constraints. In the data, nurses are crying out for defined nursing roles, guidance from nursing regulatory bodies and interprofessional acknowledgment of the full scope of nursing practice. Nurses are more than robots initiating intravenous sites and drawing up medications. Nurses are trained professionals with the therapeutic skills to connect deeply and meaningfully with patients, when allotted the opportunity to practice to their full scope.

Addressing The Gaps in Nursing Practice Support in MAiD

It has been demonstrated in this study that the impact of these gaps in nursing practice support have upon the quality of caring connections made, and the quality of care provided from the nurses' perspectives are a source of great distress for nurses caring patients seeking MAiD. Further, when considering the practice implications that disrupted therapeutic relationships and stunted nursing autonomy have on the quality of patient care provided, it is evident that increased attention to these issues is required. The concerns of nursing autonomy and role fulfillment can be addressed through several measures. These measures include the development of robust nursing practice guidelines and education related to MAiD, along with increased systemic and increased management support. Notably, these measures will also help nurses to develop more robust therapeutic relationships with patients, to shape deeper intensive caring practices and nursing role fulfillment.

Further, the implementation of targeted measures to develop nursing resiliency in practice will support a reduction in nursing moral distress to encourage longevity in nursing careers. Creating spaces for nurses to exercise autonomy through the development of clearly defined nursing practice guidelines, and acknowledgement of the extensive skillset that nurses possess, creates the opportunity for nurses to be perceived as, and more importantly, to *feel* that they are a valued member of the interdisciplinary healthcare team throughout the MAiD journey.

Resiliency in nursing practice is a quality that protects the nurse and supports sustainability of individuals within the profession (Kelly, 2020). Increasing nursing resiliency is linked to positive nursing outcomes such as improved capacity for caring toward patients, colleagues, and self (Kelly, 2020). The value of resiliency-focused practice support is evident in the data and the thirst for formalized post-provision mental health support is palpable from the participants. To foster resiliency, the desire for formal debriefs to facilitate closure to the patient's journey is requested repeatedly by participants.

Additionally, nurse-to-nurse mentorship is a suggestion that emerges often in the data as an additional tool to develop resiliency in novice nurses. Novice nurses are at increased risk for emotional fatigue, burnout, and moral distress (Kelly, 2020), and without structured mentorship programs consistently in places, limited opportunities for nursing mentorship exist. Further, the capacity for care settings to offer structured mentorship is dwindling as the healthcare system continues to undergo significant loss of experienced nurses, who are choosing to leave the profession (Tomblin Murphy et al., 2022). However, mentorship is identified in the data as a desired tool to support novice nurses to develop improved nursing therapeutic communication and knowledge of MAiD. Consideration of how nurses can be well supported to have the emotional stamina to provide care, as well as be a resourceful mentor to novice nurses is needed.

Nursing specific education to support an understanding of the MAiD process and provide therapeutic communication tools relevant to MAiD is noted as a gap in nursing practice support in the data. Nurses identify these knowledge gaps as tremendous barriers in achieving meaningful therapeutic relationships with patients seeking MAiD. Further, targeted education is needed to support nurses to have a deeper understanding of how the MAiD process works and provide nurses with the therapeutic communication tools required to connect relationally with patients, without overstepping nursing role boundaries, to address the identified nursing education gaps.

The gap in interprofessional collaboration that emerges from the data reflects the current thin nursing roles and guidelines in MAiD. Just as nurses are uncertain of their role, it is difficult to collaborate with interprofessional colleagues with blurred role boundaries. Nurses identify in the data that limited interprofessional collaboration also hinders continuity of nursing care for patients due to the imposed role constraints that evolve in the absence of collaboration. These experiences reflect what is previously reported in the literature, with (Pesut et al., 2019a; Pesut et al., 2020a) reporting that nurses cannot maintain high quality care without adequate interprofessional communication. Further, when therapeutic nursing communication is hindered with patients this impacts the healthcare team’s overall understanding of patient care needs. For example, the MAiD team is an interprofessional resource that is identified in the data as both a supportive and a hindering element. Nurses report that while the MAiD team may be a valuable source of information in some respects, the disjointed communication and interruption of the nurse-patient relationship that occurs when the MAiD team becomes involved is identified as a hindering factor. More fluid, bi-directional communication between the MAiD team and the nurses may allow nurses to access the valuable information that the MAiD team holds, while still maintaining a deep therapeutic relationship with the patient. Interprofessional professional collaboration must be addressed in a manner that allows nurses to be seen as an asset to the MAiD patient experience, with more cohesive communication channels. Further, resiliency is supported when nurses feel valued as an integral role within the healthcare team. Creating a culture of interdisciplinary teamwork and acceptance within the MAiD delivery systems would support nurses in feeling validated in their roles within the healthcare team.

Finally, the systemic structure of the healthcare system and the MAiD delivery systems were identified in the data as an influential aspect of how nurses perceive the quality of care that they can provide throughout the MAiD journey. Siloed communication structures and limited information sharing across care teams are identified in the data of this study as hindering aspects of nursing autonomy and therapeutic nursing relationships alike. Much like the barriers seen in interprofessional collaboration in this study, the disconnection across the MAiD delivery systems must also be addressed to support nursing autonomy in practice and therapeutic nursing relationships. Increased communication about MAiD provisions, the status of a patient's MAiD eligibility assessment process and patient care needs are all important pieces of information that need to be communicated effectively across the healthcare circle to maximize patient care.

Overall, the gaps in nursing practice support that are identified in the data, related to the development of robust therapeutic nursing relationships, are limited educational resources, management support, systemic communication and interprofessional collaboration. Increased training and education about MAiD are needed outside of the palliative care context as well, to increase nursing confidence in these curative care areas, to ensure that patients are receiving safe, supportive care. While there is variability in nursing roles and staffing across larger urban centers, the need for more robust nursing practice frameworks in smaller, more rural care settings is elevated to address the issue of access and limited resources within the rural care settings.

Practice Recommendations to Address the Gaps

Given the current findings from this study, recommended actionable interventions that would support nurses in their practice. The following list provides easily implanted practice recommendations that have the potential to create immediate impact upon nursing practice:

1. Clear, well-defined nursing practice guidelines that include considerations for the full RN scope of practice must be developed to provide clear direction in nursing practice.
2. Nursing education focused on understanding of the MAiD processes, where and when to access MAiD resources, and therapeutic communication tools must be developed. This education should be further tailored to support nurses across a multitude of care settings, from palliative care spaces to acute care settings.
3. Resiliency support initiatives such as healthcare team debriefs following a MAiD provision should be implemented to support the psychological safety of nurses caring for patients accessing MAiD

4. Nursing mentorship programs must be created in a meaningful and sustainable way to foster the growth and development of nursing autonomy. This must be done in an intentional way that acknowledges the existing fatigue of experienced nurses remaining within the profession, and the high risk for burnout that nurses are experiencing.
5. MAiD provision planning and communication strategies must be streamlined and simplified to ensure timely, comprehensive communication occurs among the circle of care in the care team. Communication must include changing care needs and alterations in the care plan to enhance patient and family care.
6. Management considerations such as adequate staffing, the availability of nurses who support MAiD to provide care, and timely communication about provisions to allow nurses time to close therapeutic relationships should be included when staffing allows. Additionally, awareness of conscientious objectors to ensure an appropriate staffing mix when MAiD events occur, to support patient care needs and reduce nursing moral distress.

Limitations

As principal researcher, I acknowledge the limitations of this study. Limitations of this study include my positioning as a palliative care nurse within the research. I am mindful of my own practice experiences pertaining to MAiD, as well as my own values and perceptions of the necessity of robust relational practice as it relates to quality patient- and family-focused care.

This research is also limited by the size and capacity of the research team working within the given time constraints for the project. A larger pool of researchers would allow for a greater sample size, which could allow for broader sampling nationally to provide more robust exploration from each province and territory. This would allow for deeper exploration of nurses' experiences providing care to patients seeking MAiD and provide further insight into gaps in practice supports. This would allow for more generalizability of the study results. Further, a larger sample of participants could also provide greater diversity in the geographic location of participants and a larger number of significant experiences shared. Geographic diversity of participants would enhance analysis of experiences from each of the provinces and territories to examine the impact of the variance in practice supports across each of the regulatory practice frameworks. The small sample size therefore limits generalizability of the research.

This inquiry is also limited by the relatively short existence of MAiD in Canada. While thousands of Canadians have accessed MAiD since its inception in 2016, MAiD deaths have been particularly concentrated in British Columbia and Ontario (Health Canada, 2021). The new existence of MAiD therefore limits the number of nurses who may have encountered conversations about MAiD with their patients and limited educational experiences with MAiD to support their practice. Further, stigmatization of MAiD may also lead to hesitancy to speak out about experiences caring for individuals seeking MAiD. The controversial, highly politicized nature of MAiD may deter nurses from sharing their experience.

While the focus of the inquiry is not to debate the topic of MAiD, and although the positioning of the participants within the context of MAiD was not explicitly asked of the participants, it is evident from the conversation that the participants were unanimously in support of MAiD as a treatment option to support their patients' wishes.

Further, the research question unintentionally created a biased towards nurses who support MAiD, as these nurses would have more experience caring for patients pursuing MAiD. Therefore, the study does not explore the practice supports that would be most relevant to nurses who identify as conscientious objectors. While some of the practice supports identified in this study may be helpful to nurses conscientiously object to MAiD, it is important to ensure that there are resources and practice supports available for these nurses too. Given the positioning of the participants, it cannot be concluded that any or all of the practice supports identified in this study would be appropriate for conscientious objectors to MAiD.

Implications For Future Research

The findings of this study offer further research opportunities to develop deeper understanding of the nurse's experiences navigating MAiD. Future considerations for research include examining the experiences of a larger population of nurses to further validate the current findings, to gather generalizable results. Including larger numbers of participants, across more provinces and territories would add validity and depth of understanding to the current findings. Furthermore, focusing on specialized nursing groups, such nurses outside of palliative care roles and conscientious objectors would provide greater insight into how these populations of nurses can be well supported in care provision. Additionally, a broader sample size creates an opportunity for understanding more diverse perspectives. Future research could include consideration of the challenges faced by nurses who conscientiously object to MAiD.

Finally, future research opportunities may focus on each gap in nursing practice support independently. By implementing practice changes and evaluating the outcomes of these interventions, the impact on patient care may be assessed from a nursing or a patient and family perspective. As Canadian MAiD legislation continues to evolve, it is important to gain a solid understanding of current nursing practice concerns to prevent snowballing of these issues as further complexities in nursing practice arise. Using future research opportunities to strengthen nursing practice supports the evolution of quality patient care.

Summary

The findings of this study highlight the gaps in nursing practice support that exist within the context of MAiD. The experiences shared by nurses exemplify how the gaps in nursing practice support bear impact upon the depth of nursing-patient therapeutic relationships they are able to establish and fulfill. Further, the existing nursing practice gaps impact nursing autonomy and created imposed role constraints. This creates further disrupted nurse-patient relationships and an inability to fulfill nursing roles in caring. Further, nurses report that these role constraints lead to emotional distress and perceptions of lower quality care than they strive to provide.

Future considerations for research include examining the gaps in nursing practice support in MAiD on a broader scale. Including a larger number of nurses from an even more diverse geographic representation would allow for further validation of the results, and to obtain a deeper understanding of nurses’ experiences within this context. Future research considerations also include implementation and subsequent evaluation of the recommended interventions to address the gaps in practice support identified within the current study. Finally, future research opportunities may also consider exploring the experiences of nurses who are conscientious objectors to MAiD to identify how nurses in that specific population can be supported in their nursing therapeutic relationships when patients seek MAiD as a treatment option.

Chapter 7. Conclusion

This qualitative inquiry was shaped by curiosity about nurses' experiences supporting patients seeking assistance in dying in Canada, and the nursing practice supports in place to guide their practice. Using CIT methodology, the data generated in the qualitative interviews shed light up on the helping, hindering and desired aspects of nursing practice supports to underpin nursing care in MAiD. Analysis of the data revealed that nurses perceive imposed nursing role constraints, challenges in exerting autonomy in practice and barriers to developing therapeutic nursing relationships when caring for patients seeking MAiD.

The participants identified practice supports that support the development of therapeutic nurse-patient relationships, including defined nursing roles in MAiD, therapeutic communication skill and management support. Further, additional practice supports identified in the data that supported nursing autonomy within the context of MAiD include interprofessional collaboration, resiliency support and self-confidence in nursing practice related to MAiD. Nurses also identified factors that hindered nurses' capacity to develop robust therapeutic relationships, including poorly defined nursing roles in MAiD, limited nursing education pertaining to MAiD, systemic communication barriers, and limited interprofessional collaboration. Additionally, the data identified that nursing autonomy is impacted by the same hinderances and is further hindered by limited resiliency support for nurses. Finally, nurses discussed the practice supports that they wished were in place to support the development of meaningful therapeutic relationships with patients seeking MAiD include well defined nursing roles and practice guidelines within MAiD and increased nursing education relevant to MAiD.

The impact of imposed role constraints and reduced capacity for nursing autonomy in practice are noted. Nurses describe the challenges in establishing and maintaining therapeutic relationships with patients seeking MAiD as their nursing roles are truncated by a lack of clearly defined nursing roles and siloed systemic communication within MAiD. The findings of this study suggest that nurses continue to carry the burden of creating a positive EoL and MAiD experience for the patient. Nurses are being asked to fold into imposed role constraints, while simultaneously stretching to meet practice demands beyond their comfort and expertise with little direction or consideration. This leads to challenges in nursing role fulfillment and nurses experiencing emotional distress, furthering the risk for burnout.

Therefore, it is essential that the gaps in nursing practice supports relevant to MAiD are addressed. By providing nurses with well-defined nursing roles and targeted education to support therapeutic communication, nurses will be better equipped to support patients through the MAiD journey. Further, by including consideration for resiliency supports and formalized mentorship opportunities, nurses will be supported to develop confidence and autonomy in practice. Overall, this will allow for more robust therapeutic nursing relationships and improved nursing care for patients seeking MAiD.

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Appendix A: Semi-structured interview questions

Audio and Video Recorded (with permission)
Research questions: What are the gaps in nursing practice supports related to MAiD? How can these gaps be addressed to support improved nursing relational practice?

- Include demographics (care areas, length of time nursing, designation, etc)
- Tell me about what is meaningful in nursing for you?
- Reflect upon experiences navigating MAiD. Tell me about your experiences
- Does a particular experience stand out to you? Describe the experience (+ or -? Why?)
- What went well in that interaction?
- What could have gone better?
- If there was one thing you could have had to support you in that interaction, what would it be? (wishlist item)
- What factors influence how you feel about this?
- How has this experience impacted subsequent interactions with patients navigating MAiD?
- How do you feel about advocating for patient needs in the MAiD journey?
- What information are you comfortable providing about MAiD to a patient or their family if they approach you seeking this information?
- Tell me about your thoughts and feelings about talking to a patient who has asked about MAiD or is pursuing MAiD
- How do you feel about providing information about accessing MAiD to patients?
- Tell me about the workplace supports that you have experienced related to MAID
- Tell me about how accessible practice support documents r/t MAiD are to you? Tell me about any education you have received at your workplace about MAiD
- Tell me about your understanding of nursing roles related to MAiD
- What kinds of training/practice support have you received related to MAiD throughout your practice?
- What additional types of practice supports would you like to able to access, if any?
- Is there anything else that you would like to share with me today related to nursing practice supports and MAiD?

Appendix B: Invitation to participate

INVITATION TO PARTICIPATE

Gaps in Nursing Practice Support for Medical Assistance in Dying

October 21, 2022

Principal Investigator (Researcher):	**Supervisors:**
Jill Henderson	Dr. Lorraine Thirsk
jhenderson6@athabasca.edu	lthirsk@athabasca.ca
705-772-7766	Dr. Jennifer Stephens
	jsteph35@uwyo.edu

My name is Jill Henderson and I am a Master of Nursing student at Athabasca University. As a requirement to complete my degree, I am conducting a research project about nursing practice supports that are currently in place to support nurses caring for patient who may be seeking Medical Assistance in Dying (MAiD). I am conducting this project under the supervision of Dr. Lorraine Thirsk and Dr. Jennifer Stephens.

I invite you to participate in this project because you are a nurse who has previously or is currently caring for patient(s) seeking information about MAiD or have cared for a patient navigating the MAiD journey in Canada.

The purpose of this research project is to determine how nurses perceive the current practice supports that exist in relation to MAiD, and how these supports empower nurses to engage in meaningful relational practice when patients express the desire to pursue MAiD.

Your participation in this project would involve participating in a one-on-one interview with the principal investigator. The interview will take place face-to-face (if reasonable geographically), or virtually using an online meeting platform. The interviews will take approximately 30 to 60 minutes and both audio and video will be recorded. The interview will be arranged for a time and place that is convenient for your schedule, during the period of February or March 2023.

A follow-up conversation may be scheduled if further clarification of responses or to review the interview transcript, if you would like the opportunity to do so.

All information you provide during the study will be anonymized and coded to protect your identity and maintain confidentiality. Data will be stored on the principal investigator's computer, encrypted and password protected to prevent unauthorized access. Data will be accessed only by the principal investigator, and results will be shared with the supervisors.

The research should benefit the development of knowledge related to nursing practice, leading changes in practice supports, and enhanced nursing practice. I do not anticipate you will face any risks because of participating in this research. You will be reimbursed with a $20 gift card for Chapters for your time.

Thank you for considering this invitation. If you have any questions or would like more information, please contact me, (the principal investigator) by e-mail jhenderson6@athabasca.edu or my supervisors by emailing Dr. Lorraine Thirsk *(lthirsk@athabasca.edu*) and Dr. Jennifer Stephens (jsteph@uwyo.edu).

Thank you.

Jill Henderson

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, please contact the Research Ethics Officer by e-mail at rebsec@athabascau.ca or by telephone at 780.213.2033.

Appendix C: Letter of information/informed consent form

LETTER OF INFORMATION / INFORMED CONSENT FORM

Gaps in Nursing Practice Support for Medical Assistance in Dying

Principal Investigator (Researcher):
Jill Henderson
jhenderson6@athabasca.edu
705-772-7766

Supervisors:
Dr. Lorraine Thirsk
lthirsk@athabasca.ca
Dr. Jennifer Stephens
jsteph35@uwyo.edu

You are invited to take part in a research project entitled 'Gaps in Nursing Practice Support for Medical Assistance in Dying'.

This form is part of the process of informed consent. The information presented should give you the basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. To decide whether you wish to participate in this research project, you should understand enough about its risks, benefits and what it requires of you to be able to make an informed decision. This is the informed consent process. Take time to read this carefully as it is important that you understand the information given to you. Please contact the principal investigator, *Jill Henderson,* or their supervisors if you have any questions about the project or would like more information before you consent to participate.

It is entirely up to you whether you take part in this research. If you choose not to take part, or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now, or in the future.

Introduction

My name is Jill Henderson, and I am a Master of Nursing Student at Athabasca University. As a requirement to complete my degree, I am conducting a research project about nursing practice supports that are currently in place to support nurses caring for patient who may be seeking Medical Assistance in Dying (MAiD). I am conducting this project under the supervision of Dr. Lorraine Thirsk and Dr. Jennifer Stephens.

Why are you being asked to take part in this research project?

You are being invited to participate in this project because you have identified that you are a nurse who has previously or is currently caring for patient(s) seeking information about MAiD or have cared for a patient navigating the MAiD journey in Canada.

What is the purpose of this research project?

The purpose of this research is to determine how nurses perceive the current practice supports that exist in relation to MAiD, and how these documents support nurses in engaging in meaningful relational practice when patients express the desire to pursue MAiD.

What will you be asked to do?
To engage in this study, you will be asked to participate in a one-on-one interview with the principal investigator. The interview will take place face-to-face (if reasonable geographically), or virtually using an online meeting platform. The interviews will take approximately 60 minutes and both audio and video will be recorded. The interview will be arranged for a time and place that is convenient for your schedule, during the period of February or March 2023.

A follow-up conversation may be scheduled if further clarification of responses or to review the interview transcript, if you would like the opportunity to do so.

What are the risks and benefits?
Participation in this study may elicit emotional distress, as difficult nursing experiences may be discussed over the course of the interview. Access to mental health supports will be provided to support you if needed following the interview.

Benefits of participation in this study include the development of more robust understanding of the nursing experience related to MAiD, and changes to the practice supports that are currently available to nurses, to align with practice needs. Additionally, participants will receive a $20 gift card for Chapters following the interview as a thank you for your time.

Do you have to take part in this project?
As stated earlier in this letter, involvement in this project is entirely voluntary. If at any point during the interview process you would like to end your participation, you are invited to let the researcher know, and the interview will be terminated. Any data that has been collected up to a decision to withdraw consent to participate, will be destroyed (paper documentation will be shredded, audio and video recordings will be deleted) and data will not be included in the study. If consent is retracted following completion of the interview, intent to withdraw must be received by **April 30, 2023**, to ensure your data is not included in the data analysis process of the study.

Participants will not incur any consequences for withdrawing from the study, however, will not be eligible to receive the gift card that has been offered as a thank you for participation.

How will your privacy and confidentiality be protected?
The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use or disclosure. Privacy and confidentiality will be maintained using pseudonyms and coding during the process of data collection and transcription. Specific identifying characteristics will be removed in the data collection process. Interviews will be conducted one-on-one with the principal investigator to increase privacy in the data collection process.

Please note, all information will be held confidential, except when legislation or a professional code of conduct requires that it be reported.

How will my anonymity be protected?

Anonymity refers to protecting participants' identifying characteristics, such as name or description of physical appearance.

Every reasonable effort will be made to ensure your anonymity; you will not be identified in publications without your explicit permission. Within the design of this study, the data collected during the interview will be anonymous, your name and other identifying information will not be associated directly with your interview data. However, if you have consented to video recording of the interview, your face will be visible in the recorded data. This recorded data will not be shared without your explicit consent.

How will the data collected be stored?

- Data will be collected using a virtual meeting platform, Microsoft Teams. This will include recording of audio and video, with your consent. The data will be housed with Microsoft until it is transferred to the principal investigator's computer.
- Recorded data will be stored on a password protected, encrypted computer by the principal investigator, who will be the only person with access to the data.
- Data will be shared with the research supervisors, Dr. Lorraine Thirsk and Dr. Jennifer Stephens. The final report will be available to Athabasca University. Data collected and recorded videos will not be available to anyone outside of the research team.
- Pseudonyms and data codes will be used to create anonymity in the data. No anticipated secondary use of the data is anticipated at this time. Further REB approval would be sought if a later project is designed.

Data collected/processed may be housed for a time on a server located in the United States. The US Patriot Act allows authorities to access the records of internet service providers. Therefore, anonymity and confidentiality cannot be guaranteed. If you choose to participate in this survey, you understand that the data you provide will be stored for a time (i.e., until it is transferred from that company's server to the principal researcher's computer) and may be accessed in the US during that time. The security and privacy policy for the web survey company can be found at the following link: *Microsoft Privacy Statement – Microsoft privacy*.

Who will receive the results of the research project?

Direct quotations will be reported in the final research report, however, will not be associated with any personally identifying components to maintain your confidentiality. The audio and video recordings will not be used in dissemination of the research.

The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper will be publicly available. A copy of the completed report will be available to participants following project completion. A link to access the repository will be provided to participants once the project is complete and the final report is available.

Who can you contact for more information or to indicate your interest in participating in the research project?
Thank you for considering this invitation. If you have any questions or would like more information, please contact the principal investigator by e-mail jhenderson6@athabasca.edu or my supervisor by Dr. Lorraine Thirsk at lthirks@athabasca.ca or Dr. Jennifer Stephens at jsteph35@uwyo.edu. If you are ready to participate in this project, *please complete and sign the attached Consent Form and return it by* email to jhenderson6@athabasca.edu.

Thank you.

Jill Henderson

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, please contact the Research Ethics Officer by e-mail at rebsec@athabascau.ca or by telephone at 780.213.2033.

Informed Consent:
Your signature on this form means that:

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand what the research project is about and what you will be asked to do.
- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You understand that if you choose to end your participation **during** data collection, any data collected from you up to that point will be destroyed.
- You understand that if you choose to withdraw **after** data collection has ended, your data can be removed from the project at your request, up to **April 30, 2023.**

	YES	**NO**
I agree to be audio-recorded	○	○
I agree to be video-recorded	○	○
I agree to the use of direct quotations	○	○
I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript.	○	○

Your signature confirms:

- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.

- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.

- You have been given a copy of this Informed Consent form for your records; and

- You agree to participate in this research project.

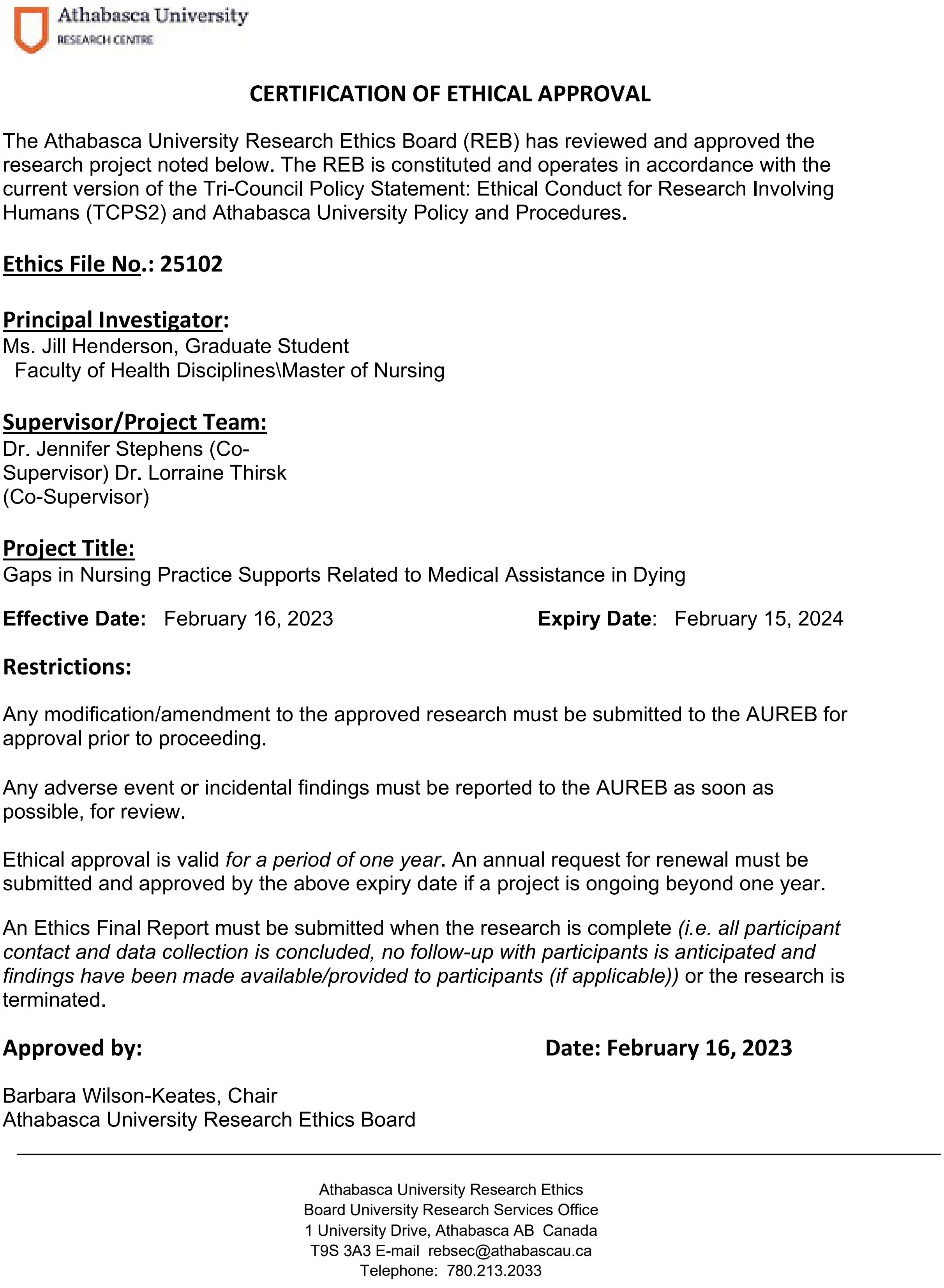
Signature of Participant Date

Principal Investigator's Signature:

I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in participating in the research project, any potential risks and that he or she has freely chosen to participate.

Signature of Principal Investigator Date

Appendix D: Athabasca University Certificate of Ethical Approval



Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: 25102

Principal Investigator:
Ms. Jill Henderson, Graduate Student
Faculty of Health Disciplines\Master of Nursing

Supervisor/Project Team:
Dr. Jennifer Stephens (Co-Supervisor) Dr. Lorraine Thirsk (Co-Supervisor)

Project Title:
Gaps in Nursing Practice Supports Related to Medical Assistance in Dying

Effective Date: February 16, 2023 **Expiry Date**: February 15, 2024

Restrictions:

Any modification/amendment to the approved research must be submitted to the AUREB for approval prior to proceeding.

Any adverse event or incidental findings must be reported to the AUREB as soon as possible, for review.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

An Ethics Final Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: February 16, 2023**

Barbara Wilson-Keates, Chair
Athabasca University Research Ethics Board

Athabasca University Research Ethics
Board University Research Services Office
1 University Drive, Athabasca AB Canada
T9S 3A3 E-mail rebsec@athabascau.ca
Telephone: 780.213.2033

Appendix E: Budget

Budget for Research Project

Gaps in Nursing Practice Support in Medical Assistance in Dying

Item	**Cost**
Chapter gift cards for participants 7x $20	$140
Miscellaneous office supplies (printer ink, paper)	$100
Internet connection throughout research	$200
Total Costs	**$440**
Funding Award Graduate Student Research Fund	$440
Balance	**$0**