Paradoxes, nurses’ roles and Medical Assistance in Dying: A grounded theory

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Abstract

Background: In June 2016, the Parliament of Canada passed federal legislation allowing eligible adults to request Medical Assistance in Dying (MAID). Since its implementation, there likely exists a degree of hesitancy among some healthcare providers due to the law being inconsistent with personal beliefs and values. It is imperative to explore how nurses in Quebec experience the shift from accompanying palliative clients through “a natural death” to participating in “a premeditated death.”

Research question/aim/objectives: This study aims to explore how Quebec nurses personally and professionally face the new practice of MAID and their role evolution.

Research design: A grounded theory design was used.

Participants and research context: We recruited 37 nurses who participated in or coordinated at least one MAID. Semi-structured interviews and focus groups were conducted and audiotaped. Data collection and analysis followed Strauss and Corbin steps.

Ethical considerations: Ethics approval was received from the investigator’s affiliated University. Participants were informed regarding the research goal, signed a written consent, and were assigned pseudonyms.

Findings/results: Results show that nurses experienced the wide range of paradoxes during MAID centering around the following eight elements: 1) confrontation about death, 2) choice, 3) time of death, 4) emotional load, 5) new Bill, 6) relationship with the person, 7) communication skills, and 8) healthcare setting. The shifting of views and values in this new role is presented by the contradiction of opposites.

Conclusions: A better understanding of the paradox experienced by nurses involved with MAID paves the way for the development of interventions.

Keywords
Medical assistance in dying, nurse role, end of life, grounded theory, ethics, paradoxes

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Introduction

Medical assistance in dying (MAID) is a special form of palliative care and has been associated with several ethical dilemmas, resulting in substantial media attention. According to the Commission on End-of-Life Care, a total of 2 268 people in 2020 received MAID in Quebec compared to 494 in 2016. In Canada, a total of 21 589 MAID have has occurred since legislative enactment. Although this number seems marginal, the number of people seeking MAID continues to increase as this practice becomes more and more well-known.

MAID is an end-of-life care option available since December 2015 in Quebec. In Quebec, MAID is defined as a “care consisting of the administration of medication or substances by a physician to a person at the end of life, at the request of the person, with the aim of relieving his or her suffering by causing death.” Assisted death is prohibited by law in Quebec, which is why we focus solely on MAID. MAID represents a historic change in Canadian and Quebec society. Although physicians play a crucial role in MAID administration, the nurse’s role is intertwined in the larger responsibility of “providing palliative care” as stated in article 36 of the Nurses Act. Nurses are largely widely involved in the care before, during, and after MAID across a number of settings, including hospitals, nursing homes, palliative homes, and in the community. The portrait of palliative care in Quebec is being transformed and it carries an important ethical issue for nurses, since they are pillars of palliative care.

People in palliative care, who respect the six criteria, can now decide how and when they want to die. This choice initiates a paradigm shift for healthcare workers and, for some, this change is difficult and still taboo. What was once considered “killing” is now legally recognized as “caring.” As this practice is still fairly new and infrequent, it is imperative to study the experience of nurses who provide this care. The impact of MAID on nursing has been studied in a number of emerging studies; however, few of them were conducted in the province of Quebec which has a different legislation and practice. Thus, using grounded theory as a method, we aimed to investigate how French-speaking nurses in Quebec perceived their role in accompanying clients and their families through MAID care.

Research question/aim/objectives

The goal of this study is to explore the nursing role evolution in the accompaniment of clients and families seeking MAID.

To do so, the objectives are as follows:

1. to explore the nursing role evolution in accompanying clients and families through the various stages (before, during, and after) of MAID;
2. to describe the needs of nurses accompanying clients and families through MAID; and
3. to describe the paradoxes experienced by nurses in accompanying clients and families through MAID.

This article focuses on objective 3. Results from objectives 1 and 2 will be presented in another article.

Background

The adoption of the Canadian law on MAID in 2016 means that it is a recent topic with emergent research and literature on the subject. The literature appears to be more concerned with the concepts of euthanasia and assisted suicide, which are distinct themes from MAID. Relevant studies indicate that MAID is causing shifts in how palliative and end-of-life care is being perceived by nurses, with effects at ethical, professional, and personal levels. This extension of the nursing scope of practice is often met with a moral sensemaking and with some expressing distress.
Mitchell\textsuperscript{15} defines living paradox as a “rhythmic shift in perspectives, where awareness arises from experiencing the contradiction of opposites in the daily relationship of value priorities while traveling toward the not-yet.” Indeed, in choosing the values to participate in MAID care, nurses struggled with deciding to affirm certain values while simultaneously disconfirming others. The paradox is the moment when nurses struggle to decide. It is the process of changing perspectives that leads to the clarification of values and may lead to an ethical dilemma.\textsuperscript{15} It differs from an ethical dilemma which refers to a “situation when nurses are unable to solve the ethical problems they face, which includes difficulties in balancing interests, allocating resources, and establishing interpersonal relationships.”\textsuperscript{16} Fundamentally, the cause of a dilemma in nursing ethics is the gap between existing nursing practice and the ideal nursing goal.\textsuperscript{17}

**Research design**

*Design.* A qualitative methodology of grounded theory design appeared preferable as the study’s phenomenon of interest is both a social interaction and a process. More specifically, the method of Corbin and Strauss\textsuperscript{18} was the methodological foundation since the authors are positioned in a pragmatist and constructivist paradigm. Derived from symbolic interactionism, grounded theory maintains that the reality of the world is subjective and that the interpretation of situations is influenced by social interactions.\textsuperscript{18} Nurses, therefore, can manifest their behaviors as a result of their interpretation of the world. In this way, their actions and treatment choices toward MAID are based on their meaning of it. This meaning emerges through situational interpersonal interactions and an intersubjective reality based on shared language symbols.\textsuperscript{19} For example, the term “medical assistance in dying” may be a social symbol. For some nurses, it may represent the end of suffering, while for others it signifies the end of care and, thus, an ethical conflict emerges. Grounded theory, through symbols drawn from social interactions, provides a better understanding of how nurses define and explain the process of care, as it reflects a social process. Rooted in the empirical world, grounded theory proposes to take the form of an exploration, careful examination, and constant return to the concreteness of phenomena as experienced by nurses to interpret their reality as caregivers. This approach will provide relevant information, increase understanding, and provide a sound guide for action.\textsuperscript{18,20}

**Ethical considerations**

Following research ethics board approval received from the investigator’s affiliated site # CER-19-255-07.02, participants were recruited through social media postings and also through the university’s communication department in order to reach nurses. Finally, the snowball sampling technique allowed us to recruit participants in various regions of Quebec. After the explanations, all participants were free to resign or sign the consent form and participate in the interview.

**Participants and research context**

Between June 2019 and March 2020, we recruited French-speaking Quebec nurses who had experience accompanying clients through MAID. They had to be Registered Nurses practicing in Quebec and must have participated in MAID to some extent. In the province of Quebec, nurse practitioners were not licensed to practice MAID at the time the study was conducted, which is why they were excluded.

By conducting theoretical sampling that targets nurses who had different experiences with MAID, the nursing role was explored and clarified. Data collection continued until theoretical saturation was reached.\textsuperscript{18} We used four data collection tools: 1) a sociodemographic and personal characteristic questionnaire, 2) a semi-structured interview,\textsuperscript{21} 3) a journal,\textsuperscript{20} and 4) memos.\textsuperscript{20}
The sociodemographic questionnaire gathered information regarding nurses’ age, marital status, ward, education, previous experience with MAID, and their support network. The qualitative semi-structured interviews were recorded in digital audio format, took place in the participants’ homes or any other place chosen by the participants, and lasted between 45 and 90 minutes. Most of them were conducted face-to-face and two were done virtually.

The semi-structured interview is based on a guide developed by a clinical expert, a content expert, and an expert in grounded theory. The draft interview guide addresses themes such as experience, perceptions of MAID, and the evolution of the nursing practice responsibility. Questions include, but are not limited to, the following: “How did you become involved in MAID?” and “How do you perceive MAID?” Throughout the interview, inductive hypotheses were verified with the participants and the questions evolved along with the understanding of the phenomenon, to be ultimately framed as follows: “Tell me how your perception of MAID has evolved from before and after having participated in it?” If necessary, clarification questions such as “What do you mean by…?” and “Can you explain a little more…?” were asked to get a better understanding of what the participants’ comments meant. This interview guide remained open-ended and was modified depending on the theoretical saturation of the interviews conducted.

Researchers also kept a journal in which they noted their preconceptions through memos in order to be sensitive to empirical data. Memos are the written records of the researchers’ methodological reflections, which are created as the analysis evolves and are noted at any point in the research process. These memos also reflected researchers’ reflexivity as well as their field observations, such as a description of the locations and the non-verbal observations of the participants.

Analysis

Data was analyzed concomitantly with data collection to respect the grounded theory principle of circularity. This circularity allowed the researchers to constantly compare by going back and forth between the data, the results of the analysis, and the memos. The discussions with the research team were very productive and helped to generate new ideas or hypotheses. The latter led to changes in the interview guide to support the theory being developed. This study aimed to discover new ideas and not to validate a theory, so the emerging data was not inserted into an existing analysis grid derived from a theoretical model or literature review.

Each interview was transcribed by undergraduate and graduate student research assistants. Subsequently, QSR NVivo 12 software was used to aid in data entry and organization of transcripts, memos, and extracts from scientific articles, facilitating data management. Data was analyzed through open, axial, and selective coding. Open coding is the first step in which the researcher reads the transcripts and labels (codes) to each important concept present in each line and paragraph. Next, the data is grouped together to create categories in axial coding. Finally, in selective coding, the researcher finds an overarching category that captures the essence of the data.

Results

Participants’ sociodemographic profile

Thirty-seven nurses contacted the researchers following a publicity on social media and consented to participate. The demographic characteristics of the 36 participants are shown in Table 1. One participant did not fill out the form. Nurses were between 22 and 64 years of age with a mean of 36 years, 26 had a university degree, and 27 worked full-time. They worked in different clinical settings: 1) 5 in community setting general, 2) 6 in community setting specialized in palliative care, 3) 11 in palliative care unit, 4) 9 in medicine ward, 5) 2
in geriatric unit, and 6) 3 in long-term care facility. Twenty-one had more than 10 years of experience in nursing and 19 had more than 5 years in palliative care specifically. Finally, 25 of them needed psychological assistance after they participated in MAID and 22 took part in MAID four times or fewer.

**Paradoxes during the care of MAID**

We found that study participants had all experienced substantial paradoxes during MAID. From our qualitative analysis of the interviews, we identified eight elements causing paradoxes. These eight elements are represented in Figure 1 and are as follows: 1) confrontation about death, 2) choice, 3) time of death, 4) emotional load, 5) new Bill, 6) relationship with the person, 7) communication skills, and 8) healthcare setting.

**Confrontation about death.** The first paradox centers around death itself. MAID forced the nurses interviewed to be confronted with the subject of death. Nurses felt that they were providing a patient with unique care through MAID; however, they also felt that they were taking someone’s life as MAID is not a natural death. Nurses are trained to save lives. At first glance, therefore, MAID goes against what they were trained to do, as this participant testified: “We were trained to save life at all costs and, here, we take life away. We are doing the opposite of what we were taught. If the person is not well, they code, we will massage, and we will do everything to bring them back. This is the opposite. We’ll do everything we can to make sure they leave with dignity.” (P.36) “We give the lethal dose in fact.” (P15) “Well, that’s another big question, a Pandora’s box and now that’s a lot of ethical dilemmas about death.” (P30).

To rationalize their decision to participate in MAID, several nurses explain that they contribute to ending the suffering, as explained in detail by participants 17 and 31: “That first experience troubled me. Not because of the experience itself, but because of all the previous events that could have ended much better if MAID had been available before. I have images of people I have accompanied in painful end-of-life situations (P17). We do MAID, it is not painful. There is pain, but there is much less pain and suffering compared to someone slowly dying for two or 3 days with pulmonary complications (P31).” A third participant concurred, stating, “I helped someone get out of that. I don’t like to see someone suffer, I felt privileged to be able to accompany my patient. It was very intimate. I got to know his fears, to learn how he lived, to get to know his family and to accompany them from A to Z. I didn’t say to myself: ‘Oh my god, I killed someone!’” (P7) As illustrated through these nurses’ testimonials, MAID creates a paradox and sometimes even an ethical dilemma since it is not a standard death, yet nurses rationalized their actions by stating that they are ending a patient’s suffering by providing this care.

**Choice.** The second paradox arising from nurses’ experience with MAID was related to a patient’s choice in seeking MAID. Nurses could either respect it and see MAID as palliative care they are providing or claim conscientious objection and refuse to participate in it. Nurses that did not experience any distress related to a patient’s decision to pursue MAID were reassured in knowing that they had respected the person’s wishes, and that MAID is legalized care. As the following participants explained, these nurses did not judge and respected the person’s choice to end their suffering: “I find that it is part of our care as much as anything else. Since they are in palliative care, we relieve their physical and psychological suffering with medication and psychotherapy. MAID, I find, is also a kind of care in the sense that it’s what the patient wants. He has no quality of life, has physical or moral suffering, and I can help him with that.” (P12) “It’s care that you have to get familiar with and it’s new.” (P16). “It’s care. It’s a choice. It’s a treatment. So, for me, that’s what it is: care that relieves the person according to the decision that they have made.” (P7, P20, P23) “Who am I to say it’s right or wrong? We can’t judge that.” (P21, P36) “I was there to accompany them in what they want for the end of their lives. It’s not for me to decide.” (P27)
Table 1. Participants' sociodemographic profile

|                          | N = 37 | 36 filled out the form |
|--------------------------|--------|------------------------|
| **Mean age**             |        | 36 years (22–64 years) |
| **Education**            |        |                        |
| College degree           | 10 (28%) |                      |
| Bachelor’s degree        | 21 (58%) |                      |
| Master’s degree          | 5 (14%)  |                      |
| **Status**               |        |                        |
| Civil union              | 21 (58%) |                      |
| Single                   | 13 (36%) |                      |
| Divorced or separated    | 2 (6%)   |                      |
| **Work status**          |        |                        |
| Full-time                | 27 (75%) |                      |
| Part-time                | 6 (17%)  |                      |
| Retired                  | 3 (8%)   |                      |
| **Setting**              |        |                        |
| Community setting general| 5 (14%)  |                      |
| Community setting specialized in palliative care | 6 (17%) | |
| Palliative care unit     | 11 (30%) |                      |
| Medicine ward            | 9 (25%)  |                      |
| Geriatric unit           | 2 (6%)   |                      |
| Long-term care setting   | 3 (8%)   |                      |
| **Years of experience**  |        |                        |
| 1–2                      | 2 (6%)   |                      |
| 3–5                      | 2 (6%)   |                      |
| 6–10                     | 11 (31%) |                      |
| >10                      | 21 (58%) |                      |
| **Years in palliative care** |        |                        |
| <1                       | 3 (9%)   |                      |
| 1–2                      | 7 (20%)  |                      |
| 3–5                      | 6 (17%)  |                      |
| 5–10                     | 9 (26%)  |                      |
| >10                      | 10 (29%) |                      |
| **Need for psychological assistance from peer or specialist** | | |
| Yes                      | 25 (69%) |                      |
| No                       | 11 (31%) |                      |
| **Number of MAID**       |        |                        |
| 1–2                      | 12 (33%) |                      |
| 3–4                      | 10 (28%) |                      |
| 5–6                      | 3 (8%)   |                      |
| 7–8                      | 1 (3%)   |                      |
| 9–10                     | 1 (3%)   |                      |
| > 10                     | 9 (25%)  |                      |
In contrast, nurses who were not comfortable participating in MAID had the option of refusing by stating a conscientious objection. This objection was primarily related to religious beliefs or beliefs related to life and death. Participants, moreover, recommended not participating in MAID if they felt discomfort, stating that “I don’t think it’s the care you should give if you’re not comfortable, because it’s going to be felt by the family.” (P8)

Time of death. The third paradox centers around the time of death. The scheduled and planned moment of death caused a lot of discomfort for many nurses because it is not as natural. As participant 29 said: “I had an obsession about the time and the moment. If I was obsessed with it, maybe the patient was too! There’s something scary about it because there’s a time. All day long, everyone reminds us: ‘Don’t forget that at such
and such a time, there is the MAID. At such and such a time, yes, the doctor is going to be there. Did we remind him? At such and such a time, he must be there!” (P29)

Contrasting, participants also felt that MAID enabled people to regain control over their lives by deciding how and when they would die so as not to let the disease take everything away from them. “The lady had been given the chance to say goodbye, to decide how it would happen, where it would happen, and with her little dog by her side.” (P15) “I remember my patient said to me, ‘I’ve controlled my whole life, why can’t I control my death?’ People want to control until the end. We’re in an era where we control everything. This lady wanted to control the time and date of her death.” (P7) “A patient said to me, ‘I can’t do anything about cancer, but yes, I’m going to decide when I’m going to go.’” (P24)

**Emotional load.** The fourth paradox concerns the emotional load, dividing nurses in their perceptions of MAID. On the one hand, nurses perceived MAID as beautiful, soft and a worthy death. Some participants claiming that “It’s so beautiful. It’s wonderful to be able to help these people who are suffering so much” (P15). “It’s super sweet.” (P34) “I think it’s wonderful. They talk about dying with dignity in hospice; well, I’ve seen all kinds of different end of life scenarios and I think MAID is the most beautiful.” (P12)

On the other hand, others found it sad and difficult to overcome. “You get home and it’s harder. You think about it. It’s an emotional burden too.” (P23) Some participants even mentioned it was a traumatizing event and did not wish to repeat it. “I kind of had the image of the lady all weekend in everything I did. It’s like it’s in us. It’s like a post-traumatic shock that we experienced.” (P17). The majority of the participants (69%) asked for psychological assistance from a peer or specialist after participating in the MAID program.

**New bill.** The fifth paradox centers around the fact that the Bill is still quite new. For some, this is seen positively. It is perceived as a new challenge with the ability to do good. As one participant stated, “I actually had a personal interest. I wanted to learn about it because I had a very close family member with multiple sclerosis. It started from a personal interest in understanding the process and, in the end, I find that it allows for real, human exchanges” (P4). Another participant felt that “It’s okay to take part in MAID. It exists. We have access to that now. It comes with everything else in the evolution of care.” (P24)

For others, it is regarded as unknown and stressful, as evidenced by the following testimonials: “I was a little anxious because I didn’t know what to expect.” (P12) “The night before I was very stressed and I didn’t sleep very well. I was not stressed about taking part in MAID, I was stressed about the procedure in general. I was thinking, ‘Oh my God, what if this doesn’t go well? What if I do something wrong?’ It was the unknown that scared me a little bit.” (P37)

**Relationship.** The sixth paradox stems from the nurse’s relationship with the patient. Some nurses find that having a close relationship with the patient makes the experience more rewarding, as evidenced by the following testimonials: “The beauty for me is really in the approach, in being there for the person and their family. This is an aspect we learn in school that I feel we leave out of our practice far too often.” (P36) “That’s what it is all about for me, to form a special bond with these patients.” (P26)

On the contrary, some nurses find that having a close relationship with the patient makes providing MAID more difficult as there is significant emotional burden and distress and, consequently, opt for a more distant relationship with the patient. One nurse reporting, “I could have gone to see her every day, to see how she was doing and get attached to her, but I think I was more effective by keeping a certain distance.” (P15)

**Communication skills.** The seventh paradox relates to communication skills. The better interpersonal skills a nurse has, the more competent they feel and the less distress they experience. The participants who felt competent with MAID stated that listening was essential: “Listening, a lot of listening and seeing how people
feel. The patient, yes, is a priority, but the family is also around and must be taken care of as well.” (P25) Additionally, gaining experience with MAID allows nurses to be more comfortable and less task-oriented: “When it’s the sixth MAID you have on a unit, it’s not the same as the first. It’s less procedural.” (P11)

Other participants expressed not knowing what to say: “I felt like I had a lack of tools. From the moment you are asked, you don’t know what to say.” (P9) “Before MAID is provided, it’s the anxiety of what the family is going through. Then, afterward, we are stuck with our dissatisfaction in knowing that maybe we could have offered more as a nurse.” (P29). For those less comfortable with communication, being focused on the task and procedure during MAID served as a coping mechanism. “I don’t know if it’s a way to protect myself psychologically, but when I’m busy with nursing tasks, I’m fine with it.” (P22)

**Healthcare setting.** Finally, the eighth paradox centers around the characteristics of the healthcare setting. When nurses participating in MAID are released, meaning they only have one patient to take care of, and when they have mentorship and team support, providing MAID is a lot easier, as evidenced by the following testimonials: “On my unit, if there is a nurse tasked with MAID, they will only have that one patient because a patient who receives MAID needs a lot of attention. You really can’t take care of other patients, that nurse is really dedicated.” (P12) “It is well done in our department. The head of our department liberates us after MAID care so we don’t have to continue to work with a head full of emotions.” (P23)

On the other hand, when they have many patients to care for, when they do not have support from their team and head nurse, and when information is not effectively communicated, MAID is stressful, as evidenced by the following testimonial: “It’s very difficult emotionally. It takes an incredible amount of self-sacrifice. Right now, most nurses do it knowing that they must go on with their day. That’s why it puts a damper on most of them.” (P35)

**Discussion**

This research is the first Quebec grounded theory study to explore the nursing experience related to their role in the care of MAID. It provides an initial depiction of the paradoxes experienced by nurses supporting clients and their families through MAID in Quebec, Canada, where the practice is still new, and informational support and clinical guidelines are hard to find or non-existent. The discussion presents the eight paradoxes that emerged from the data that demonstrated “the opposing views of the same contradiction in the structuring of meaning.”

**Confrontation about death**

The first paradox concerns death itself, which confronts nurses who are used to saving lives. This study goes in the same way as Joolaee, Ho for whom participants considered MAID as a form of care for patients and a unique learning experience that was in a different paradigm than the education they had received previously. Our participants referred to the dignity of the patient in providing this care. Kabigting explains this paradox by quoting Parse who highlights the fact that it is through paradox that “the whole truth of a phenomenon is revealed.” Therefore, dignity can only be truly known in light of a paradox, through our experiences of lack of dignity. Our participants were in favor of MAID because they have seen too many people suffer in their end of life as in the Pesut, Thorne research and they were advocates of the dignity of the person.
Choice

By studying how nurses develop their values, Sastrawan and Weller-Newton\textsuperscript{30} found three reference points: religious lens, humanity perspective, and professionalism “resulting in a unique combination of personal–professional values that comprise nurses’ value system.” Nurse’s values, and more specifically related to MAID, were explored in this study showing that our participants respect the patient’s request, choice, and the right to autonomy. Nurses’ ethical conflicts are activated when someone disagrees with treatment decisions or questions the harm/benefit ratio of MAID.\textsuperscript{31} These authors use the term “range of moral responses,” rather than conscientious objection, to reflect the uncertainty about MAID that was characteristic of nurses in their studies. As observed in our study, no participants expressed conscientious objection to MAID, but some were uncertain about their feelings about it.\textsuperscript{12} This process can lead to moral distress.\textsuperscript{6} These authors also suggest to expand nurses’ ethical approaches to conscience in care to create opportunities for nurses to inclusively discuss challenging ethical issues they encounter in practice. Failure to do so can cause stress related to issues that trouble their conscience, and to burnout.\textsuperscript{6}

Time of death

Our results corroborate those from other researchs conducted until now that indicate that nurses are glad to contribute to a dignified death, but the unnatural and the planned aspect generates stress and paradoxes.\textsuperscript{4,13,29,32} For the person requesting MAID, deciding the time of death is a way to regain control of their life.\textsuperscript{29} This information was reported as a positive aspect of MAID at the individual level in the study of Joolaee Ho\textsuperscript{11} and as a way to respect patients’ autonomy\textsuperscript{33} over the illness.\textsuperscript{33}

Emotional load

On the one hand, nurses perceived MAID as a beautiful, gentle, and dignified death, and on the other hand, others found it sad and difficult to overcome. Nurses were surprised that MAID resulted in a peaceful death\textsuperscript{29} while others even described their experience as post-traumatic shock. This is new information in the spectrum of the nurse’s emotional burden that has not been found in other studies of moral distress. Moral distress is, according to Peter and Liaschenko,\textsuperscript{34} a reaction to the constraints of a nurse’s moral identity, relationships, and responsibilities that underlie a morally uninhabitable workplace, in which incoherent understandings and unsustainable practices are present. Most studies report that healthcare professionals express moral ambiguity and distress without describing the broad spectrum of emotions.\textsuperscript{7,9,10}

New Bill

The new Bill is seen positively by participants in this study. Our results go along other studies that perceive that legislation allows patients to have a new end-of-life option that was not previously available.\textsuperscript{11} It is perceived as a new challenge with the ability to do good and a new learning opportunity for HPCP.\textsuperscript{11} With the new legislation comes the negative side of uncertainty\textsuperscript{12} as unknown\textsuperscript{13} and stressful because nobody knows what to expect because few healthcare settings have established a protocol.\textsuperscript{11}

Relationship with the person

Nurses have a unique relationship with patients because of the intense and continuing nature of their interaction and this unique relationship can be challenged in the context of MAID.\textsuperscript{14} Some nurses find that having a close relationship with the patient makes the experience more rewarding and on the contrary, some
nurses find that having a close relationship with the patient makes providing MAID more difficult as there is significant emotional burden and distress and, consequently, opt for a more distant relationship with the patient. This intimacy/distance paradox was observed by Boroujeni, Mohammadi. Although the socio-cultural context of our two researches is different, the essence is the same. The length of the care and the connection, or bond, created with the client and its family affected the nurses feelings greatly. “The more interdependent the nurse and the patient and/or the patient’s family had been, the greater the impact of the patient’s death on the nurse.” Although it is in nurses’ code of ethics, few studies have reported how the intimacy/distance paradox impacts nurses’ care and feelings.

**Communication skills**

Having excellent technical capacity with requisite communication skills was described as essential. Nurses identified empathy, listening, engaging, and being comfortable with intense emotion as key elements to effective communication with patients and families. The better interpersonal skills a nurse has, the more competent they feel and the less distress they experience. Additionally, gaining experience with MAID allows nurses to be more comfortable and less task-oriented. For those less comfortable with communication, focusing on the task and procedure during MAID served as a coping mechanism. It was also observed that nurses who practice in a more procedural, rather than an existential manner, will be less involved and experience less distress, as shown by Bellens and Debien.

**Healthcare setting**

As evidenced by Beuthin and Bruce, the role of registered nurses in MAID varied dramatically across different settings and ranged from simply being involved in the technical aspect to orchestrating most of the communication, advocacy, and relational care. Many had to be leaders and create their role to include the following: providing information about MAID to patients and families, coordinating the MAID process, preparing equipment, ensuring IV access for medication delivery, coordinating and informing healthcare professionals related to the MAID procedure, documenting the care provided, supporting patients through the entire experience, and providing post-death care.

Like in Pesut and Thorne’s study, nurses in this research were working within systems that differed greatly in their response to MAID. This patient-centered perspective meant that nurses prioritized a MAID-related request and/or provision over other duties and that when the clinical setting and leaders put favorable context like nurses participating in MAID are released from other case load and duties, meaning they only have one patient to take care of, and when they have mentorship and team support, providing MAID is a lot easier. Participants described teamwork as essential to a successful MAID process and to benefit mutual support. Multidisciplinary MAID debriefs are a vital source of education and support and unfortunately, healthcare professionals are dissatisfied with the support that their institution offers. Nurse leaders’ role in MAID is to support nurses by ensuring they have the required knowledge to manage patients requesting the service, whether or not the nurse is directly involved in the MAID process. The heterogeneity of the clinical settings and diverse Quebec regions are the main strengths of the study although the main limitation is the lack of ethnic diversity, which hinders transferability. Transferability of results is facilitated by the description of the research process, participant characteristics, and the context, as well as by the variation in sample composition when searching for theoretical saturation.
Conclusions

This grounded theory research is the first in Quebec to identify the wide range of paradoxes nurses face as they evolve to accompany clients and families seeking MAID. These are on: 1) confrontation about death, 2) choice, 3) time of death, 4) emotional load, 5) new Bill, 6) relationship with the person, 7) communication skills, and 8) healthcare setting. The shifting of views and values in this new role is presented by the contradiction of opposites. This significant contribution also adds that nurses may suffer from post-traumatic shock disorder following this care when they are not clear about their values. It also demonstrates that a lot is needed in clinical settings to support nurses in overcoming the paradox of this new and unusual caring role. Finally, it reinforces the importance for healthcare managers to release nurses participating in MAID from their daily caseload, allowing them to provide dedicated one-to-one care to best accompany patients and their families through this experience, and to provide team debriefs post-MAID although it is costly. This study paves the way for the development of supportive and educational interventions.

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