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Nurses' Values and Perspectives on Medical Aid in Dying

A Survey of Nurses in the United States

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The aim of this study was to describe the values and perspectives of nurses regarding medical aid in dying (MAiD). The values of nurses regarding this controversial topic are poorly understood. A cross-sectional electronic survey was sent to American Nurses Association nurse members; 2390 responded; 2043 complete data sets were used for analysis. Most nurses would care for a patient contemplating MAiD (86%) and less during the final act of MAiD (67%). Personally, 49% would support the concept of MAiD, and professionally as a nurse by 57%. Nurses who identified as Christian were less likely to support MAiD. Only 38% felt that patients should be required to self-administer medications; 49% felt MAiD should be allowed by advance directive. The study results provide new insight into the wide range of nurses' values and perceptions regarding MAiD. Health care policy and nursing standards need to be written to accommodate the wide variation in nurses' values.

KEY WORDS
assisted death, end of life, ethics, hospice, nursing, right to die, scope of practice, suicide, workforce

Medical aid in dying (MAiD) is defined as the highly regulated process of allowing a physician to prescribe a terminally ill, cognitively competent patient a lethal dose of medication intended to end their own life. Where it is legal, MAiD is not considered euthanasia or suicide. The patient must be competent at the time of making the decision to enact MAiD and physically able to take the medications independently. The term "assisted suicide" is no longer considered to accurately describe the process.[1]

Historically in nursing, in 1994, the American Nurses Association (ANA) published position statements on euthanasia and assisted suicide in response to burgeoning end-of-life care issues related to patient's autonomy over death, proposed legislation for assisted suicide, and national media attention given to health care professionals' participation in assisted suicide.[2] Representatives from the ANA stated that based on the social contract of trust between nurses and the public, nurses will not participate in actively taking a human life. By 2013, ANA continued this position prohibiting nurse participation in assisted suicide and euthanasia as these acts were determined to be in direct violation of the Code of Ethics for Nurses With Interpretive Statements.[3]

The data are extremely limited, with only 1 outdated empirical study available conducted in the United States that focuses on nurses' role in MAiD. The data were conducted in a single state.[4] By 2012, the term "death with dignity" had replaced physician-assisted suicide. Authors found that nurses were not adequately educated prior to the enactment of the Death With Dignity Act in Washington State. Lack of knowledge led to nurses being ill-prepared

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to deal with questions about the act posed by patients. Nurses also feared losing their jobs for engaging in discussions about death with dignity because of the perceived conflict between the legalization of Death With Dignity and their interpretation of the Code of Ethics and Interpretive Statements.[4]

By approximately 2017, the value-neutral term *medical aid in dying* (MAiD) was adopted.[5] A societal shift in perspectives of autonomy and decision-making at the end of life and an increase in MAiD legalization across the United States stimulated personal and professional tension regarding the concept of MAiD. Heightened awareness surrounding MAiD and an increasing number of nurses working in regions where MAiD was legal exposed ambiguity in the ANA guidance for nurses. The challenge was in operationalizing the term *participation*. No specifics regarding the role of the nurse were provided.[3] The Hospice and Palliative Nurses Association issued a position statement in 2017 declaring that MAiD is not within the scope of palliative care, but did endorse the nurses' role in providing information to patients when requested after assessing that all other palliative care needs were met.[6] They were not alone. Between 1974 and 2017, there were 104 declarations reported in the literature on the topics of euthanasia and MAiD with inconsistent interpretations of role definitions and a wide range of opinion and demands to professional associations and lawmakers.[7] Nurse experts within the American Academy of Nurses conducted a policy dialogue in 2016 demystifying the nurses' role to include education and supportive care with end-of-life.[8,9] In addition, concerned nurses published opinion pieces in an attempt to clarify the intention of the ANA's seminal documents and how to translate into practice.[10-12]

Thereafter, in 2019, the ANA addressed the ambiguity directly releasing a new position statement "The Nurse's Role When a Patient Requests Medical Aid in Dying," which signified a shift in language and provided clarification on participation. This position continues to prohibit nurses from administering medication intended to hasten death, consistent with the law. Currently, nurses in the United States are not legally or ethically permitted to prepare or administer the lethal medication provided in the MAiD process; however, a nurse may provide education and promote physical and emotional comfort.[13] A similar document was published acknowledging the same nurses' role in MAiD by the Oncology Nurses Association.[14]

Little is known about how nurses in the United States view MAiD. Religion is difficult to define but may be explained as organized practices and belief systems shared by a group of people. These beliefs help individuals to find meaning in life.[15,16] Internationally, it has been demonstrated that those nurses who oppose MAiD generally do so for religious reasons.[17,18] This is consistent with what has previously been found in Washington State.[4] However, US nurses have not been studied recently or nationally to evaluate whether religion is associated with values regarding MAiD. The separate concept of spirituality, a personal belief system not bound by organized religion,[19] has also not been studied.

The legal boundaries surrounding inclusion criteria for MAiD make those with predictable deterioration of cognition or physical status ineligible as the patient must be of sound mind when MAiD occurs and be able to self-ingest the medications.[1] These restrictions essentially exclude those patients with dementia or neuromuscular diseases. In Canada, where MAiD has been legal since 2016, 83% of nurses queried agreed that patients should be able to declare a request for MAiD prior to losing the ability to meet cognitive criteria.[20] Although historically studied in Washington State,[21] there are no current or national data to know whether US nurses would support expanding the boundaries of MAiD to include allowing the patient to declare the intention for MAiD by advance directive.

Further, it is unknown whether nurses support the legal and professional restrictions prohibiting them from supporting the patient with medication administration. Lastly, the ANA position statement addresses the fact that nurses may conscientiously object from caring for patients where participation violates their personal values.[13] It has been hypothesized that all nurses working in hospice in states where MAiD is legal will eventually be asked to care for a patient experiencing MAiD.[22] It is unknown what proportion of nurses would conscientiously object to caring for patients in the process of MAiD. The purpose of this study was to begin to fill these gaps in knowledge.

Aim: Identify nurses' values and perceptions regarding MAiD.

Research Questions Regarding Values

1. Do nurses support the practice of MAiD professionally?
2. Do nurses support the practice of MAiD personally?
3. Would nurses support the practice of MAiD by advance directive?
4. Do nurses support requiring the patient to self-administer medications?
5. Of those who personally support MAiD, what percent also
   a. feel that the patient should have to administer the medications themselves?
   b. feel that the patient should be able to declare MAiD in an advance directive?
6. Of those that have greater knowledge of MAiD, what percent also
   a. feel that the patient should have to administer the medications themselves?
   b. feel that the patient should be able to declare MAiD in an advance directive?

7. Does type of religion correlate with:
   a. personally support MAiD?
   b. support MAiD professionally as a nurse?
   c. would care for a patient during contemplation?
   d. would care for a patient during end-of-life care?
   e. would allow for MAiD by advance directive?
   f. would allow someone other than the patient to administer the medications?
8. Does having knowledge of MAiD, having worked in a job routinely exposed to death, religion, years of experience, or living in a state where MAiD is legal predict
   a. personal support of MAiD?
   b. professional support of MAiD?
   c. would care for the patient during contemplation phase of MAiD?
   d. would care for the patient during the end-of-life final act of MAiD?
9. Does religion, years of experience, living in a state where MAiD is legal, having worked in a job routinely exposed to death or knowledge of MAiD, or personal support for MAiD predict
   a. support changing the boundaries of the practice to allow patients to receive MAiD with help administering the medications?
   b. support changing the boundaries of the practice to allow MAiD by advance directive?

METHODS

Design

Institutional review board approval was obtained (#191046 exempt) prior to creating the survey and conducting the study. This study was a cross-sectional descriptive, correlational, predictive survey of nurse members of the ANA members.

Instrument

The 33-item Nurses' Values and Perceptions of Medical Aid in Dying survey was developed by these investigators. Content validation was conducted with both experts and end-users.[23]

Sample/Sampling Method

Inclusion criteria were being a nurse in the ANA. Because the ANA also has student members, students were excluded from participating in the study. The survey was open between September 3 and 30, 2020. A recruitment email was sent to nurse members one time with an invitation to participate in the study. The link to the survey was also available in a call for participation in the ANA newsletter. A Qualtrics survey link provided in the email brought the participant to the research consent form. Once clicking consent, the survey continued. Data were housed in the ANA Qualtrics account.

Data Analysis

Respondents with missing data were deleted. The demographic variables of gender, race, education, marital status, and religious affiliation were classified into two groups due to small sample size of each response option. Identifying with Christian versus not was set because of the large number of Christian respondents. Variables asking MAiD in knowledge, attitudes, experience, and willingness to provide care for the patients were also classified into two groups: yes and no/not sure/mixed feelings. Bivariate correlation was performed between knowledge of MAiD, religion, living where MAiD is legal, exposure to death during work, personal support of MAiD, and willingness to care for patients on MAiD. After reviewing overall association among variables, binary logistic regression analysis was conducted to evaluate the differences in nurses' values and perspectives regarding MAiD. Statistical significance was set at .05.

RESULTS

Demographics and Support of MAiD (Research Questions 1-4)

Of a total 2390 registered nurses (RNs) who responded nationwide, 2043 (85.48%) were used for this study. Most nurses were women (91.5%); mean age was 52.4 (SD, 14.07) years (range, 23-90 years), non-Hispanic White (84.3%), with a graduate degree (55.1%), married (65.4%), with average 24.3 (SD, 15.63) years (range, 1-63 years) of work experience, and Christian (51.4%) (Table 1). Of the respondents, 25.4% lived or practiced in a MAiD legalized state, 48.5% reported familiarity with the concept of MAiD, and 35.9% knew "some" or "a lot" related to the practice of MAiD. While 49.4% of nurses personally supported MAiD, 57% support MAiD in the context of their professional role as a nurse. Only 38% felt that patients should be required to self-administer medications; 49% felt MAiD should be allowed by advance directive. Most nurses (83.6%) did not have experience with direct care of MAiD patients or friends/family who had experienced MAiD. The majority of nurses (86%) would care for a patient who was contemplating MAiD and 66.6% during the final act of MAiD (Table 1).

Nurses' Perspectives Surrounding Expanding the Legal Boundaries of MAiD (Research Questions 5 and 6)

Nurses who personally support MAiD were less likely to agree that patients should be required to self-administer medications of MAiD (33.1% vs 43.1%) ($\chi^2_{(1,N\,=\,2039)} = 21.3$, $P < .001$). Nurses supporting MAiD were more likely to agree that MAiD should be allowed with advance directive in 71.3% versus 27.0% ($\chi^2_{(1,N\,=\,2039)} = 400.1$, $P < .001$). On the other hand, nurses who disclosed familiarity with the concept of MAiD (versus those not knowing about MAiD)

TABLE 1 Profile of Registered Nurses in Medial Aid in Dying Survey (N = 2043)

	Mean	SD
Demographics		
Age (23-90 y), y	52.4	(14.07)
Experience of RN (1-63 y), y	24.3	(15.63)
	n	(%)
Consent for survey participation	2374	(99.3)
Gender		
Men	169	(8.3)
Women	1870	(91.5)
Neither of these	4	(0.2)
Race		
White	1722	(84.3)
Black	123	(5.1)
Hispanic	73	(3.6)
Native American	38	(1.9)
Hawaiian Island	15	(0.7)
Asian	60	(3.0)
Others (Caribbean, Middle East)	33	(1.6)
Education (degree)		
Associate's	176	(8.6)
Bachelor's	736	(36.1)
Master's	728	(35.6)
Doctoral	398	(19.5)
Marital status		
Single	319	(15.6)
Married	1336	(65.4)
Widowed	101	(4.9)
Divorced	198	(9.7)
Domestic partner	81	(4.0)
Spiritual/religious		
Religious	362	(17.7)
Spiritual	705	(34.5)
Both	767	(37.5)
Neither	208	(10.2)
Religious affiliation		
Christianity	1050	(51.4)
Islam	6	(0.3)
Buddhism	7	(0.3)
Judaism	19	(0.9)
Neo-Paganism	3	(0.1)
Unitarian-Universalism	4	(0.2)
Other	39	(2.0)
No answer	915	(44.8)
Christian	1050	(51.4)
Catholic	351	(33.6)
Protestantism	408	(39.0)
Other type of Christianity	287	(27.4)
Nursing experience		
Specialty certification in nursing		
Yes	1026	(50.2)
No	1015	(49.7)
Currently provides direct patient care		
Yes	1142	(55.9)
No	681	(33.3)
Retired	219	(10.7)
Area (unit) of nursing experience (overlapped)		
Intensive care unit	872	(42.7)
Oncology	634	(31.0)
Hospice/palliative	890	(43.6)
Inpatient care	1703	(83.4)
Long-term care	639	(31.3)

(continues)

(continues)

TABLE 1 Profile of Registered Nurses in Medial Aid in Dying Survey (N = 2043), Continued

	Mean	SD
Public health	428	(20.9)
Home care	641	(31.4)
Regarding MAiD		
Live in state where MAiD is legal		
Yes	519	(25.4)
No	1524	(74.6)
Familiar with MAiD		
Yes	991	(48.5)
No	1052	(51.5)
Knowledge of the practice of MAiD among those who are familiar with MAiD		
A lot	157	(7.7)
Some	577	(28.2)
Little	241	(11.8)
None	16	(.8)
No response	1052	(51.5)
Personally support the concept of MAiD		
Yes	1009	(49.4)
No	327	(16.0)
Mixed feelings	672	(32.9)
Unsure	32	(1.6)
Professionally support the concept of MAiD		
Yes	1165	(57.0)
No	392	(19.2)
Mixed feelings	439	(21.5)
Unsure	40	(2.0)
The patient should be required to self-administer the medication in MAiD		
Yes	774	(37.8)
No	439	(21.5)
Mixed feelings	686	(33.6)

(continues)

TABLE 1 Profile of Registered Nurses in Medial Aid in Dying Survey (N = 2043), Continued

	Mean	SD
Unsure	132	(6.5)
No response	12	(0.6)
The patient should be allowed to request MAiD by advance directive		
Yes	997	(48.8)
No	541	(26.5)
Mixed feelings	367	(18.0)
Unsure	134	(6.5)
No response	4	(0.2)
MAiD experience		
I have cared for a patient, friend, or family member considering MAiD		
Yes	336	(16.4)
No	1698	(83.1)
No response	9	(0.4)
I have cared for a patient, friend, or family member when being evaluated by a physician for MAiD		
Yes	155	(7.6)
No	1862	(91.1)
No response	26	(1.3)
I have cared for a patient, friend, or family member when obtaining the prescription for MAiD		
Yes	55	(2.7)
No	1955	(95.7)
No response	33	(1.6)
I have cared for a patient, friend, or family member when filling the prescription for MAiD		
Yes	49	(2.4)
No	1960	(96.0)
No response	33	(1.6)
I have cared for a patient, friend, or family member when self-administered MAiD medication		
Yes	41	(2.0)

(continues)

TABLE 1 Profile of Registered Nurses in Medial Aid in Dying Survey (N = 2043), Continued

	Mean	SD
No	1971	(96.5)
No response	31	(1.5)
Willingness to provide care for MAiD patient		
As a nurse, I would care for a patient contemplating MAiD		
Yes	1756	(86.0)
Conscientiously object	104	(5.1)
No	37	(1.8)
Mixed feelings	97	(4.7)
Unsure	43	(2.1)
No response	6	(0.3)
As a nurse, I would care for a patient during the final act of MAiD		
Yes	1360	(66.6)
Conscientiously object	171	(8.4)
No	170	(8.3)
Mixed feelings	203	(9.9)
Unsure	130	(6.4)
No response	9	(0.4)

Abbreviation: MAiD, medical aid in dying.
Sum of the percentages of each category may not be 100% because of missing values.

showed no significant differences in values regarding patient self-administration of medications in MAiD or allowing MAiD by advance directive. There were no significant differences in personal support of MAiD between nurses with associate/bachelor of science in nursing versus those with graduate degrees. No difference was found between knowledge of MAiD and personal support (Table 2).

Support of MAiD and Willingness of Care by Type of Religion (Research Question 7)

Bivariate associations between religious affiliation (Christian vs non-Christian) and MAiD values are presented in the Electronic Supplement 1, http://links.lww.com/JHPN/A73. As shown in Table 2, all MAiD-related values were significantly associated with religious affiliation: nurses identifying with the Christian religion indicated significantly lower rates of support MAiD concept personally (odds ratio [OR], 0.23; 95% confidence interval [CI], 0.19-0.28) and professionally (OR, 0.26; 95% CI, 0.22-0.31) than non-Christian religious nurses ($P < .001$). Similarly, rates of willingness to care for a patient during the final act of MAiD (OR, 0.34; 95% CI, 0.28-0.41) and willingness to provide care to a patient contemplating MAiD (OR, 0.40; 95% CI, 0.30-0.52) were also higher in the group of non-Christian nurses ($P < .001$). Although it is not legal currently, Christian nurses were less likely to support the concept of MAiD by advance directive than non-Christian nurses (OR, 0.44; 95% CI, 0.37-0.52; $P < .001$).

Factors Predicting Support of MAiD, Willingness to Provide Care, and Personal Values (Research Questions 8 to 9)

Multivariate logistic regression analysis was used to identify the predictors of differences in support of the MAiD concept with years of nursing experience, knowledge of the MAiD practice, living status in legal MAiD jurisdiction, routine exposure to death, and religion (Christian vs others). More knowledge about the practice of MAiD predicted personally supporting MAiD (OR, 1.79; 95% CI, 1.47-2.19; $P < .001$) and living in MAiD legal jurisdiction (OR, 1.50; 95% CI, 1.20-1.86; $P < .001$). Contrarily, those identifying with Christian religion predicted less likely to personally support MAiD (OR, 0.25; 95% CI, 0.21-0.30; $P < .001$), as were nurses with longer years of RN experience (OR, 0.99; 95% CI, 0.99-1.00; $P < .01$). Nurses could select multiple areas of practice, yet when evaluated separately, the percent "yes" to personally supporting MAiD was similar among all areas of practice, ranging from 48% to 51%. The variable "area of practice" was clustered into those with routine exposure to death (intensive care, oncology, hospice, palliative care) versus others. Experience of death exposure in the workplace did not significantly predict nurses' personal support of MAiD. From a nurse's perspective, professional support of MAiD was predicted by the same variables as in the personally supporting MAiD; there was no difference between personal and professional support of MAiD.

Within the role of a nurse, willingness to provide care for a patient who was contemplating MAiD was more likely when the nurse had greater knowledge about MAiD (OR, 1.42; 95% CI, 1.07-1.89; $P < .05$) and less likely in the Christian group (OR, 0.43; 95% CI, 0.33-0.43; $P < .001$). Similarly, willingness to care for a patient during the final act of MAiD was also more likely in the MAiD knowledgeable group (OR, 1.31; 95% CI, 1.07-1.62; $P < .01$) and less likely in the Christian group (OR, 0.35; 95% CI, 0.29-0.43; $P < .001$). However, the length of RN experience, living in MAiD legalized jurisdictions, or routine exposure to the death experience as a nurse did not predict the willingness to care for a patient during contemplating MAiD or the final act of MAiD ($P > .05$).

TABLE 2 Nurses' Perspectives of Patient Self-administration of MAiD and Allowing MAiD by Advance Directive and Education

	Personally Support MAiD n (%)				Maid Concept Is Familiar to Me n (%)			
	Yes	No	χ^2	*P*	Yes	No	χ^2	*P*
	1008 (49.7)	1021 (50.3)			986 (48.5)	1045 (51.5)		
A patient should be required to self-administer medications in MAiD								
Yes	334 (33.1)	440 (43.1)	21.3	[a]	367 (37.2)	407 (38.9)	.64	
No or mixed/unsure	674 (66.9)	581 (56.9)			619 (62.8)	638 (61.1)		
A patient should be allowed to request MAiD by advance directive								
Yes	718 (71.3)	278 (27.0)	400.1	[a]	487 (49.2)	510 (48.6)	.09	
No or mixed/unsure	289 (28.7)	752 (73.0)			502 (50.8)	540 (51.4)		
RN's educational degree								
Associate or BSN	461 (50.6)	450 (49.4)	0.756		423 (46.4)	489 (53.6)	3.04	
Graduate	547 (48.7)	557 (51.3)			566 (50.3)	560 (49.7)		

Abbreviations: BSN, bachelor of science in nursing; MAiD, medical aid in dying; RN, registered nurse.
[a] *P* < .001.

There was no relationship between values surrounding years of experience as a nurse, religion, living in a state where MAiD is legal, religion, or routine exposure to death and whether the patient should be able to have help administering the medications in MAiD ($P > .05$). On the other hand, an opinion that MAiD should be allowed to be requested by advance directive was less likely to occur among experienced RNs (OR, 0.99; 95% CI, 0.98-1.00; $P < .01$) and the Christian group (OR, 0.75; 95% CI, 0.61-0.92; $P < .001$). Support to change the boundaries of practice to allow MAiD by advance directive was predicted by fewer years of nursing experience (OR, 1.00; 95% CI, 0.98-1.00; $P < .01$), fewer nurses living in legal MAiD jurisdiction (OR, 0.64; 95% CI, 0.51, 0.81; $P < .001$), 25% fewer in those who identified as Christian (OR, 0.75; 95% CI, 0.61, 0.92; $P < .01$), and more than 6 times in those who personally supported MAiD (OR, 6.53; 95% CI, 5.29-8.06; $P < .001$).

DISCUSSION

Nurses' Perspective on MAiD

In this study of 2043 nurses, approximately half of nurses supported the concept of MAiD. This is different than in a study of 377 nurses from Australia, where 83% agreed with MAiD.[24] The difference may be explained by difference in sample size, geography, or religious affiliation as there were fewer participants in Australia with declared religious affiliation. Direct comparison is difficult because data on religion were collected differently between the studies.

Consistent with previous research,[25] our study demonstrated that the personal (49%) and professional (57%) values related to MAiD were similar. In the future, it is recommended that the question regarding "professional support of MAiD" be deleted to decrease research burden of participants as the answers are no different from "personal support." Nurses may experience harm if their personal values and beliefs are ignored or violated when professionally involved in situations involving MAiD.[11,24,26] Our findings illustrated a wide range in personal values. Therefore, managers may expect some nurses to embrace participation in the care of these patients, whereas others will conscientiously object. Policies need to be constructed with the flexibility to honor the diversity of personal and professional values. For instance, it was surprising to find that those who were opposed to MAiD may even conscientiously object to caring for patients in the contemplation phase of MAiD. Those working in states where MAiD is legal and in areas of practice where MAiD is conducted (hospice and home care) may want to proactively assess nurses' values surrounding MAiD to anticipate staffing needs and prevent distressing situations. Given that the medication of MAiD is now legally administered by nurse practitioners in Canada, a proactive evaluation of the perspectives of nurse practitioners in the United States is warranted in the event that a practice change is considered.[27,28]

Pesut and colleagues[29] found, similar to results reported here, that most nurses sought to provide holistic care without judgment of patients requesting MAiD, regardless of their moral stance on the practice. Similarly, they found that nurses valued the ability to honor patient choices in pursuit of a good death. However, in contrast to Pesut and colleagues' results, this ability had a more significant impact on experienced nurses because of the increased exposure to suffering of patients at the end of life.[30] In our study, 66% would participate in MAiD at end of life by supporting the patient and providing emotional care, which was higher than those who supported MAiD professionally (57%), signifying that some nurses would provide this care despite their objections to the practice. The differences in outcome may be explained by either geography or religion, as explained below, and warrant further exploration.

Expanding the Legal Boundaries of MAiD

The only previous US study, performed with a sample of nurses from Washington State, revealed that 63% of nurses were in favor of MAiD, and of those, 33% were in favor of including patients who were no longer competent but had previously documented the desire to use MAiD in an advance directive.[21] In the study reported in this article, more than 71% of nurses who supported MAiD would also support MAiD by advance directive, which is not legal in the United States at this time. A change of this nature, albeit highly controversial, would allow those with diseases who have a predictable decline in cognitive function to make their wishes known prior to losing cognitive function. Similarly, 67% of nurses who supported MAiD would agree to expand the practice to allow someone to help the patient take the medications at end of life. Changing this boundary to the legal scope of MAiD practice would allow those with physical limitations such as neuromuscular degenerative diseases to be eligible for MAiD. By comparison, 83% of nurses studied in Canada would agree that a physician could administer MAiD to patients with terminal illness or those with incompetent patients with dementia.[20]

Religion

Other studies from nurses worldwide have shown a significant positive relationship between religious or ideological affiliation and attitudes toward MAiD.[17,24] Roman Catholics were more often opposed to MAiD; of those nurses who opposed the legalization of MAiD, 42% cited religious reasons.[17] The results of the study of US nurses from the state of Washington concurred with international data demonstrating that nurses opposing MAiD most often objected for religious reasons. These same nurses opposed to MAiD stated they would still give patients information when asked.[21] In Canada, nurse practitioners who declined participation in MAiD also posed religious reasons for their objection, albeit the context was different. These nurses were objecting from personally administering the medication of MAiD to a patient.[31]

In this current study, Christian religion predicted not supporting MAiD or willingness to participate in caring for patients experiencing MAiD. In contrast, those who described themselves as spiritual were more likely to support MAiD. This finding has geographic implications for areas where Christian religion is dominant in the society or the workforce. Caution is taken, however, with these results as the numbers representing each of the other religions were quite small in comparison. Larger samples in future studies may affect the results regarding religion.

Significance to Nursing

Ethical issues surrounding MAiD and nursing practice are complex. Nurses' personal beliefs and professional values may either facilitate the act of MAiD or interfere with the patient's ability to reflect on the implications of MAiD adequately. In this study, knowledge of MAiD had a clear impact on nurses' willingness to care for patients contemplating MAiD. Nurses need additional education about the legal issues relevant to MAiD and care of the family.

Significance to Nursing Education

Increased knowledge regarding MAiD increased the likelihood that a nurse agreed with the concept and would care for patients experiencing MAiD. We also found that knowledge regarding MAiD increased the likelihood that nurses would endorse the practice. The inclusion of MAiD-related content into prelicensure and postlicensure curriculum by nurse educators may impact the response of future nurses. Nursing students would benefit from a complete discussion and understanding of MAiD, beginning with nursing ethics courses and clinical nursing courses where students may be in contact with patients considering MAiD. Such discussions should be extended to graduate nursing education, where nurses may serve in leadership positions over nurses providing care to patients contemplating MAiD.

The findings of this research have implications for faith-based educational programs as the practice of MAiD may be perceived as violating the religious norms, even in states where MAiD is legal. Nurses will benefit from the opportunity to work through their personal feelings about the subject prior to being exposed in the workplace.

Significance to Health Care Policy

The study results provide new insight into the wide range of nurses' values and perceptions regarding MAiD. These perspectives may be used to inform updates to "The Nurse's Role When a Patient Requests Medical Aid in Dying."[32] In states where the legislature is considering MAiD, a thorough understanding of nurses' knowledge and perceptions of

MAiD may influence policy development, facilitate changes in clinical practice and educational requirements, and require revision of the state's nurse practice act.

Implications for Future Research, Strengths, and Limitations

Only 49 nurses in this sample had direct experience with MAiD at the end of life; replicating this study with a larger group of nurses purposefully sampled to have had MAiD experience is indicated. Future research should include a targeted approach toward sampling to include nurses with direct experience with MAiD. Expanding the sample to include other disciplines such as pharmacists, medical social workers, and physicians would also be valuable.

Qualitative studies with focused interviews of nurses working with patients contemplating or experiencing MAiD would also be valuable for deeper insights and theory development surrounding the process of MAiD. The generalizability of results is limited by a nonexperimental design. Although preliminarily validated, this was the first use of this tool in research. Repetitive administration of the survey is recommended to further validate the survey and document changes in values and perceptions over time. Strengths include the breadth of experience of the research team, the effort taken toward validation of the tool, and end-users' use in the validation process.

CONCLUSION

Nurses were divided in their values surrounding MAiD, with approximately half supporting and half not. Those who supported MAiD had more knowledge about MAiD, implying that increased education may shift values over time. Identifying with a Christian religion predicted nonsupport of MAiD and unwillingness to care for the patient during the MAiD process. Future research is needed to explore the experiences and values of a targeted group of nurses who provide care to patients experiencing MAiD. Policies need to be written with the flexibility to honor the values of both those who support MAiD and those who do not.

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