NURSING CARE IN ASSISTED DYING: PLASTICITY AND RELATIONAL COMMITMENT

ABSTRACT

Background: Spain's Euthanasia Law came into force in 2021. Nurses are involved throughout the entire process and yet the law only recognizes their role in the final administration of the drug.

Objective: To understand the practice and experience of nurses involved in the euthanasia process.

Research Design: Qualitative study with a phenomenological approach. An interpretative phenomenological analysis was conducted using ATLAS-ti.

Participants and research context: This study is part of a larger project for which the study population comprised professionals who have participated in the euthanasia process in Catalonia since the law came into force. This study is based on data collected from nurses through 6 in-depth interviews and 3 focus groups.

Ethical considerations: This study was approved by the Ethics Committee (22/094-P). All participants granted their informed consent. Interviews and focus groups were anonymized.

Findings: The results revolve around two themes: 1) Plasticity of nursing care in the face of regulatory gaps and 2) managing emotions while providing assisted dying. Nurses respond to patients and families by adapting to the demands of the process and self-managing any emotions that arise from participating in this practice. Nurses use rationalization to manage the range of emotions they experience resulting from the tension between respecting a person's autonomous decision to request euthanasia and upholding their professional duty to prevent harm. The team stands out as a crucial element in managing these emotions.

Conclusions: Spanish nurses are involved throughout the entire euthanasia process, demonstrating great plasticity of care. Euthanasia care is complex and the relational context between professionals and the patient/family and between team members is key. The law should define and envisage the role of nurses, as it does for other professions.

Keywords: assisted dying, euthanasia, nursing, phenomenology qualitative research.

INTRODUCTION

A growing number of countries are regulating euthanasia or considering adding it to their health service portfolio. Despite the unique involvement and contribution of nurses in end-of-life care [1], their participation and role in providing euthanasia are often poorly defined even in legislation [2, 3].

After the Netherlands became the first country to legalize euthanasia in 2001, others have followed suit, including Belgium (2002), Luxembourg (2008), Colombia (2015), Canada (2016), the state of Victoria (Australia) (2017), and New Zealand and Spain in 2021 [4, 5] . In other countries and some US states, medically assisted suicide is the only legal option available. It is also encompassed by Spanish legislation [6] in the Organic Law Regulating Euthanasia (LORE) [7]. Regulating and implementing this practice has been a challenge for healthcare professionals. This is especially true for nurses, who are scarcely named in the Spanish law [7] and not have clearly defined roles, despite being involved in the process [2]. This gap leaves nurses in a legal limbo. The protocols and guidelines also reflect the lack of defined roles. One recent review highlights the importance of outlining protocols, defining the distinct professional duties, and translating them into specific evidence-based guidelines [3].

Several researchers have attempted to define the duties of nurses in this process, which go beyond the direct or supervised administration of the life-ending drug [8]. Rather, their duties cover everything from guiding and supporting patients and their families to participating in care procedures [9]. Based on an analysis of scientific reports from various countries where euthanasia is legal, Bellon et al. [3] identified 15 roles and 80 tasks that nurses perform in assisted dying. They include detecting the patient's and family's need for information and directly receiving requests, participating in decision-making, identifying emotional needs, preparing informational material, administering the drug, and tending to the family’s grief.

Although the euthanasia process usually involves a multidisciplinary team, Spanish legislation focuses on the physician. It acknowledges the participation of nurses only in the final stage and in the possibility of them being on the autonomous community’s Commission of Guarantee and Evaluation (a multidisciplinary body that reviews cases before assisted dying is performed, resolves claims when requests are denied by the doctor or consultant in charge, and verifies that the service has been provided lawfully). Nurses participate at various stages and spaces and take on functions and tasks beyond those legally defined, as required by the care circumstances. Failure to recognize the profession generates tension and upset among nurses and the team, which hinders the assisted dying process [10].

This study is part of the multidisciplinary project entitled *Assisted dying in Catalonia: Experiences of the professionals involved and the foundations for a guide to good practices for the entry into force of Spain's Euthanasia Law.* Two papers already published under this project [10, 11] lay out the protocol, main challenges, and sources of upset related to the professional practice. This study focuses exclusively on nurses and aims to answer the following questions: What does the nursing practice and experience look like in the euthanasia process? Much of the research on voluntary assisted dying focuses on the role of physicians [1]. While other studies have reported on the role of nurses in euthanasia [3, 8, 9], to our knowledge, none have been conducted in Spain since the practice was legalized in March 2021.

Aims

To understand the practice and experience of nurses involved in the euthanasia process.

METHODOLOGY

Design

A qualitative study with a phenomenological approach was conducted using Interpretative Phenomenological Analysis (IPA). We used a phenomenological approach to study nurses' lived experiences of participating in euthanasia and the way things are perceived and appear to the consciousness [12]. With IPA, we could conduct a detailed and nuanced analysis of the lived experiences of a small number of participants.

Participants and research context

This study forms part of a larger project (see introduction) with a study population of professionals who have participated in the implementation of Spain's Euthanasia Law in Catalonia. In 2022, 32% of euthanasia cases in Spain were performed in Catalonia [13]. The sole exclusion criterion was suffering from significant emotional trauma that might be exacerbated by participating in the study. Purposive and theoretical sampling was used with maximum variation in sex, age, professional profile, level of care, and territory. We first performed recruitment following the aforementioned criteria by contacting the Commission of Guarantee and Evaluation of Catalonia since it has a general view of how the law is being implemented in the region. We later used snowball sampling, asking interviewees if they could refer us to any potential participants for more individual interviews and focus groups.

Data collection

In-depth individual interviews and focus groups were conducted, audio-recorded, and transcribed verbatim. The interviews were conducted in 2 phases: the first consisted of exploratory interviews with 8 participants (2 lawyers, 1 bioethics lawyer, 1 intensivist/organ donation coordinator, 1 bioethics psychologist, 1 psychologist in

palliative care, 1 nurse, and 1 social worker) to identify main themes; the second comprised in-depth interviews on the themes identified (21 professionals participated, including 6 nurses). In the third phase, 3 focus groups were held to delve deeper into important aspects that emerged during the interviews (3 nurses out of 19 professionals participated. Two of them had already participated in the interviews.) The interviews lasted between 43 and 75 minutes. The focus groups lasted 60 minutes. The interviews were conducted by MV and E M-G, experts in qualitative research. The focus groups were led by three pairs of researchers (moderator/observer), all of whom are also experts in qualitative research (A AM & M F-C; E M-G & M V; M D & L I-R).

The semi-structured interview script dealt with 5 main themes identified during the exploratory phase: 1) Connection to euthanasia; 2) Description of the processes experienced; 3) Shared expectations about the process; 4) Impact on professional and personal identity, and 5) Suggestions to improve the process. The script included open-ended questions such as "Could you tell me how you initially got involved in assisted dying procedures and the implementation of the new euthanasia law? Can you describe in detail a case you consider outstanding (due to its paradigmatic, exceptional, etc. nature)? How do you think these experiences have affected you both personally and professionally?"

For this study, we used the 6 in-depth interviews with nurses and the information from the nurses who participated in the 3 focus groups. In phenomenological studies, researchers must collect a sample small enough to adequately describe expressions of consciousness and center participants' voices [14]. On the other hand, we used nurses' participation in the focus groups to compare and improve the validity of our findings, valuing the shared expression of lived experiences that may come from group data collection [14] Moreover, the participation of nurses in a multidisciplinary group allows us to observe whether they bring up the same essential themes as they did in the individual interviews. Data sufficiency was guaranteed through the adequate selection of participants based on their relevance to the research; data triangulation (interviews and focus groups); data saturation (reached by checking the repetition of the information from the interviews and confirming it with the focus groups); and the verdict of experts on the team who determined that the data gathered were sufficient to respond to the research questions.

Ethical considerations

This study was approved by the IDIAP Jordi Gol Independent Ethics Committee, code 22/094-P. Informed consent was obtained from all participants. The interviews and focus groups were anonymized. Data confidentiality was also guaranteed.

Analysis

Standard interpretive phenomenological analysis (IPA) was performed [12] using Atlas-ti to explore in detail and understand the lived experiences of nurses who participated in euthanasia. This approach allows participants to narrate the research findings through their lived experiences. The researchers seek to give meaning to the participants' narratives of their lived experiences.

Following the steps of the IPA data analysis, we first did multiple readings and took notes. We then transformed notes into emerging themes to identify relationships and cluster themes. We moved on to the next transcript, always bearing in mind the individual nature of each case and bracketing the prior themes. We then compared and contrasted themes detected in these individual cases, looking for patterns across them. Lastly, we conducted a deeper interpretation, emphasizing the individuality of each participant in addition to the patterns of meaning that emerged across participants, and we wrote up our findings using verbatim quotes from nurses to exemplify them. The researchers (A-AM& M-FC) analyzed the interviews and focus groups independently using inductive coding. They then triangulated their respective work and agreed on the final coding (see Table 2), as described in the results section.

Rigor criteria

We adhered to the criteria of Lincoln and Guba [15] to ensure the rigor of this study. Credibility: Each participant was given the opportunity to review their interview. The analysis was performed separately by 2 researchers. Reliability: We provide a detailed description of how we collected, analyzed and interpreted data. Transferability: We also describe contextual factors and participants in detail.

Researchers' positionality

Two of the authors are references for euthanasia in primary health care and a third-level hospital. Another author was the president of the Catalan Right to Die with Dignity Association (DMD). The entire research team supports the right to die with dignity.

RESULTS

In total, 7 nurses participated (see Table 1). The main results revolve around two themes: 1) Plasticity of nursing care in the face of regulatory gaps and 2) managing emotions while providing assisted dying. Table 2 shows the distribution of the themes, subthemes and codes.

1. PLASTICITY OF NURSING CARE IN THE FACE OF REGULATORY GAPS

Nurses involved in euthanasia perform more tasks than those recognized by Spanish law. They essentially facilitate the assisted dying procedure, initiate or assist in activating the application, and care for the person and their family before, during, and after the

procedure. The term “plasticity” refers to flexibility and capacity for adaptability and hints at creativity in nursing care.

1.1 Facilitating the assisted dying procedure

Activating the assisted dying procedure is essential. In Spain, only physicians can legally do this, yet patients often communicate their wishes to their nurse. The nurse then undertakes the task of finding a physician. The law does not mention these search and coordination tasks but they are a necessary part of this health service as they guarantee the implementation of the assisted dying procedure. If nurses didn’t perform them, the process of finding a professional willing to take charge — which can sometimes be challenging — would be unnecessarily dragged out.

> *The most challenging part was like two things. Coordinating the case. Finding the agents who had to respond (…) We needed a physician to transmit everything. It’s true that there was a lot of nursing and social work involved in this case (…) but as of today, the main agent is the physician and we didn’t have one.* (EF02)

In addition to searching for physicians willing to participate in the process, nurses perform follow-up tasks until the assisted dying process is initiated. Nurses know where to find reports, gather them, read them, know the appropriate person to speak to during each step of the procedure, etc.; all of these are just some of the tasks that nurses perform and that are not included or acknowledged by the law. Occasionally, the physicians want the nurses to initiate the assisted dying procedure despite this option not being included in the law, which some nurses find controversial.

> *On top of that, we did it [the application] by hand, I printed the page… I mean, we did it by hand with the patient. I scanned it, I prepared everything on the computer, to transfer it… I mean, all the work was done, sign here [the physician], that was all I was missing, the physician’s signature (…) That was the hardest thing for me. Because I thought, all I need is the card [of the physician], I already have everything else*… (EF04)

> *Yes, I have actively participated in a case and, later, as a nurse in the support unit, initially, since the law was passed. The oncologists in my unit expected all the requests, when implementing the assisted dying procedure, they expected us to be the ones to implement it. Obviously, we said no.* (FG01)

When the nurse is part of the Commission of Guarantee and Evaluation, another important task is coordination with the center so that it can facilitate and support them in this search.

> *And coordinating it, right? Getting the center’s administration to give us this space and support us in finding a physician willing to do it.* (EF02)

Although only the physician is supposed to have access to the assisted dying computer application, sometimes the team seeks out alternative solutions such as having the nurse upload documentation, fill in data, and collaborate on and facilitate the team's work. Some nurses think it might be more convenient if they had the card. They demand more

realistic regulations that include access and a space to record data as professionals who also participate in the process. And not just for nurses but for all the other professionals who collaborate and are involved in the euthanasia process

> *It needs some change. To make it more open, and so it's not just the physicians who can work on it. It's important that (…) we can access it with our cards to enter the assisted dying procedure. A section for the nursing department, not just physicians, but a nursing section where we can explain things.* (EF04)

1.2 Caring for the patient and family after activating the assisted dying procedure

Although it is not outlined in the law, nurses care for the patient and their family throughout the entire euthanasia process, once again demonstrating the plasticity of their care practice. Basic patient care includes supporting the patient, which can be understood as being there and responding to their needs to ensure they are as calm and comfortable as possible. But for nurses, supporting patients means knowing them, their history, their reasons, understanding their suffering, and why they want euthanasia. Establishing a bond and strengthening it through personal knowledge is viewed positively in the care of the person and their family.

> *Speaking with her… (…) in the sense of saying, what does she have to request euthanasia? It helps you understand. And, for me, if it helps me understand it makes my work easier. I need to understand to do things (…) It's very important to me to understand the reason and the why…*(FG03)

> *You support the person and you go through the suffering with them, and so you also start understanding more and it was easy for me to apply it. Because in the end, what do you want? For them to be at peace.* (EF01)

Caring for the family also involves accompanying them during the process. Nurses often act as a bridge between the patient's request and the family's rejection of it. They inform families so they can understand the decision, reach agreements with them, and support them emotionally through their anticipatory grief, the administration of drugs, and afterward. It is a slow process that involves accompanying the family step by step, at each visit, to ensure the process of listening, understanding, and accepting the patient's wishes and that their family members support them until the end.

> *You spend many hours talking with the family, compromising, working through it, helping them understand that it's the patient's choice and no matter how much they're [the family] against it, no matter how angry they are, they have to respect it. It takes a long time to work with the family. A very long time.* (EF22)

1.3. Administering the drug: one of the final acts of respectful and compassionate care

Nursing care plasticity is also observed in the moment of providing euthanasia (which is where the law mentions their role) because they transform a medical act — the mere administration of a drug — into an act of respectful and compassionate care. Nurses understand that this is one of the final acts of care they will provide these people before

postmortem care begins. Nurses describe this moment as intense and extreme, during which patients "stare death in the face." Throughout the administration of the drug, they talk to them, ask if they need anything, and provide all the necessary information about the injection, about what they are going to feel. They understand that theirs are the last words those patients will hear. They also say goodbye and wish them a pleasant journey.

> *Sh*t, it's staring death in the face and saying, it's you and me now, sit down, and right then… The time has come and, because they [the patients] decided so.* (EF03)

When the situation or the patient encourages it, they engage in humorous, informal conversation.

> *Well, with [patient name] there was humor until the very last moment. I was giving it [the drug] to them and I had a resident with me, who had beautiful eyes, and he says "Look at what beautiful eyes before I die." They meant, what a lovely view.* (EF01)

In some cases, "relational care" is visible when the patients use humor to "take care" of the nurses administering the final drug to create a relaxed, normal atmosphere. They also encourage this sense of normalcy with their relatives by asking about everyday topics such as lunch.

> *The other woman too, who asked her nieces if they had taken their lunch out of the freezer. If they'd taken their lunch out, so they'd have their lunch ready and all. I mean, they're worried about others (…).* (EF01)

> *It was a woman who made things very easy, she was joking and said, "Don't mess it up now, get it right for me, eh?" I said, "No, honey. I came here specifically for this, I won't mess it up now." And I also said, "No second thoughts now, eh. I came just for this…".* (FG03)

2. MANAGING EMOTIONS WHILE PROVIDING ASSISTED DYING

2.1. Strategies for managing emotions

Nurses need to be involved from the start, to get to know the patient and understand their decision. This is essential for redirecting thoughts while administering the drug and managing emotions, consolidating new learning, and processing a new experience that goes against everything they have learned: to save lives.

> *I prepared myself by ensuring that what I was going to do was what she really wanted. And clearly understanding that gave me a lot of strength to go forward and understand that it was part of process that we had to go through. Really understanding that, deep down, is what allows me to be okay now. Because if I didn't really get that, ugh...* (EF15)

In the experience of nurses, it is essential to clearly understand the principle of patient autonomy and the meaning of a dignified death. Nurses argue that it is the patient who gets to choose what to do and what not to do. When a patient requests euthanasia, they have already thought it over thoroughly, and their final decision is that they do not want to continue living like they are.

> *This person has decided what they want to do and it's been legally approved. I mean, it's not like I, as a nurse, decide to end someone's life, but them (the patient) who has made a choice and who has the power and who has said yes. So then it's simply being on their side.* (FG03)

Despite fully understanding their role in euthanasia, nurses mention that the process shakes the foundations of their existence as a human and as a nurse. As professionals, they are used to sedation, to responding to the physical symptoms of imminent death, *not* to speeding up the process. And euthanasia does hasten death, even when desired: patients are not in that inevitable process of dying; rather they can speak, they are conscious and sometimes their suffering is not a "visible symptom".

> *When someone requests euthanasia, what comes to your mind? Someone bedridden, who can't move… This was a woman who got out of the elevator on her own, pressing the button.* (FG03)

> *These patients are alive, they speak… That shakes you up… We're not used to that (…) You're administering a drug that kills someone, and that's hard for us to manage. Because we understand sedations and everyone sees the moment for that, but this shakes you up. Because you say, in the end, life or death is in my hands.* (FG02)

The administration of the drug is a transcendental moment with a great emotional impact. It is difficult and emotionally intense, marked by the immediacy of the drug's effect. The drug is administered, the person is sedated, their eyes close, and within minutes they are gone. Although nurses understand the principle of autonomy, the meaning of a dignified death, and that they are an instrument in making the patient's wishes come true, administering the drug is still fraught with emotional ambivalence.

> *The end was difficult (…) It's the moment when you administer the drug and see the speed, that's the most impactful (…) the immediacy of the drug and… boom! They close their eyes and there is no one there (…) She [the patient] was smiling, saying goodbye and she said, "See you soon." And that was the last thing she said. I gave her the drug and she was gone.* (EF15)

> *But using a drug that directly causes someone's death has a significant impact. We're not trained for something like that.* (FG01)

Euthanasia means there is a date and a time: "You meet to die." At this point, it is vital for nurses to rationalize, to remember that, as nurses, they are helping the patient. They need to redirect thoughts from "I'm giving them a drug that will end their life" to "You are not ending their life but helping them exercise their right" to choose one type of death over another. For most nurses, it is a shocking moment when someone dies; it's not something they are used to.

> *I would imagine it, the moment of inserting the IV and administering the drug that would end their life. I had to redirect my thoughts the whole time. I told myself, "You're not ending their life, [name], you're helping with their right and the request they're making.* (EF02)

Rationalizing that final act of care is necessary, as is managing the turmoil of emotions that can arise before, during, and after administering the drug. Once the patient has died, nurses describe the end as a moment of gratitude, and peace. The family, doctors, and nurses all get emotional, hug each other, and cry. The emotions last for days after the death; the process is intense and takes time to digest.

> *It's a process that stirs up a lot, it shakes you and all your foundations. They teach you to heal, to save lives… It needs some reflection, some time to digest it.* (EF02)

2.2. The team: a crucial piece of managing emotions

The team emerges as a crucial piece in managing emotions throughout the process. Feeling supported from the start to the end of the process helps and comforts professionals. Nurses value feeling like they belong to a team and like everyone is rowing in the same direction with a single object in mind: the patient. In addition, having someone accessible and willing to listen when needed resounds in the positive aspects of the team.

> *The great thing about this team is that, when one doesn't make it, there's someone to step in. We're all in it together. The patient is not just one person's, it's all for one, and that makes us stronger. There's always a listening ear, and that's very important.* (EF15)

Having trusted and experienced professionals on the team provides peace of mind to other professionals and the families, especially when administering the drug. Some nurses also report having helped their colleagues manage doubts about how the process works and whether they are doing the right thing, and having supported and helped manage the emotions inherent to participating in euthanasia.

> *What's more, leading up to it I told him, "NAME, it's going to be okay, you'll see. It's going to be the experience of a lifetime," I told him. He (the doctor) said "Oh, I don't know, you're very…", I said "Yes, you'll see, besides, it's something that will unite us… You'll always remember that you did your first euthanasia with [name] and I'll remember it with [name]. It's going to be a great experience, you'll see."* (EF03)

Feeling supported and being able to count on other team members when administering the drug — a particularly sensitive moment — is essential. This is the case regardless of one's experience with such situations or understanding that they are exercising the person's will.

> *I was nervous while preparing it, shaking. I'm not the kind of person to get (…) I'm pretty confident with this stuff. But I was nervous and [the doctor] said "[Name], calm down." I said, "Oh, I'm nervous".* (EF03)

The hug between team members upon completing the euthanasia procedure is an act of empathy, of acknowledging the other's feelings through the projection of their own, and is comforting to the professionals.

> *We went into another room and we hugged. All three of us started crying. It's a feeling, you could call it "mixed feelings".* (FG03)

Many professionals express the need to share the experience afterward, to talk about it, explain it, and be heard. Although the support of family and friends is important, the differentiating factor is to do so with colleagues, with people who understand what you are talking about, so they feel understood by their peers, in the case of both physicians and nurses. Where and how this sharing happens are also relevant factors. Sometimes it occurs in the workplace itself; other times sometimes it needs to be done elsewhere, in a more playful, less sober space to soften the significance of the event.

> *That day I really did need to express it very well. And the truth is we arrived, and when we all analyzed it together calmly, we said it was a hard process, but at the same time, liberating for that person.* (EF22)

> *After doing the procedure, they gave me the day off and I went to my primary care center and sat down to talk to my colleagues. And they asked, "But why did you come here instead of going home" And a more senior one, [name], said: "Because she needed to talk about it with someone who understands." And I said, well yeah, I really needed to come here, talk about it, cry if I needed and…* (FG02)

DISCUSSION

This study aimed to understand the practice and experience of nurses who participated in euthanasia cases in Catalonia after Spain's Euthanasia Law came into force. Although these care activities are not included or specified in the law, nurses are present throughout the entire euthanasia process, demonstrating great plasticity of care. Furthermore, they view their participation as a major challenge, in which they must face a wide variety of emotions that they manage in different ways and in which the team plays a crucial role.

The nurses in our study performed activities similar to those reported in other studies: they received requests for euthanasia, informed the physician of the request, listened to the person, and provided or facilitated access to accurate information. Despite their involvement throughout the entire process, the Spanish law does not mention the role of nurses and instead focuses on the physician's role and tasks. The Spanish law obfuscates not just the nurses but also the various roles they take on in the process. This is the case in most countries where euthanasia is legal: the nurse's role is not specified in the legislation [3]. In Canada, however, the law states that a registered nurse may perform euthanasia under the authority of a physician. In Belgium, the law explicitly describes the role of the nurse and specifies that the physician must discuss the patient's request with the nursing team in regular contact with the patient [16]. In any case, the broad consensus is that nurses are essential in providing care in euthanasia cases [3] and that the process includes various nursing tasks related to caring for patients and family members [17, 18].

While nurses are not legally allowed to initiate the procedure, our results show that they seek alternatives where their role should be described and facilitate the bureaucratic procedure when a request is made, ensuring it gets initiated. Once again, the work of nurses is obfuscated since none of the tasks they perform – from purely administrative to care tasks and providing information – can be properly recorded without access to the assisted dying computer application. Implicit in this seemingly trivial act is a firm desire to help the person who is suffering and who has made a decision, to prevent them from waiting and suffering unnecessarily.

Basic care focuses on supporting the patient and family throughout the entire process and is understood as being present and responding to needs that may arise to enable the patient's decision. Canadian nurse practitioners worked to humanize and personalize MAID by 1) establishing the relational context, 2) participating in meticulous planning, 3) orchestrating the act of MAID, and 4) supporting [19]. Providing patient- and family-centered care requires creating a relational context that enables rapid engagement with patients and families. Creating this relational context is fundamental, regardless of the setting where the patient decides to undergo euthanasia (at home, the hospital, or a skilled nursing facility). Patients usually choose their home, and sometimes the hospital. However, in the case of organ donation, it must done at the hospital. Performing euthanasia in a hospital poses challenges such as good coordination between primary and hospital care and [20], as well as establishing a good relational context between the patient and hospital professionals who may hold divergent opinions about assisted dying [21, 22]. When applicable, euthanasia with organ donation is an exponentially more complex situation in which 1) good coordination between primary and hospital care and 2) optimal logistics for the organ donation [20] must be guaranteed, as well as humanization and personalization of care. In Spain, as in other countries, organ donation is allowed after assisted dying. In these cases, euthanasia is generally performed in the operating room. Here, the challenge is to maintain humanization as best as possible. Based on the experience of some of the research team members, we know that personalization is maintained but it is very challenging to maintain humanization in an operating setting.

Spanish nurses point out that "they need to know the person to understand their decision." Canadian nurse practitioners, who are legally allowed to participate throughout the entire MAID rather than just administer the drug, also sought to understand the unique reasons why individuals chose MAID [19]. The relationship between nurses and patients/families weighs heavily in assisted dying [19] given that euthanasia care is basically a relational process. Our results indicate that Spanish nurses need this relational context for two reasons: 1) to understand the patient's decision and 2) to support them until the end. We would venture to say that establishing the relational

context is elemental for any nurse/professional who participates in providing euthanasia.

As for managing emotions, in our results Spanish nurses clearly understand that it is the patient who has decided what to do and what not to do, but they express intense emotional ambivalence about euthanasia. On the one hand, participating in planning assisted dying (“meeting to die”), administering the drug (“staring death in the face”), witnessing how immediately death occurs (“I gave her the drug and she was gone”), and the death itself (“close their eyes and there is no one there”) all generate a high emotional impact (“We hugged”; “All three of us started crying"). On the other hand, they speak of the end, of the death itself, as a moment of peace and happiness. These ambivalent feelings/emotions have also been underscored in other research [23, 24]. One Belgian study points out that although the passage of time helps with the emotional experience — it has been 15 years since it was legalized there —, euthanasia remains an emotionally intense experience for the nurses involved, characterized by intense emotional ambivalence [17]. The law entered into force just 3 years ago in Spain [7], so the emotional ambivalence expressed before such a complex and recently implemented procedure may seem logical.

To manage these emotions, nurses in this study used various strategies such as rationalizing the process and reaffirming their participation based on two main arguments: 1) euthanasia dignifies the end of a person's life and 2) euthanasia guarantees/respects patients’ right to decide (autonomy). The first argument corresponds to “promoting a peaceful end of life,” one of the objectives of nursing according to Virginia Henderson [25]. However, nurses experience strong tension between respecting the autonomous decision of a person requesting euthanasia and maintaining the professional duty to avoid harm [26]. This is why they use this strategy of rationalizing and recalling these arguments when administering the drug, after the death, and when caring for the family. One narrative review points to the principle of autonomy — one of the four fundamental principles of biomedical ethics — as a basic argument in favor of euthanasia [26]. Some arguments in favor defend a person's right to die; respect for people requires respect for their autonomous decisions [26, 27]. Other discourses are based on arguments against the absolutism of autonomy, assuming that an individual's decision to request euthanasia significantly affects those around them and, as such, “cannot be a purely private decision” [27]. This is relational autonomy. Relational autonomy condemns the dominant individualistic interpretation of autonomy for omitting social connection and external forces exerted over one's autonomy [28]. The evidence points to dialogical methods as the best way to implement relational autonomy in decision-making at the end of life [29]. However, relational autonomy in end-of-life care is far from clearly conceptualized or operationalized in practice [29]. Since euthanasia is a fundamentally relational process, debating relational ethics — and the

four main elements of mutual respect, commitment, environment, and embodiment — can provide nurses with a framework to reflect on the moral complexity that accompanies euthanasia [26].

In a situation of high emotional impact such as assisted dying and a setting with limited experience since the practice was legalized, the team emerges as a fundamental aspect that influences how the professionals involved experience the process and ultimately end up feeling. Although the role of nurses on the euthanasia healthcare team may be ambiguous [3], and regardless of the degree of their participation on the team, nurses consider teamwork essential for assisted dying to be successful and to feel comfortable with the process [30]. Nurses' assessment of teamwork in voluntary assisted dying ranges from the recognition of being members of the team to the experience of emotional and practical support through conversations with colleagues. They mention "interdependence within the team for a smooth process of assisted dying" [1]. The need for mutual help and support among team members is reflected in our study as well as others [19]. Nurses value working alongside a supportive physician during an experience as emotionally complex and impactful as this. But they are also aware that in other situations they provide support to the physicians [30]. Sharing the experience is a necessity for professionals to gain proper closure after the euthanasia process [10]. However, there does not appear to be a standardized process for monitoring professionals or peer support after providing the service [1], so some professionals seek out informal avenues. Healthcare institutions (health systems) should remedy these shortcomings and be prepared to support professionals involved in experiences as complex and difficult as providing euthanasia, thus avoiding unnecessary depletion.

Limitations

Firstly, data was collected in just one autonomous community of Spain, which might limit the transferability of the results. However, it was in Catalonia (7,751,000 inhabitants, 2022) where the most euthanasia cases are performed in all of Spain (32%). Although the law does not specify who must be on the management team for euthanasia cases, in Catalonia such teams comprise a nurse and a physician. We believe that the composition of teams is very similar in other autonomous communities, which improves the transferability of our results. Secondly, we used data from a larger project aimed at answering another research question focused on nurses. However, given the scarcity of research of this nature in Spain, and specifically in nursing, the data are very useful and serve as a basis for future research. In-depth interviews and focus groups were also conducted based on a script prepared by professionals who had participated in euthanasia. Lastly, this study only includes professionals who participated in the assisted dying process. This should be addressed as a priority in future lines of research.

CONCLUSIONS

The nursing practice in euthanasia is characterized by its plasticity and relational commitment. Despite the legal gaps regarding their role, Spanish nurses have responded to patients and families by adapting to the demands of the process. Nurses engage in rationalization to manage the range of emotions that emerge from the tension between respecting a person's autonomous decision to request euthanasia and their professional duty to avoid harm. Feeling like part of the team helps them managing emotions, which is as necessary as it is complex. To meet the objective of guaranteeing quality and expert care for these patients, it must be emphasized that nurses are an essential part of the team of professionals involved in assisted dying and the main providers of care. Therefore, their role should be defined and envisaged in the law, as other professions are.

REFERENCES

[1] Sandham M, Carey M, Hedgecock E, et al. Nurses' experiences of supporting patients requesting voluntary assisted dying: A qualitative meta-synthesis. *J Adv Nurs* 2022; 78: 3101–3115.

[2] Fujioka JK, Mirza RM, McDonald PL, et al. Implementation of Medical Assistance in Dying: A Scoping Review of Health Care Providers' Perspectives. *J Pain Symptom Manage* 2018; 55: 1564-1576.e9.

[3] Bellon F, Mateos JT, Pastells-Peiró R, et al. The role of nurses in euthanasia: A scoping review. *International Journal of Nursing Studies*; 134. Epub ahead of print 1 October 2022. DOI: 10.1016/j.ijnurstu.2022.104286.

[4] Derecho a Morir Dignamente (DMD). Eutanasia y suicidio asistido en el mundo. https://derechoamorir.org/eutanasia-mundo/ (accessed 24 October 2022).

[5] World Federation of Right to Die Societies. Were is aid in dying alowed?, https://wfrtds.org/worldmap/ (accessed 24 October 2022).

[6] León-Vázquez F, Ogando Díaz B, Álvarez Montero S. Actualización en Medicina de Familia. *Eutanasia. Situación legislativa en el mundo*.

[7] Jefatura del Estado. Boletín Oficial del Estado número 72 (25 de marzo 2021). Ley Orgánica 3/2021, de 24 de marzo, de regulación de la eutanasia. *https://www.boe.es/eli/es/lo/2021/03/24/3.*

[8] De Beer T, Gastmans C, Dierckx de Casterlé B. Involvement of nurses in euthanasia: a review of the literature. *J Med Ethics* 2004; 30: 494–8.

[9] Bellens M, Debien E, Claessens F, et al. "It is still intense and not unambiguous." Nurses' experiences in the euthanasia care process 15 years after legalisation. *J Clin Nurs* 2020; 29: 492–502.

[10] Verdaguer M, Beroiz-Groh P, Busquet-Duran X, et al. La ley de eutanasia y experiencias profesionales: tensiones en la práctica clínica. *Gac Sanit*. Epub ahead of print 11 March 2024. DOI: 10.1016/J.GACETA.2024.102373.

[11] Verdaguer M, Vallès-Peris N, Busquet-Duran X, et al. Implementation of Assisted Dying in Catalonia: Impact on Professionals and Development of Good Practices. Protocol for a Qualitative Study. *https://doi.org/101177/16094069231186133*; 22. Epub ahead of print 4 July 2023. DOI: 10.1177/16094069231186133.

[12] Smith JA, Flowers P, Larkin M. *Interpretative phenomenological analysis: theory, method and research*. 2nd Edition. USA: Sage publication, https://uk.sagepub.com/en-gb/eur/interpretative-phenomenological-analysis/book250130#description (2022, accessed 5 March 2025).

[13] Ministerio de Sanidad, Gobierno de España. Informe de evaluación anual 2022 sobre la prestación de ayuda para morir. Ley Orgánica 3/2021, de 24 de marzo, de regulación de la eutanasia.

[14] Bartholomew TT, Joy EE, Kang E, et al. A choir or cacophony? Sample sizes and quality of conveying participants' voices in phenomenological research. *Methodological innovations* 2021; 14 (2). *https://doi.org/101177/20597991211040063*

[15] Lincoln YS, Guba EG. *Naturalistic Inquiry*. London: Sage, 1985.

[16] The Belgian act on euthanasia of May, 28th 2002. *Eur J Health Law* 2003; 10: 329–35.

[17] Bellens M. 'It is still intense and not unambiguous.' Nurses' experiences in the euthanasia care process 15 years after legalisation. *J Clin Nurs* 2020; 29: 492–502.
[18] Crusat-Abelló E, Fernández-Ortega P. Nurses knowledge and attitudes about euthanasia at national and international level: A review of the literature. *Enfermería Clínica (English Edition)* 2021; 31: 268–282.
[19] Pesut B, Thorne S, Schiller C, et al. Constructing Good Nursing Practice for Medical Assistance in Dying in Canada: An Interpretive Descriptive Study. *Glob Qual Nurs Res*; 7. Epub ahead of print 2020. DOI: 10.1177/2333393620938686.
[20] Masnou N, Quintanas A, Planas C, et al. La eutanasia: un estudio de metodología mixta sobre la experiencia de los referentes en Cataluña. *Gac Sanit* 2024; 38: 102435.
[21] Stergiannis P, Fanouraki-Stavrakaki E, Manthou P, et al. Investigation on the Attitudes and Perspectives of Medical and Nursing Staff About Euthanasia: Data From Four Regional Greek Hospitals. *Cureus* 2024; 16: e53990.
[22] Bloomer MJ, O'Neill K, Hewitt J, et al. 'How to navigate this new area': Intensive care clinicians' perceptions of voluntary assisted dying in the intensive care unit: A multisite exploratory study. *Aust Crit Care*; 38. Epub ahead of print 1 January 2025. DOI: 10.1016/J.AUCC.2024.05.007.
[23] Beuthin R, Bruce A, Scaia M. Medical assistance in dying (MAiD): Canadian nurses' experiences. *Nurs Forum (Auckl)* 2018; 53: 511–520.
[24] Denier Y, Dierckx de Casterlé B, De Bal N, et al. "It's intense, you know." Nurses' experiences in caring for patients requesting euthanasia. *Med Health Care Philos* 2010; 13: 41–48.
[25] Horta Reis Da Silva T. Death and its significance in Nursing Practice. *Palliative Medicine & Care International Journal* 2024; 4: 1–7.
[26] Pesut B, Greig M, Thorne S, et al. Nursing and euthanasia: A narrative review of the nursing ethics literature. *Nurs Ethics* 2020; 27: 152.
[27] Kopala B, Kennedy SL. Requests for assisted suicide: a nursing issue. *Nurs Ethics* 1998; 5: 16–26.
[28] Stoljar, Natalie, "Feminist Perspectives on Autonomy", *The Stanford Encyclopedia of Philosophy* (Summer 2024 Edition), Edward N. Zalta & Uri Nodelman (eds.) https://plato.stanford.edu/archives/sum2024/entries/feminism-autonomy/>.
[29] Gómez-Vírseda C, De Maeseneer Y, Gastmans C. Relational autonomy in end-of-life care ethics: a contextualized approach to real-life complexities. *BMC Med Ethics*; 21, 50 (2020). DOI: 10.1186/S12910-020-00495-1.
[30] Pesut B, Thorne S, Schiller CJ, et al. The rocks and hard places of MAiD: a qualitative study of nursing practice in the context of legislated assisted death. *BMC Nurs* 2020; 19: 12.

Table 1. Participants' characteristics

Characteristic	Frequency
Gender	
Female	6
Male	1
Age (in years)	
25-30	0
31-35	3
36-40	0
41-45	2
46-50	2
Field	
Hospital care	2
Primary care	4
Primary Care/Home Care Program and Support Teams	1
Participation in euthanasia processes	
Direct (provision)	11
Indirect (related)	Several

Table 2. Themes, subthemes, and codes

Themes	Subthemes	Codes
Plasticity of nursing care in the face of regulatory gaps	Facilitating the assisted dying procedure	-Activating the assisted dying procedure -Facilitating the documentation -Disagreement in the request to activate the assisted dying -Coordination with the center -Access to the computer application -The call for nursing records
	Caring for the patient and family after activating the assisted dying procedure	-Knowing the patient to understand them -Caring for the family
	Administering the drug: one of the final acts of respectful and compassionate care	-The final act of care -Humor -Relational care
Managing emotions while providing assisted dying	Strategies for managing emotions	-Understanding the choice -Recognizing patient autonomy -Suffering is not a visible symptom -Emotional ambivalence -Rationalizing -Time for post-reflection
	The team: a crucial piece of managing emotions	-Feeling like part of the team -Help managing emotions -Feeling supported -Recognizing others' feelings -Sharing about the experience