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Emotional Impact on Health Care Providers Involved in Medical Assistance in Dying (MAiD): A systematic review and qualitative meta-synthesis.

Journal:	BMJ Open
Manuscript ID	bmjopen-2021-058523
Article Type:	Original research
Date Submitted by the Author:	12-Nov-2021
Complete List of Authors:	Dholakia, Saumil; Ottawa Hospital General Campus, Department of Mental Health Bagheri, Alireza; Lakehead University, Research affiliate Center for Healthcare Ethics Simpson, Alexander; Centre for Addiction and Mental Health, Chair in Forensic Psychiatry
Keywords:	MEDICAL ETHICS, MEDICAL LAW, International health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

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Title: Emotional Impact on Health Care Providers involved in Medical Assistance in Dying (MAiD): A systematic review and qualitative meta-synthesis.

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Key words: Ethics-Medical, Health Personnel, Euthanasia, Right to Die.

Word count: 3826 (excluding title page, abstract, references, figures and tables, acknowledgement, contributory, competing interests, data-sharing and funding statements)

Objective: To determine the emotional impact on health care providers involved in Medical Assistance in Dying.

Introduction: Medical Assistance in Dying (MAiD) traverses challenging and emotionally overwhelming territories: Health Care Providers (HCPs) across jurisdictions bridge the divide between normative yet opposing values of sanctity of life and dignity in death and dying resulting in a myriad of affective responses. These range from a rewarding experience on one end to an overwhelming sense of apprehension and unpreparedness on the other.

Methods: A systematic review research methodology was adopted to review qualitative research studies from 4 databases (OVID Medline, EMBASE, CINAHL, and Scopus) and grey literature. Key author, citation, and reference searches were also undertaken. Papers were included if they presented qualitative data regarding the emotional impact on HCPs involved in MAiD. Studies were restricted to English language. Analysis was conducted using thematic meta-synthesis. Once thematic synthesis was completed, the cumulative evidence was assessed using the Confidence in the Evidence from reviews of qualitative research (CERQual) approach.

Results: The search identified 4523 papers. After applying inclusion/exclusion criteria and The Joanna Briggs Institute Critical Appraisal Tool for qualitative research, 35 papers were included in the metasynthesis. Three distinct emotional themes were identified— (1) Strong, internalized basic emotions including moral distress, (2) Role-based emotions based on individual personal/moral/professional values, and (3) Reflective emotions that point towards MAiD being a 'sense-making process'.

Key words: Ethics-Medical, Health Personnel, Euthanasia, Right to Die.

Strengths and Limitations of this study:

Strengths:

- An eligibility criteria and subsequent search strategy that focusses on emotional impact of MAiD on HCPs with qualitative research methodology.
- Use of Joanne Brigg's critical appraisal tool for assessment of risk of bias and use of the CERQual
 approach for assessing the methodological limitations, relevance, coherence and adequacy of the
 evidence after completion of meta-synthesis.

Limitations:

- Qualitative signals of absence of sub-group analysis, eligibility criteria limited to published Englishlanguage literature and fast-moving pace of research on emotional impact of MAiD on HCPs likely contributes to significant publication bias.
- Generalizability of evidence limited by presence of selection bias in included studies.

Introduction:

Medical Assistance in Dying (MAiD) poses ethically complex challenges that can be a major source of distress to Health Care Providers (HCPs) who choose to participate—especially since MAiD involves navigating conflicting personal and professional values. These values are contextual, dynamic and often not in alignment with each other; for example, duty to care and reducing suffering in case of terminal illness through MAiD is in sharp contrast with the value of preserving sanctity of human life in the dying process (1, 2). Except for Switzerland, all other countries require HCPs to be at the forefront in discussing and executing eligible requests for assisted death within their defined jurisdictions (3).

Assisted death in selected jurisdictions-overview and current status

The number of jurisdictions across the world with medically assisted death legislation continues to grow. Switzerland, Netherlands, Belgium, Luxemburg, Canada, besides jurisdictions in the USA (Oregon, Vermont, California, Washington State, Colorado, the district of Columbia, Hawaii, Maine and New Jersey) along side the State of Victoria, Tasmania and South Australia in Australia and Columbia in South America, and most recently Spain and New Zealand, have legalized medically assisted death in some form (3, 4). MAID in Canada, the State of Victoria in Australia and the Benelux countries includes both assisted suicide and euthanasia. Jurisdictions in the USA and Switzerland allow only assisted suicide.

Broadly speaking, the 'Benelux' countries (Belgium, Netherlands and Luxemburg) have less restrictive rules in place for MAiD than the American jurisdictions that permit this practice. For example, Benelux countries allow advanced directives and terminality of illness is not a requirement to be eligible for MAiD in Belgium and Netherlands. Jurisdictions in the USA, on the other end, have strict eligibility criteria that the illness must be terminal and there must be some timeline to foreseeability of natural death—commonly 6 months in most jurisdictions.

Right to bodily autonomy, voluntariness of request and terminality/irremediableness of the medical condition are the mainstay of the eligibility criteria for MAiD, with each criterion receiving variable emphasis, depending on the legislative jurisdiction. For example, "reasonable foreseeability of natural death" criterion was removed from Canada's MAiD eligibility criteria following recent changes in the legislation (5-8).

HCPs and MAiD—current knowledge and knowledge gaps.

Amongst the HCPs, the physician's role in providing MAiD is perhaps the most ambiguous. Historically, medicine as a profession is rooted in the ethical principle of 'first, do no harm' while providing care. While this is true, medical futility and the sense of powerlessness and loss of control at end-of-life are a reality in modern medical practice, which is often reflected as physician ambivalence to participate in MAiD (9-11).

While this sense of ambiguity and a morally contradictory stance distances physicians from the practice of MAiD, nurses also share the complex attitudes and polarized feelings towards MAiD (12). This complexity is often due to the dual role that nurses play in most health care systems around the world: on one end, they act as a strong advocate for patient's wishes, whereas on the other end, they only have a supportive role in medical decision-making process. A recent synthesis of qualitative studies describing registered nurses' experiences with MAiD from Belgium, the Netherlands, and Canada showed that while the nurses played a central role in providing important 'wrap-around' care for patients and family, their participation in MAiD required significant moral work (13).

A recent scoping review exploring the challenges faced by HCPs while handling MAiD requests found lack of clear guidelines/protocols, role ambiguity, difficulties in evaluating capacity/consent, conscientious objection, lack of inter-professional collaboration and difficulties in assessing nature and severity of suffering as major barriers in developing comprehensive care models for implementation of MAiD (14).

Furthermore, the scoping review also pointed out that HCPs need substantial degree of time and emotional commitment to participate in a MAiD request. A scoping review and thematic meta-synthesis of qualitative studies exploring HCPs' attitudes towards assisted death practices in Belgium, Netherlands, Israel, Australia, Germany and the USA showed that their attitudes were shaped by a deep sense of moral responsibility and contextual care-relationships (15).

This empirical evidence provides valuable insights on experiences and attitudes of HCPs towards MAiD; however, the nature and extent of emotional impact remains unexplored. Preliminary evidence suggests that the shift away from the medicine's fundamental values of cure/control of a disease process to hastening death with the aim of alleviating intolerable suffering can have significant emotional effects on participating HCPs. These can range from feeling overwhelmed with a sense of powerlessness on one end, to a rewarding and a positive experience on the other (16, 17).

Objectives: To determine the emotional impact on HCPs involved in MAiD.

Methods:

Search strategy, screening and eligibility criteria:

The inclusion and exclusion criteria were developed in line with SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) (18). We included all qualitative research studies that evaluated the emotional impact of MAiD on HCPs. In order to ensure qualitative richness of themes, we excluded all surveys, personal anecdotes, experiences without in-depth qualitative analysis, opinions, attitudes or comments published on this topic.

Relevant definitions: For the sake of this review, we define a Health Care Provider as a person "lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person" (19). This definition includes pharmacists, nurses, nurse practitioners, social

For the sake of this review, the term 'MAiD' refers to (20):

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

Eligibility criteria:

- 1) Includes worldwide published literature on the research question in English language, inclusive of all age groups; articles published up to April 30, 2021 were included.
- 2) Describes or mentions 'HCPs' and 'MAiD' as defined above
- 3) Describes or mentions the emotional impact on HCPs in terms of emotions /affective responses experienced or expressed while accessing, discussing, participating or caring for the patient who has made a valid MAiD request.

- 4) Includes all qualitative studies evaluating the emotional impact through qualitative research methodologies like grounded theory, semi-structure interviews, lived experiences, phenomenology, thematic analysis, narrative inquiry or others.
- 5) Excludes case studies, anecdotes or studies without a description or mention of a rigorous qualitative research methodology.

Search strategy:

An iteratively developed search strategy was developed and piloted with the help of 3 librarians with expertise in systematic review search strategies. Considering the inter-disciplinary nature of the objective, the search strategy was conducted on OVID Medline (to cover all the North American literature), CINAHL (to cover all the nursing literature), EMBASE (to cover all the European literature) and SCOPUS (to cover all miscellaneous literature, presentation abstracts, etc.). The search terms included three main domains—MAiD, HCPs and qualitative research methodology and their synonyms.

A combination of subject heading and key word searches were trialed to ensure a balance between sensitivity and specificity. Full search strategy on the OVID medline database as reference is available in supplementary appendix 1.

In addition to database searches, the study team conducted a grey literature search (21) which was informed by search methods outlined by Godin et al (22). The search terms included MAiD, qualitative research, HCPs, and their synonyms. Grey literature was retrieved between December 10, 2018 and March 1, 2019 and updated on August 10, 2020 and August 10, 2021 from:

(1) Databases including Google scholar, the Canadian electronic library and the Canadian Institute for Health Information and

The grey literature search strategy and results are included in supplementary appendix 1. For the purpose of feasibility and relevance, only reports from the year 2000 and beyond were retrieved. In addition, backward citation tracking was conducted by hand searching the reference lists of all included papers.

Study selection process:

All identified records were imported into the reference management software, Zotero and duplicates removed by the lead researcher (SD). 20% of the title and abstracts of peer reviewed records were independently screened by two reviewers (AS and AB) based on the eligibility criteria. Given that a substantial portion of grey literature did not include abstracts, the grey literature screening process was initiated at the full-text phase. Records were excluded if they did not follow a qualitative research methodology and were not peer reviewed. SD consulted the keywords of yielded academic records if the title and abstract lacked clarity in relation to core concepts and reviewers AB and AS independently assessed any records for which there was a discrepancy and/or uncertainty regarding their inclusion. The researchers met at the beginning, middle and end of the screening process to ensure consistency. The same inclusion and exclusion criteria, successive team meetings and approach to discrepancies was applied to second level screening of the full-texts of the academic literature, as well as the full-texts of the grey literature.

Patient and Public involvement: No patients involved.

Assessment of risk of bias:

We used the Joanna Briggs Institute Critical appraisal tool for use in systematic reviews: checklist for qualitative research to critically appraise the included full-text qualitative research studies over 10

constructs. These constructs range from congruency to philosophical construct to theoretical and cultural location of the researcher (23). The results of the assessment of risk of bias were independently reviewed by AB and AS and are presented in detail in supplementary appendix 2.

The search results and reasons for exclusion at each stage of screening were recorded and are represented in the adapted Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) flow diagram in Figure 1.

Data Analysis:

Data Extraction and Data analysis:

We adopted a Thematic Synthesis Approach to analyze and synthesize data. Thematic synthesis is an adaptation of thematic analysis and provides a set of established methods and techniques that help synthesize qualitative research outcomes, especially when there is heterogeneity in the outcome variables (24). A Thematic Synthesis Approach is especially useful in our case since it enables us to examine the meaning, significance and social constructions around the emotional experience of a healthcare provider involved in MAiD. The coded data were sent to AB and AS to cross check for any discrepancy. Subsequent thematic synthesis was done by SD, AB and AS in the following 2 stages:

Stage 1: Identifying the similarities between the codes.

All relevant qualitative data from the selected primary studies were extracted manually from the results, discussion and conclusion section of individual studies and are represented in Table 2 of supplementary appendix 2. The codes (done line-by-line to search for concepts) were grouped into descriptive themes inductively so that patterns could be identified. Each theme was entered as boxes and codes from each study illustrated in those boxes, so that constant comparison analysis process could be done (see Table 3 in supplementary appendix 3).

Stage 2: Development of analytic themes.

In this last stage, meaning of the patterns was analyzed against the research question so that a narrative component could be developed.

Once thematic synthesis was completed, each researcher independently evaluated the cumulative evidence from individual studies for methodological limitations, relevance, coherence and adequacy using the Confidence in the Evidence from reviews of qualitative research (CERQual) approach (see table 1) (25).

All researchers met during regular research-review meetings to resolve any discrepancies and achieve consensus over the assessment.

This systematic review was a part of an academic capstone project and was not registered with any international database. The review protocol is available from the research team on request.

In addition to employing the PRISMA Checklist for systematic reviews, in order to improve the reporting of our qualitative meta-synthesis, we use the Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) checklist which is accessible from supplementary appendix 4.

Results:

Characteristics of included studies:

35 qualitative research studies were included in the review. The included literature was based in 5 countries: The United States of America (7), The Netherlands (9), Canada (14), Belgium (1), Switzerland (3), and one study was an international study with participants from the United States of America and Netherlands. The data included 393 physicians, 169 nurses, 53 social workers in hospice care, 11 allied health care professionals (7 personal support workers, 1 pharmacist, 1 genetic technologist and 2 psychologists) and 8 directors of socio-medical institutions and 3 socio-cultural animators. A detailed description of the included studies is included in Table 2 of supplementary appendix 3.

Thematic synthesis:

Three overarching emotional dimensions were derived from the thematic synthesis:

<u>Dimension 1: Strong, internalized and polarized emotions (26-36)</u>: These included three subordinate categories/genres:

- Positive emotions of 'reward', 'relief', 'active openness', 'overwhelming but uplifting' feelings
 while participating in MAiD,
- Negative emotions of 'powerlessness', 'guilt', 'emotional exhaustion', 'vicarious suffering' and fear of a slippery slope and losing control, and
- Individual conscience-based emotions of 'moral shudder' on one end and feelings of 'mercy' on the other end while participating in MAiD.

This emotional dimension was strongly embedded in the cultural and political milieu and the interpersonal communication strategies used by the HCP.

Dimension 2: Reflective, discourse-based emotions (26,30,36,37-45): These included emotions of 'growing with the patient's experience', MAiD as a 'sense-making process', 'de-tabooing the philosophical meaning of death through MAiD' and various degrees of 'dynamic conflict' secondary to a reflective sense of insecurity. These emotions were descriptively laid on a platform of 'interpretative therapeutic engagement', where they seemed to aid in the larger philosophical and societal discourse around MAiD (46).

<u>Dimension 3: Emotions that resonate with professional values and/or legislative frameworks (28,30,34,47-61)</u>: These included emotions embedded in and modulated by the HCPs professional and legal milieu.

They resonated with professional values like 'competency and perfection', 'intimate care', 'colloque

singuliar' (singular language of trust and conscience in context of therapeutic relationship) and various degrees of commitment ranging from 'contractual' to 'sacrificial'.

In order to explore how HCPs represent themselves, or their emotions, to themselves and to larger health care environment, we adopted a narrative inquiry approach. This allowed us to extract how and why did the HCPs participating in MAiD experience such complex emotions. While the thematic synthesis focused on broad aspect of the 3 dimensions of emotional impact described above, the narrative inquiry approach focussed on contextual factors leading to the emotional impact. Based on the narrative inquiry approach, a narrative summary was formulated and is described below:

- 1. In jurisdictions that legislate MAiD with the central aim to alleviate intolerable suffering in context of terminally ill medical conditions (example the USA), the HCPs experience strong polarized emotions that are modulated by their individual cultural/religious background. The extent of emotional impact ranges from positive emotions of reward/relief on one end, to negative (burden, emotional exhaustion) and conscientious based moral distress on the other.
- 2. In jurisdictions that legislate MAiD with an emphasis on alleviating intolerable suffering without terminal illness being a necessary requirement (for example Benelux countries, Switzerland, Canada), the HCPs experience the emotional impact of MAiD as a 'sense-making' process—this allows them to reflect on the emotional dissonance between basic emotions and emotions that conform to legislative rules.
- 3. Values associated with the health care provider's profession (example, physician, nurse or social worker), their degree of engagement in the MAiD process, depending on their hierarchical position in the health care system and legislations of respective jurisdictions are strong influential factors that shape the emotional impact of MAiD.

Table 1: Grading of Recommendations, assessment, development and evaluation (GRADE) Confidence in the evidence of reviews of Qualitative Research (CERQual) evidence profile

in the evidence of reviews of Qualitative Research (CERQual) evidence profile								
Summary finding	Studies	Methodological	Coherence	Adequacy	Relevance	CERQual	Explanation of	
9	contributing	11				CDADE	CERQual	
10	substantially to	Limitations				GRADE	assessment	
1 1 1 2	the summary					evidence		
13	theme (studies							
14	numbered as							
15	per Table 2 in							
16 17	supplementary							
18	appendix 3)							
19	4 2 2 5 4 2 4 0	N 4:		N 4*	NI.	re d	No de la	
20HCPs	1,2,3,5,13,18,	Minor	Moderate	Minor	No or very	High	Variability in	
² 1 experienced	19,21,	methodological	concerns	concerns	minor		experiences of	
22 strong,	24,26,28.	limitations	regarding	regarding	concerns		participants	
₂₄ internalized,		concerning	coherence	adequacy	regarding		posed a	
²⁵ often polarized		location of the			relevance		challenge with	
²⁶ and deeply	oluina tha CDADE	researcher					respect to	

On applying the GRADE CERQual approach to ascertain the degree of confidence in these findings, we graded the evidence in terms of adequacy, relevance, coherence as well as methodological limitations (25).

While evidence supporting all three dimensions of emotional impact had methodological limitations, evidence for emotions shaped by professional values and corresponding legislative boundaries had significant selection bias leading to lack of generalizability. Variability in experiences of participants posed a challenge with respect to coherence, especially in studies that reflected emotional impact driven by HCPs' cultural and religious background; however, this variance enhanced the richness of the results. The evidence from studies describing the emotional impact on HCPs due to the socio-political environment in which MAiD was practiced showed good coherence, adequacy and relevance; however, it was understandably influenced by the position of the researcher. A detailed account of the summary of findings is described in Table 1.

1

57 58 59

	T			1	T	I	1.
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emotions that		culturally, And					however, this
were modulated		influence of					also added to
by the HCP's		the researcher					the richness
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_O religious		and vice versa					Hence, we
1background. 2							have graded
² 3 Level embedded :							the
4 cultural/religious							confidence in
							quality of
6 7							findings as
8							high.
9 Influenced by the	2,5,6,8,11,14,	Moderate/min	No or very	No or very	No or very	High	Paper 6 did
1socio-political	23,25, 28,30,	or	minor	minor	minor		not approach
² environment as	32, 34.	methodological	concerns	concerns	concerns		the ethics
3 well as the social		limitations	regarding	regarding	regarding		committee
5discourse on		concerning	coherence	adequacy	relevance.		and hence
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⁷ death, HCPs 8 ₉ shared emotions		theoretically/					committee
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/ ₈ compassion and							the summary
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conform to							confidence in
0 ₁ legislative rules.							the quality of
2 3 Level embedded :							the findings to
T .							be high.
4Socio-political 5							

2							
HCPs expressed	3,4,5,7,9,10,12,	Moderate	minor	No or very	No or very	Moderate	Most of the
HCPs expressed emotions aligned with their	15, <u>16</u> ,	Methodological	concerns	minor	minor		studies in this
	17,20,22,24,27,	limitations	regarding	concerns	concerns		group had
⁷ individual	29,31, 33,35.	concerning	coherence	regarding	regarding		methodologic
individual professional		location of the		adequacy	relevance		al problems of
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²¹ legislation of 22		Paper 16, one					hospital-based
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41							findings to
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43							

Discussion:

This systematic review and thematic meta-synthesis attempts to answer the question of 'what it means at an emotional level' for HCPs involved in providing MAiD.

Discourse on emotional Impact of MAiD in Benelux vs. Non-Benelux countries—key features:

The substantive and procedural requirements for MAiD across global jurisdictions rests on 3 main pillars: patients' right for self-determination and respect for bodily autonomy expressed through voluntariness of request and a valid, informed consent process, foreseeableness of natural death due to terminal medical illness and subjective nature of individual suffering (62,63). The key difference between the legislations for MAiD in Benelux countries and countries like the USA is the differential emphasis on eminent or foreseeableness of death. The MAiD legislations in Belgium, Netherlands, Switzerland, and Canada have a more permissive legal framework that allows people to access MAiD as a service to end their intolerable suffering that has no prospect of improvement but is not necessarily terminal.

On one end, attitudes of physicians towards MAiD has shown reflective trends to legislative standards; countries like Belgium and Netherlands find much stronger physician support than their USA counter parts (64). On the other end, public support towards MAiD has been reflective of the prevailing cultural and religious practices; central and eastern European countries have shown a decline in support with corresponding increase in religiosity as opposed to western European countries (65,66). The attempt by HCPs to align themselves with their own individual values, legislative standards and public perceptions while engaging in MAiD can lead to intense emotional responses, both, within their internal, personal and their external professional spaces.

An important take home message from this research is how legislations have a shaping effect on emotional responses. The HCPs who practice in the Benelux countries and Switzerland seem to experience reflective emotions over strong polarizing emotions expressed by HCPs who practice in non-Benelux countries like the USA. Canada seems to have a unique, transitional position—with the emphasis of the legislation going the Benelux countries' way, the HCPs emotional experiences show a mixture of emotions driven by their professional values as well as the ongoing societal discourse on MAiD. This observation

conforms to Michel Foucault's position on how law acts as an element in the expansion of power(s) (67); legislatures along with other platforms of knowledge expression modulate every fiber of human society. Our narrative synthesis points out that the Law that limits application of MAiD to terminally illnesses provide for a more broad range of emotional expression. Thus, legislation on MAiD across the globe provides the HCP with a locus of administrative control which then decides how the emotional discourse around MAiD is shaped; the question is—how do we want the emotional discourse around MAiD to be shaped?

Emotional discourse amongst HCPs involved in MAiD: position of the HCP and ethics of Care

The right to choose when and how to die has always been a contentious issue across various societies (68-70). Public perceptions on MAiD are shaped through societal emphasis on individual as well as contextual factors associated with assisted death—these are often linked with sense of identity, awareness of personal pain and suffering, religious beliefs regarding sanctity of human life and personal meaning of death, and loss of autonomy and dependence associated with illness-related intolerable suffering. With advancing medical technologies, the potential to prolong life has increased significantly (71,72), and the HCPs assumes a central position to shape the discourse around assisted death.

In countries where MAiD is legalized but is restricted to terminal illnesses with imminent chance of death, the position of a HCP continues to be one that of a provider of 'Care'. Here, the moral dimension of 'Care' continue to be defined as 'everything we do to maintain, continue or repair our world so that we can live in it as well as possible' (73). The Value of Care in context of health care have always been traditionally associated with attentiveness, responsibility, nurturance, compassion and meeting others' needs (74). While emotional responses to legal requests of hastening death is affected by policies, professional identity, commitment to patient autonomy, personal values and beliefs, the patient-clinician relationship and will vary on a case-by-case basis (75); this systematic review raises an important question—How does

legalizing MAiD with emphasis on alleviating intolerable suffering without the context of a terminal illness change the moral dimensions of Care?

Conclusion:

The myriad of emotions experienced by HCPs participating in MAiD are influenced by their individual socio-cultural values, professional role and position in the health care system and the legal framework under which they practice MAiD. This emotional discourse is rich and diverse; HCPs experience dimensions of strong positive/negative emotions, reflective, sense-making emotions and/or professional value driven emotions. HCPs practicing MAiD under jurisdictions that require terminal illness as an essential criterion experience more polarized, positive/negative emotion. HCPs practicing in jurisdictions that do not require this as an essential criterion but are legislated with greater emphasis on allaying intolerable suffering experience more reflective emotions driven by the larger societal discourse around MAiD.

Limitations of the review:

This review is limited by its focus of emotional impact on HCPs only and the obvious selection bias in the included studies—those who could and volunteered to express their emotions are represented in the review. The review is also limited with absence of sub-group analysis with respect to HCPs' age, years of experience and the influence of gender on the emotional discourse on MAiD. In addition, although our search strategy does include specialized bibliographic databases and an extensive grey literature search, inclusion of only English language studies likely points towards high risk of publication bias.

There are several gaps in our understanding of the emotional impact on HCPs involved in MAiD that would benefit from further research. Unbearable or intolerable suffering is the driving force for patients

requesting MAiD, and an empathetic understanding of suffering regulates the unique emotional experience of a HCP providing MAiD. An in-depth exploration of this nebulous concept of intolerable suffering in context of MAiD may help HCPs navigate their emotional experience while providing MAiD.

Ethics statement: This is a systematic review and meta-synthesis of already published and accessible research data and does not require ethics committee or Institutional board approval.

Acknowledgements: The authors acknowledge the valuable contribution of Erica Lenton, Heather Cunningham (Library services, Gerstein's library, University of Toronto) and Fiona Inglis (Library services, Center for Addiction and Mental Health, University of Toronto) for consultations and assistance with devising the search strategy.

Contributorship Statement: The authors confirm contribution to this systematic review and metasynthesis as follows:

- study conception and design: Dr. Saumil Dholakia, Dr. Alireza Bagheri, Dr. Alexander Simpson.
- development of eligibility criteria: Dr. Saumil Dholakia, Dr. Alireza Bagheri and Dr. Alexander
 Simpson.
- search strategy developed by Erica Lenton, Heather Cunningham (Library services, Gerstein's library, University of Toronto) and Fiona Inglis (Library services, Center for Addiction and Mental Health, University of Toronto) in close consultation with Dr. Saumil Dholakia and reviewed by Dr. Alireza Bagheri and Dr. Alexander Simpson.
- Study selection and data extraction process by Dr. Saumil Dholakia and independently reviewed by Dr. Alireza Bagheri and Dr. Alexander Simpson.
- Dr. Saumil Dholakia performed the assessment of risk of bias, which was independently reviewed by Dr. Alireza Bagheri and Dr. Alexander Simpson.

- Draft manuscript preparation: Dr. Saumil Dholakia with multiple reviews, feedback and edits in form as well as content by Dr. Alireza Bagheri and Dr. Alexander Simpson.
- All authors reviewed the results and approved the final version of the manuscript.

Competing interests: The authors disclose no competing interests.

Funding Acknowledgment: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Data sharing: Data set "Codes and themes-qualitative analysis_MAiD_HCP_emotional impact" submitted to DRYAD, doi:10.5061/dryad.08kprr53k

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<u>Figure 1: PRISMA flow diagram:</u> The PRIMSA diagram details our search and selection process applied during the review.

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Figure 1: PRISMA flow diagram:

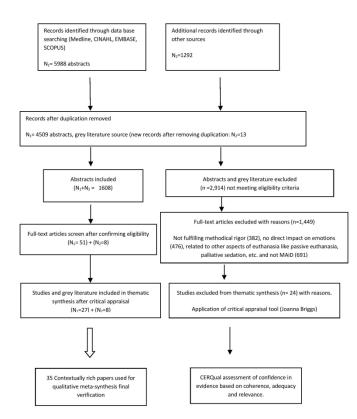


Figure 1: PRISMA flow diagram: The PRIMSA diagram details our search and selection process applied during the review.

215x279mm (300 x 300 DPI)

Supplementary appendix 1:

Database: Ovid MEDLINE(R) ALL <1946 to October 04, 2021>

Search Strategy:

- 1 euthanasia, active/ or euthanasia, active, voluntary/ or hospice care/ or suicide, assisted/ (14808)
- 2 terminally ill/ (6684)
- 3 Right to die/ (4950)
- 4 Terminal care/ (29907)
- 5 advance care planning/ or advance directives/ (9125)
- 6 ((dying or death or euthan* or suicide or terminal* ill*) adj5 (assist* or hasten*)).tw,kf. (5952)
- 7 Palliative care/ (58012)
- 8 exp Practice Patterns, Physicians'/es [Ethics] (812)
- 9 physician's role/ (30584)
- 10 Health Personnel/ (52294)
- 11 ((health care provider or clinician* or doctor* or physician* or nurse or social work* or oncologist* or palliative physician or nursing or psychiatrist* or psychologist* or psychotherapist*) adj3 (experience* or emotion* or feeling*)).tw,kf. (23976)
- 12 (Interview: or experience:).mp. or qualitative.tw. (1655368)
- health personnel/ or allied health personnel/ or anesthetists/ or caregivers/ or case managers/ or "coroners and medical examiners"/ or emergency medical dispatcher/ or epidemiologists/ or faculty, medical/ or faculty, nursing/ or health educators/ or health facility administrators/ or medical chaperones/ or medical laboratory personnel/ or medical staff/ or exp nurses/ or nursing staff/ or occupational therapists/ or personnel, hospital/ or pharmacists/ or physical therapists/ or physician executives/ or exp physicians/ (431546)
- 14 (ethnograph* or grounded theory or qualitative research or thematic analysis or semi-structured interview* or narrative inquiry or focus* group or content analysis or discourse or lived life experience*).tw,kf. (156494)
- 15 aid in dying.mp. (243)
- 16 death with dignity.mp. (607)
- 17 Bill C-14.mp. (24)
- 18 Bill C-7.mp. (2)
- 19 MAID.mp. (458)
- 20 physician assisted death.mp. (309)
- 21 physician assisted dying.mp. (142)
- 22 (assisted suicide or physician assisted suicide).tw,kf. (3163)
- 23 Qualitative Research/ (67825)
- 24 1 or 2 or 3 or 4 or 5 or 6 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 (55486)
- 25 7 or 8 or 9 or 10 or 11 or 13 (527655)
- 26 12 or 14 or 23 (1692068)
- 27 24 and 25 and 26 (5490)
- 28 limit 27 to dt=19460101-20210430 [January 1st, 1946 to April 30th, 2021] (5441)
- 29 limit 28 to english language (5073)
- 30 limit 29 to abstracts (4876)

Grey Literature databases (December 10th 2018 to March 1st, 2019, updated August 2020 and 2021)

Total # Records after de-duplication: 13. Records selected after applying critical appraisal tool 8.

Database	Search strategy	#records	# new records and
	O,	screened	records after de-
			duplication and
			applying the critical
			appraisal tool
Carala sahalan	NACH the sugar along any (A A disal	400	
Google scholar	With the exact phrase: "Medical	400	5
	assistance in dying"; "physician		
	assisted suicide"; With all the words:		
	"emotional impact on health care		
	providers involved in medical		
	assistance in dying"		
Des	Medical assistance in dying	5	0
Lebris/Canadian			
Electronic Library			
Canadian Institute	Medical assistance in dying	7	0
of Health	iviedical assistance in dying	/	U
Information (CIHI)	`/		
O A lata a salata la a sa	Additional Additional Conference of the Conferen	200	2
OAlster database	Medical Assistance in dying, Physician	206	2
(includes	assisted suicide as key word		
WordCAT)	,		
OpenGrey	Medical assistance in dying, Physician	4	0
	Assisted suicide as key word		
2.05 (2. 1.5 1 :			
BASE (Bielefeld	Subject Heading search: "Medical	670	1
Academic Search	Assistance in dying"		
Engine)			

Selected records:

Google scholar included Results:

- Beuthin R. Cultivating Compassion: The Practice Experience of a Medical Assistance in Dying Coordinator in Canada. *Qualitative Health Research*. 2018;28(11):1679-1691. doi:10.1177/1049732318788850
- 2. Bouthillier M-E, Opatrny L. A qualitative study of physicians' conscientious objections to medical aid in dying. *Palliative Medicine*. 2019;33(9):1212-1220. doi:10.1177/0269216319861921
- 3. Bruce A, Beuthin R. Medically Assisted Dying in Canada: "Beautiful Death" Is Transforming Nurses' Experiences of Suffering. *Canadian Journal of Nursing Research*. June 2019. doi:10.1177/0844562119856234
- Alison A. Townsley. Putting a Bow on Death and Dying-Health Care Professionals' Experiences with Medical Assistance in Dying (MAiD): A Foucauldian Discourse Analysis with Agambian Insights. [Practice Based Research Paper on the Internet]. York University School of Social Work; 2018. [Cited February 28,2019] Available from:
 https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/35613/Alison_Townsley_PRP_2018.pdf?sequence=1
- Gamondi C, Borasio GD, Oliver P, Preston N, Payne S. Responses to assisted suicide requests: an interview study with Swiss palliative care physicians. BMJ Support Palliat Care. 2019
 Mar;9(1):e7. doi: 10.1136/bmjspcare-2016-001291. Epub 2017 Aug 11. Available from https://pubmed.ncbi.nlm.nih.gov/28801317/

OAIster included Results:

- 1. Implementing Medical Aid-in-Dying in Vermont: a Qualitative Study. *J GEN INTERN MED* **34,** 636–641 (2019). https://doi.org/10.1007/s11606-018-4811-1
- 2. Allyson Oliphant. "If Not Me, Then Who?" The Narratives of Medical Aid in Dying (MAiD) Providers and Supporters Around Their Professional Identity and Role in MAiD [Thesis on the Internet]. MacMaster University; 2017. [Cited on February 10, 2019]. Available from http://hdl.handle.net/11375/22146

BASE included results:

1. Sheridan, Laura, "When Patients Ask to Die: The Role of Nurses in Medical Assistance in Dying" (2017). Electronic Thesis and Dissertation Repository. 5041. https://ir.lib.uwo.ca/etd/5041

						BMJ Open					.1136/bmjopen-2021-058523 on		
											-058523 on		
Study (location, number and category of participants	JBI Quest ionna ire	1.	2.	3.	4.	5.	6.	7.	8.	9.	# July 2022, Down loaded from http://bmj.ppen.brnj.com/ on Abril	Appraisal	R for exclusion
1.Voorhees et al and Netherlands physicians 23	l., US s,	Υ	Y	Y	Y	Y	Y	N	Υ	Y	2>Down	Include	
2.Van Marwjik e Netherlands 22 Primary care ph	ı	Υ	Y	Y	Y	Y	N	N	Υ	Unc	loaded	Include	
3. Denier Yyonn 2010. Belgium N n=18	Nurses-	Υ	Y	Y	Y	Y	N	N	Y	Y	f∞m ht	include	
4. Elizabeth Nor al. 2012 USA-social work		Υ	Y	Y	Y	Y	N	N	Y	Unc	t <u>p://bmj</u>	include	
5. JJ Georges et 2008. Netherlan GPs		Y	Y	Y	Y	Y	N	N	Y	Unc	open.bm	Include	
6. Snijdewind et 2014 (Netherlands, 28 physicians)		Y	Y	Y	Y	Y	N	N	Y	N	j.¢am/ on A	include	
7. Katja ten Cate 2017-33 physicia netherlands		Υ	Y	Y	Y	Y	N	N	Y	Y	27,	Include	
8. Donald G Van al., 2012. Nethe 15 physicians		Υ	Y	Y	Y	Y	N	N	Y	N	2024 by	include	
9.Veronica Lorra Fausto Melchor, USA Hospice soo worker 8	, 2018.	Υ	Y	Y	Y	Y	Y	Y	Y	Υ	guest. Protected	include	
10. Pamela Mille al., 2008 Oregor		Υ	Υ	Υ	Υ	Υ	N	N	Υ	Unc	gtec	Include	
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12.michael Young et al., 2008 Canada nurses-22	Y	N	Y	Υ	Y	N	N	Y	Υ	.2021-058523 on 15 July	exclude	Study done at a time assisted death not legal, so does not meet inclusion criteria.
13. Rosanne Beuthin et al., 2018 Canada nurses-17	Y	Y	Y	Υ	Y	N	N	Y	Y	ly 2022	include	
14.eva Bolt et al., 2017 Netherlands paediatrician-8	Υ	Y	YOA	Y	Y	N	N	Y	NR	2. Downlo	Include	
15. Dolores Angela Castelli Dransart et al., 2017 Switzerland-20 nurse, 1 physician, 8 directors, 3 socio- cultural animators.	Υ	Y	Y	Deer	Y	N	N	Y	Y	.>Downloaded from http://bmjopsn.bmj.c	Include	
16. Marianne Dees et al., 2012 Netherlands-phy-28	Y	Y	Y	Y	Y	N	N	Y	Υ	;⁄/bmjop	include	
17. Theresa Harvath et al., 2006. USA hospice social workers-20	Y	Y	Y	Y	Y	N	N	Y	Υ	esn.bmj.c	include	
18. Ina Otte et al., 2017. Switzerland GP's-20	Y	Y	Υ	Y	Y	N	N	Υ	Υ	gm/ on Apşil	include	
19. Ada van de Scheur, Arie van der Arend, 1998 Netherlands Nurse-20	Y	Y	Υ	Y	Y	N	N	Y	Unc	27	include	
20.Belanger E.et al., 2019 Canada-palliative care physicians-18	Y	Y	Υ	Υ	Y	N	N	Υ	Υ	, 20 2 4 by gu	include	
21. Jessica Shaw et al., 2018. canada phy-8	Y	Y	N	Υ	Υ	N	N	Υ	Unc	eşt.	Include	
22. Judith Schwartz 2004. USA nurses-10	Υ	Y	Υ	Υ	Υ	N	N	Υ	Υ	Protected by	include	

23. Dobscha SJ et al., 2004. USA phy-35	Y	N	Y	Y	Y	N	N	Υ	Υ	-2021-058523	Exclude	No theme of emotional
24. Galusko et al., 2015, Germany 19 specialized palliative	Y	Y	Y	Y	Y	N	N	Y	Y	8523 on 15	Exclude	impact. Desire to hasten death definition
care physicians. 25. Susanne Brauer et al., 2015. Switzerland,	Y	Y	Y	Y	Y	N	N	N	N	⊈nclear ✓	Exclude	ambiguous Opinions known, but
12 physicians										2022.		no emotiona ipact theme
26. Linda (b) Oregon phy-35	N	Y	YOA	Y	Y	N	N	Y	Y	Downlo	Exclude	Physician opinion of patients req
27. Deborah-texas nurses-36	N	Y	N	Deer	Υ	N	N	Y	Unc	Downloaded from http	Exclude	No of the nurses participated in assisted suicide in any way
28. D Van Rooyan, Dutch nurses-7	N	N	Y	Υ	Yel	N	N	Y	N	∷⁄/bmjopen.k	Exclude	More with withdrawal of treatment does not meet criteria
29. vanderspank canada Nurses	N	N	Y	Υ	Y	N	N	Y	Y	ໝj.com/ on April	Exclude	SR on nurses experience with withdrawal of treatment- does not meet criteria
30. Joanne Wolfe USA 324 Oncologists	Y	N	N	Y	Y	N	N	N	Υ	27, 2024 by guest. Protected	Exclude	Telephone based survey interviews.
31. Booij et al., 2012 Netherlands 15 physicians	Y	N	Y	Y	Y	N	N	N	Y	rotected by	Exclude	No particular description of emotional impact
32. Denier et al., 2010 Belgium 18 Nurses	Υ	N	Υ	Υ	Υ	N	N	Υ	Y	усору	Exclude	More about

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										.1136/bmjopen-20 <mark>2</mark> 1-058523 on 15		on and communicati on attitudes and not about emotional impact
33. Bernadette Dierckx 2010 Belgium 18 nurses	Y	N	Y	Y	Y	N	N	Y	Y	.2202 Aim	Exclude	Stage of carrying out a request, no emotional impact described.
34. sercu et al. 2012	Υ	N	Y		Y	N	N	Y	Y	Downloaded from	Exclude	Palliative sedation and euthanasia- boundry lines unclear in the paper.
35. Volker 2007 USA. 19 oncology advanced practice nurses	Y	N	Y	Y	N	N	N	Υ	Υ	pttp://bmjopen.br	Exclude	No engagement in assisted death as illegal in the place of practice.
36. Thulesius et al. 2013 Sweden	Y	N	Y	Y	N	N	Y	N	Y	http://bmjopen.bmj.com/ on April 27, 2024	Exclude	No engagement, assisted death is illegal in Sweden. Majority data from HCPs in Sweden.
37. Marike E. de Boer 2011 Netherlands.	Y	N	Y	Υ	N	N	Y	Y	Y	⊉ by guest.	Exclude	Experiences, but no emotional impact
38. Neel De Bal 2006 Belgium	Y	N	Y	Y	N	N	Υ	Y	Y	st. Protected by dop	Exclude	Conducted at a time when Euthanasia was still illegal, hence does not meet

										20		
										-2021-05852		inclusion
39. Bernadette 2006	Υ	N	Y	Υ	N	N	Υ	Υ	Υ	<u> </u>	Exclude	criteria. As above.
Belgium										3523		
40. Veerport et al 2006 USA	Y	N	Y	Υ	N	N	Υ	Υ	Υ	3,0n	Exclude	As above
41. Wright et al., 2017 Canada	Y	N	Y	Υ	N	N	Y	Y	Y	15 July 2022	Exclude	Data collected in 2012-2013 when MAiD illegal.
42. Curry et al., 2000 USA, Connecticut 909 physicians.	Y	N	O	Y	N	N	N	N	Y		Exclude	Assisted suicide illegal, Plus experiences and no emotional impact
43. Susan Price 2001 USA, 11 nurses and 10 physicians. North Carolina	Y	N	Y	Y	rel,	N	Y	Y	Y	.Downloaded fro <mark>ந http://bmjopen.bmj.com/ on A</mark>	Exclude	Assisted suicide illegal in North Carolina, hence does not meet inclusion criteria
44. France Norwood 2009 Netherlands	Y	N	Y	Y	N	N	Y	Υ	Y	mj⊾com/ on A∤	Exclude	No emotional impact. Evaluates absence of abuse
45. Smith et al., 2013 USA, South Mississippi	Y	N	Y	Y	N	N	Y		Y	ழ்பி 27, 2024 by guest	Exclude	Assisted death illegal in mississippi and hence does not meet inclusion criteria
46. Beuthin et al., 2020 Canada 8 physicians.	Y	Y	Y	Υ	N	N	Υ	Υ	Υ		include	
47. Khosnood et al., 2018 19 physicians, Canada	Y	Y	Y	Υ	N	N	Υ	Υ	Y	Protected by c	Include	

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Database	Search strategy	#records	# new records seected after applying
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 Description of the practice of a Medical Assistance in Dying Coordinator in Canada. Qualitative Health Research.
- le scholar included Results:

 1. Beuthin R. Cultivating Compassion: The Practice Experience of a Medical Assistance in Dying Coordinator in Canada. *Qualitative results*.

 2018;28(11):1679-1691. doi:10.1177/1049732318788850

 2. Bouthillier M-E, Opatrny L. A qualitative study of physicians' conscientious objections to medical aid in dying. *Palliative Medicine*. 2019;33(9):1212-1270. doi:10.1177/0269216319861921

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 3. Bruce A, Beuthin R. Medically Assisted Dying in Canada: "Beautiful Death" Is Transforming Nurses' Experiences of Suffering. Canadian Journal of Nursing Research. June 2019. doi: 10.1177/0844562119856234
- 4. Alison A. Townsley. Putting a Bow on Death and Dying-Health Care Professionals' Experiences with Medical Assistance in (MAiD): A Foucauldian Discourse Analysis with Agambian Insights. [Practice Based Research Paper on the Internet]. York University School of Social Work; 2018. [Cited February 28,2019] Available from: https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/35613/Alison Townsley PRP 2018.pdf?sequence=1
- 5. Gamondi C, Borasio GD, Oliver P, Preston N, Payne S. Responses to assisted suicide requests: an interview study with Swiss palliative care physicians. BMJ Support Palliat Care. 2019 Mar;9(1):e7. doi: 10.1136/bmjspcare-2016-001291. Epub 2017 Aug 11. Available from https://pubmed.ncbi.nlm.nih.gov/28801317/

OAIster included Results:

- 1. Implementing Medical Aid-in-Dying in Vermont: a Qualitative Study. J GEN INTERN MED 34, 636–641 (2019). https://doi.org/10.1007/s11606-018-4811-1
- 2. Allyson Oliphant. "If Not Me, Then Who?" The Narratives of Medical Aid in Dying (MAiD) Providers and Supporters Around Their Professional Identity and Role in MAiD [Thesis on the Internet]. MacMaster University; 2017. [Cited on February 10, 2019]. Available from http://hdl.handle.net/11375/22146

BASE included results:

1. Sheridan, Laura, "When Patients Ask to Die: The Role of Nurses in Medical Assistance in Dying" (2017). Electronic Thesis and Dissertation Repository. 5041. https://ir.lib.uwo.ca/etd/5041 ril 27, 2024 by guest. Protected by copyright.

Table 2: Description of articles included in qualitative meta-synthesis:

Country of origin of participants Discussing and primary care, may be easily and country of origin of participants Physician assisted dying discussions.	4							
country of origin of participants of participa	5	Study	Number and	Description of	Extent of	Method of	Method of	Emotional theme
MaiD process MaiD process MaiD process MaiD process			country of origin	participants	engagement in the	interview	analysis	explored
1.			of participants		MAiD process			
Voorhees From USA (5 from Oregon), and 18 From Netherlands Variable range of PCPs participated in the Support and Consultation Regarding Euthanasia (SCRN) San Denier San D								
12 et al., 2014 from Netherlands from Net	10	1.	I	@40% from	Physician assisted	40-70 min,	Modified 5-step	Themes related to
13 2014 from Netherlands years structured interviews from Netherlands years structured interviews sense of growth along with themes emotional labor and conscientious-based emotions. 2		Voorhees		primary care,	dying discussions.	one-one		reflective
14 15 16 16 16 16 16 16 16 16 16 16 16 16 16		et al.,	Oregon), and 18	majority >40		semi	familiarization,	emotions and
Interviews Interviews Charting, mapping and and conscientious based emotions. 2.		2014	from Netherlands	years		structured	identifying a	sense of growth
Charting, mapping and and conscientious interpretation. Content analysis within a coding frame of three age and gender. Content analysis within a coding frame of three emotions and sense of growth along with themes emotions.						interviews	theme, indexing,	along with themes
17 18 22 primary care Variable range of physicians, experience, 5 performing assisted death provinces of managing the event) and (3) role of the physician.							charting, mapping	emotional labor
22 many care physicians, Netherlands et al., 2007 2 primary care physicians, Netherlands et al., 2007 2 primary care physicians, Netherlands et al., 2007 3 provinces of et al., 2010 3 provinces of flanders, Belgium en of geriatric, and consultation flands (SCRN) 2 primary care physicians, Netherlands experience, 5 performing assisted death performing as							and	and conscientious-
2.							interpretation.	based emotions.
Marwijk et PCPs participated in the Support and Consultation Regarding Euthanasia (SCRN)								
PCPs participated in the Support and Consultation Regarding Euthanasia (SCRN) SCRN) Registered nurses of et al., 2010 PCPs participated in the Support and Consultation Regarding Euthanasia (SCRN) Registered nurses of et al., provinces of et al., provinces of the physician. PCPs participated in the Support and Consultation Regarding Euthanasia (SCRN) PCPs participated in the Support and Consultation Regarding emotional emotional emotional emotional along with themes emotions and sense of growth along with themes of (1) emotional along with themes of sense of growth along with themes of (1) emotions and sense of growth along with themes of (1) emotions and sense of growth along with themes of themes of (1) emotions and sense of growth along with themes of themes of (1) emotions and sense of growth along with themes of themes of (1) emotions and sense of growth along with themes of themes of (1) emotions and sense of growth along with themes of (1) emotions and sense of growth along with themes of (1) emotions along emotional along with themes of (1) emotions along emotional along with themes of (1) emotional emotional emotional along with themes of (1) emotional emotional emotional emotional along with themes of (1) emotional emotional emotional along with themes of (1) emotional emotio			-	_	_		=	
in the Support and Consultation Regarding Euthanasia (SCRN) Registered nurses of et al., 2010 Flanders, Belgium Registered nurses (1) sense of growth along with themes emotional gender. Registered nurses of the physician. Registered nurses of et al., 2010 Flanders, Belgium Retricinated in the Support and Consultation Regarding Euthanasia (SCRN) Registered nurses of the physician. Discussing and performing assisted death along with themes emotions and experience; (2) coping (dealing with themes emotions. managing the event) and (3) role of the physician. Themes related to role-assigned emotions along with themes of the physician interviews, along with themes of the physician interviews, think back the pack with themes of the performing assisted death Themes of the physician interviews, think back think back themes of the performing assisted with themes of the physician interviews, think back think back the performance of the physician interviews, think back think back the performance of the physician interviews, the performance of the physician interviews interviews.			_ · ·		_		J	
24 dl.,2007 25 and Consultation Regarding Euthanasia (SCRN) 27 (SCRN) 28 (SCRN) 29 30 31 32 3. Denier 36 et al., provinces of et al., provinces of et al., 2010 Flanders, Belgium 29 In the Support and Consultation Regarding Euthanasia (SCRN) 20 Euthanasia (SCRN) 21 Euthanasia (SCRN) 22 Euthanasia (SCRN) 23 Denier 34 2010 Flanders, Belgium 24 and Consultation Regarding Euthanasia (SCRN) 25 Euthanasia (SCRN) 26 event) and (3) role of the physician. 27 Discussing and depth design 28 emotional along with themes emotions. 28 emotional and conscientious- based emotions. 28 emotional along with themes emotions. Themes related to role-assigned emotions along with themes of			Netherlands		death	_		
Regarding Euthanasia (SCRN) Registered nurses Physician. Registered nurses (13 women, 5 provinces of Planders, Belgium Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Regarding Euthanasia (SCRN) Registered nurses (13 women, 5 performing assisted death Registered nurses (Bruchanasia (SCRN) Registered nurses (Bruchanasia (Bruchanas		al.,2007				· ·		=
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28 (SCRN) (SCRN) with and managing the event) and (3) role of the physician. 31 32 33 34						gender.	•	
managing the event) and (3) role of the physician. 31 32 33 34 35 3. Denier 18 nurses from 5 related to performing assisted death interviews, provinces of feet al., and provinces of set al., and prov								
30 and a second				(SCRN)				based emotions.
31 Sevent) and (3) role of the physician. 32 Sevent) and (3) role of the physician. 33 Sevent 18 nurses from 5 Registered nurses Discussing and performing assisted depth design role-assigned emotions along event) and (3) role of the physician. 34 Sevent and (3) role of the physician. 35 Sevent and (3) role of the physician. 36 et al., provinces of (13 women, 5 performing assisted depth interviews, emotions along event) and (3) role of the physician.								
physician. 32 33 34 35 3. Denier 36 et al., provinces of 2010 Flanders, Belgium men) of geriatric, and 38 38 39 30 30 31 34 31 32 31 32 32 33 33 34 35 30 31 31 32 32 33 34 35 31 32 32 33 34 35 32 32 33 34 35 38 38 38 38 38 38 38 38 38 38 38 38 38								
34 35 3. Denier 18 nurses from 5 Registered nurses Discussing and 1.5h in- Grounded theory Themes related to performing assisted depth design role-assigned emotions along death interviews, with themes of with themes of men or colory internal men or								
35 3. Denier 18 nurses from 5 Registered nurses Discussing and et al., provinces of Flanders, Belgium men) of geriatric, oncology internal provinces of think back of think back on the provinces of the provinces						Y ,	physician.	
37 2010 Flanders, Belgium men) of geriatric, death interviews, emotions along with themes of		3. Denier	18 nurses from 5	Registered nurses	Discussing and	1.5h in-	Grounded theory	Themes related to
38 oncology internal think back with themes of		et al.,	provinces of	(13 women, 5	performing assisted	depth	design	role-assigned
		2010	Flanders, Belgium	men) of geriatric,	death	interviews,		emotions along
20	38 39			oncology, internal		think back	4	with themes of
medicine, and to a emotional labor.				medicine, and		to a		emotional labor.
palliative care. All specific,				palliative care. All		specific,		
42 had positive recent case				had positive		recent case		
attitude, except of caring for	43			attitude, except		of caring for		
one who was a patient				one who was		a patient		
conscientiously requesting				conscientiously		requesting		
46 objecting.				objecting.		euthanasia		
48 and to						and to		
49 recount the						recount the		
50 way in						way in		
51 which they						which they		
52 experience						experience		
53 d this						d this		
55			•	•	•			

3 4 5					process as a whole		
6 7 8 9 10 11 12 13	4. Norton et al., 2012	9 social worker hospice practitioners in Oregon, USA.	Represent several health systems in Oregon	involved in discussions with family of those participating in assisted death ('add on') and 'context interpreters'	Focused group	Thematic analysis	Themes related to role-assigned emotions (for example advocacy and feeling of being a 'gate-keeper')
15 16 17 18 19 20 21 22	5. Georges et al, 2008	30 general physicians in Netherlands.	71% male, 29% female, 46% had restrictive and 14% had permissive attitudes towards euthanasia.	89% had received explicit requests and were involved in discussions, and 64% had participated in EAS	In-depth interviews	Constant comparative method of analysis	Emotional theme of reflective emotions (example, feeling of sense of growth)
24 25 26 27 28 29 30 31 32 33 34 35 36 37	6.Snijde wind et al., 2014	28 General Physicians in Netherlands	Physicians who had received a request from someone suffering from dementia or a psychiatric illness, or who was "tired of living," as these are cases that are often regarded as complex.	Involved in decision making of assisted death for respective patients.	In-depth interviews	Open coding and inductive analysis	Emotional theme of reflective emotions (example, reflecting on individual meaning of suffering)
40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 55	7. Katja ten Cate et al., 2017	15 General Practitioners in Netherlands	8 GPs with liberal attitude, 5 with conservative attitude and 2 with neutral attitude towards assisted death. Mean age 51.2 years.	1-2/>2 assisted deaths performed.	In-depth interviews	several phases of coding (axial and selective coding); codes were refined, sub codes and overarching codes were assigned and relationships between codes were explored. Interviews were also analysed as a whole, to look for	Emotional theme of reflective emotions (example, reflecting on feelings of what is happening during the last stage of life)

3 4 5 6						patterns and inconsistencies in reasoning.	
7 8 9 10 11 12 13 14 15 16 17 18 19 20	8. Donald G Van Tol et al., 2012	15 physicians in Netherlands	Fourteen of them were general practitioners. Seven of them were also active as a consulting doctor, one was a nursing home doctor who was also working as a consulting doctor.	Physicians were consulting doctors of Euthanasia and have successfully completed a formal training program.	In-depth semi- structured interviews	Grounded theory approach by Glaser and Strauss and Glaser	Emotional theme of reflective emotions (example 'imagine self', cognitive reflection)
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38	9. Melchor Lorraine 2018	8 social workers in California, USA.	75% female with 60% having an average 5 years of experience in hospice care.	assist patients and family with the death and dying process, may connect them to additional community resources, and offer counseling to improve and maintain emotional, psychological, social, and physical well-being	In-depth semi- structured interviews	Open coding, axial coding, selective coding, and conditional matrix stages of data analysis.	Emotional theme of role-assigned emotions (example, feeling of pro-self-determination and advocacy).
39 40 41 42 43 44 45 46	10. Miller et al., 2002	8 social workers in Oregon, USA	2 men, 6 women, age range of 27- 64, 3-22 years' experience in hospice care	Active engagement in end-of-life care and assisted suicide discussions.	interviews	Ethnographic study and constant comparative method of analysis	Emotional theme of role-assigned emotions (example advocacy and self- determination)
47 48 49 50 51 52 53 54 55 56	11. Beuthin et al., 2018	17 Nurses in Canada	NPs, RNs, and LPNs, from urban and rural areas across Vancouver Island, British Columbia, working across	15 nurses had direct experience with MAiD, 7 were involved in some aspect of assisted death in the patient's journey (e.g., providing	In-depth semi structured interviews	Descriptive narrative enquiry and thematic analysis	Emotional theme of reflective emotions (example, a sensemaking process)

2							
3			settings including	information, acting			
4			acute care,	as witness to the			
5 6			residential care,	medical assessment,			
7			primary care	providing care			
8			clinics, and	before or after, etc.)			
9			community and	, ,			
10			palliative care.				
11			pamative care.				
12	12. Bolt	8 pediatricians in	8 pediatricians	25% had received	Semi-	Qualitative	Emotional theme
13	et al.,	Netherlands	who were	an explicit request	structured	Analysis Guide of	of role-assigned
14	2016		interviewed were	for Physician-	interviews	Leuven method	emotions
15 16			5 men and 3	assisted death, with		was used for the	(example, feeling
17			women, aged 44–	7% in the last two		analysis. Mixed	of duty)
18						-	or duty)
19			62y, working in	years, and the		method	
20			four academic	requests were		approach.	
21			and three general	mostly made by			
22			hospitals	parents (25%) and			
23				sometimes by			
24				patients (6%)			
25							
26	13.	1 physician, 8	27 men, 13	14 had been faced	Semi-	Grounded theory	Emotional theme
27 28	Dolares	directors of	women, mean	with suicide or	directive	using 3 types of	of role assigned
29	Angela	sociomedical	age 52y.	assisted suicide in	interviews	coding-open, axial	emotions
30	Castelli	institutions or		their personal life,	conducted	and selective.	(example, feeling
31	Dransart	organizations, 10		beside the situation	at		of professional
32	et al.,	head nurses, 8		of assisted suicide	workplace.		compromise)
33	2017.	nurses, 10 nursing		at work. None of			
34		assistants or care		the respondents			
35		assistants, and 3		interviewed had			
36		sociocultural		physically provided			
37 38		animators,		the lethal substance			
39		Switzerland		to perform the		4	
40		confronted with		assisted suicide (a			
41		assisted suicide		task assigned to			
42				Right to Die			
43		requests.		=			
44				associations), nor			
45				were they directly			
46				involved in the			
47 40				decision-making			
48 49				process that			
49 50				enabled the assisted			
51				suicide to take place			
52				(except for one			
53				physician). In fact,			
54				the vast majority of			
55				these professionals			
56				. 212 p. 1.000.0			

2							
3				(except for two)			
4				declared that not			
5				only did they			
6 7				appreciate the fact			
8				that Right to Die			
9				associations			
10				assumed the task of			
11							
12				delivering the lethal			
13				substance and			
14				physically assisting			
15				the requestor, but			
16 17				they also did not			
18				want to be led to do			
19				it themselves in the			
20				future			
21							
22	14.	28 physicians in	20 males, 8	once in 3-5 years'	In-depth	Thematic analysis	Emotional theme
23	Mariann	Netherlands	females, 22 GPs, 1	experience with	interviews		of reflective
24	e Dees et		elderly care 2 GP	assisted death.	with		emotions
25 26	al., 2012		trainees and 1		patients		(example,
27			psychiatry		who had		relational and
28					explicitly		feeling of trust in
29					requested		physician-patient
30					assisted		relationship)
31					death, their		
32					most		
33					involved		
34 35					relatives		
36					and their		
37					treating		
38					physicians		
39					,		
40	15.	20 hospice social		The 20 hospice	Semi-	Thematic analysis	Emotional them of
41	Harvath	workers and		social	structured,		role-assigned
42	et al.,	nurses in Oregon,		workers/nurses	In-depth		emotions
43 44	2006	USA.		described 33	interviews.		(example, feeling
45				different cases of			of professional
46				terminally ill			failure,
47				patients who had			professional
48				requested them to			dilemmas and
49				hasten death			inner debate).
50				through physician			mici debatej.
51				assisted suicide (n =			
52 53							
53 54				22)			
55			l				

Other practitioners GPs who had Chosen to refuse Chosen t	2							
The matter of the Composition		16. Ina	20 General	GPs who had	Receive 1-3	In-depth	Thematic analysis	Emotional theme
Comprise the participant due to personal discomfort with assisted death. Description of the personal discomfort with assisted death. Description of the study and provided the most insight. Description of the study and provided the most insight into their handling of requests for participant of a request for euthanasia: 12 nurses. 2) Decision making: 14 nurses. 3) Decision making: 15 nurses. 3) Decision making: 16 et al., 4 lele Bellonger death and the study and provided the most insight into their handling of request for euthanasia: 12 nurses. 3) Decision making: 14 nurses. 3) Decision making: 15 nurses. 3) Decision making: 16 et al., 4 lele Bellonger death and the study and provided the most insight into their handling of request for euthanasia: 12 nurses. 3) Decision making: 14 nurses. 3) Decision making: 15 nurses. 3) Decision making: 16 et al., 4 lele Bellonger death and the study and provided the most insight into their handling of request for euthanasia: 12 nurses. 3) Decision making: 14 nurses. 3) Decision making: 15 nurses. 3) Decision making: 16 et al., 4 lele Bellonger death and the study and provided the most insight into their handling of requests for euthanasia: 12 nurses. 4) Decision making: 14 nurses. 3) Decision making: 15 nurses. 3) Decision making: 16 nurses. 4 Decision making: 17 nurses. 4) Decision making: 18 nurses. 4 Decision making: 19 n		Otte et	practitioners	chosen to refuse	requests of	semi-		of basic emotions
Switzerland, 3 declined to participate due to participate due to personal discomfort with assisted death. 10		al., 2016	(GPs) in	to assist a	physician assisted	structured		with conscience-
participate due to personal discomfort with assisted death. Participate due to personal discomfort with assisted death. Participants was defined to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to personal discomfort with assisted death. Participants was dead to provided the most insight into their handling of requests for PAS. Participants was different phases of Euthanasia Participants was dead to personal discomfort with assisted death. Participants was different phases of Euthanasia Participants was different phases of Euthana			Switzerland., 3	patient's suicide	suicide per year.	interviews.		based
personal discomfort with assisted death. Comparison of the study and discomfort with assisted death. Comparison of the study and provided the most insights. Comparison of the study and provided the most insight into their handling of requests for PAS.	8		declined to	comprise the	2/3 rd of the GPs			avoidance/rejectio
discomfort with assisted death. Comparison of the study and provided the most insights. Comparison of the largest group in the study and provided the most insight into their handling	-		participate due to	largest group in	interviewed had			n of MAiD
norman distress) response to the study and provided the most insight to their handling of requests for PAS. 22			personal	the study and	chosen to refuse			(example, feeling
assisted death. most insights. Suicide comprised the largest group in the study and provided the most insight into their handling of requests for PAS. 17			discomfort with	provided the				of moral distress)
suicide Comprised the largest group in the study and provided the most insight into their handling of requests for PAS. 17. Ada van de Scheur and Arie van der 29 van der 29 van der 29 van der 31 1998			assisted death.	most insights.	·			
the largest group in the study and provided the most insight into their handling of requests for PAS. 20 nurses in Netherlands Scheur and Arie van de Scheur and Arie van de van					=			
the study and provided the most insight into their handling of requests for PAS. 17. Ada 20 nurses in According to different phases of Euthanasia: Observation of a request for euthanasia: 17 nurses. 2) Decision making: 14 nurses. 3) Carrying out of euthanasia: 12 nurses. 4) Aftercare: 14 nurses Aftercare: 14 nurses Bélonger Emmanu affiliated palliative care bysicians in county of the palliative care euthanasia 2018 Belonger Euthanasia Care opposite					the largest group in			
provided the most insight into their handling of requests for PAS. 17. Ada					the study and			
insight into their handling of requests for PAS. 17. Ada van de Scheur of a request for euthanasia: 17 nurses 2) Decision making: 14 nurses. 3) Carrying out of euthanasia: 12 nurses. 4) Aftercare: 14 nurses 18. Emmanu elle physicians in cet at i., 2018 18. Bélanger et at i., 2018 18. University affiliated palliative care physicians in cet at i., 2018 19. Decision making: 14 nurses and conflicting values with palliative care physicians, and like most palliative care physicians, and series and care in an urban area of Quebec. All participants were full-time palliative care physicians, and like most palliative care physicians physician								
22 2 33				0,	•			
of requests for PAS. 17. Ada van de Scheur and Arie yan der 1998 18.					=			
17. Ada van de Scheur and Arie van de Scheur and Arend 30 Arend 31 1998 Perison making: 14 nurses. 3) Carrying out of euthanasia: 12 nurses. 41 Aftercare: 14 nurses 18. Emmanu de lie palliative care physicians in output of et et al., 2018 18. Belanger 19. Belanger 10. Ada van de Scheur and Arie (example, feeling of moral distress) 19. Belanger 19. Benational theme of role-assigned emotions 19. Benational theme of role-assigned emotions 19. Benational tierviews. 10. Benaticanalysis 10.					Handing			
17. Ada 20 nurses in Netherlands According to different phases of Euthanasia: Observation of a request for euthanasia: 17 nurses. 2) Decision making: 14 nurses. 3) Carrying out of euthanasia: 12 nurses. 4) Aftercare: 14 nurses 18.					of requests for PAS.			
Netherlands Netherlands Archer Scheur								
26		17. Ada	20 nurses in	According to	Engagement as per	In-depth	Thematic analysis	Emotional theme
and Arie and		van de	Netherlands	different phases	different phases of	semi-		of role-assigned
28 van der van		Scheur		of Euthanasia:	Euthanasia	structured		emotions
Arend 31 1998 32 1998 33 14 1998 34 1998 35 14 nurses. 2)		and Arie		Observation of a		interviews.		(example, feeling
1998 31 1998 32		van der		request for				of moral distress)
Decision making: 14 nurses. 3) Carrying out of euthanasia: 12 nurses. 4) Aftercare: 14 nurses 18. Is university affiliated palliative care physicians in Quebec, Canada 41 et al., 2018 Belanger Quebec, Canada Quebec, Canada Quebec, Canada Quebec, Canada Quebec, All participants were full-time palliative care physicians, and like most palliative Care providers in Decision making: 14 nurses. Balanger physicians on staff at the palliative care units of two public hospitals located in an urban area of Quebec. All participants were full-time palliative care physicians, and like most palliative care physicians, and like most palliative care providers in		Arend		euthanasia: 17				
33		1998		nurses. 2)				
14 nurses. 3) Carrying out of euthanasia: 12 nurses. 4) Aftercare: 14 nurses 18.				Decision making:				
Carrying out of euthanasia: 12 nurses. 4) Aftercare: 14 nurses 18.				14 nurses. 3)		Y /		
nurses. 4) Aftercare: 14 nurses 18.				Carrying out of		4		
Aftercare: 14 nurses 18	36			euthanasia: 12				
nurses 18				nurses. 4)				
18.				Aftercare: 14			4	
18.				nurses				
42 18.								
## And The Palliative Care positioned themselves physicians on staff at the palliative care physicians on staff at the palliative care physicians on staff at the palliative care units of two public hospitals located in an urban area of Quebec. All participants were full-time palliative care physicians, and like most palliative care physicians, and like most palliative care physicians on staff at the palliative care interviews. methodology of linterpretive emotions description. of role-assigned emotions (example, professional dilemmas and conflicting values with palliative care)			•	-		Ī -		
Bélanger 45 Bélanger 46 et al., 2018 Physicians in Quebec, Canada Opposite euthanasia Opposite opposite euthanasia Opposite oppo				⁻	•			=
46 et al., 2018 Quebec, Canada euthanasia units of two public hospitals located in an urban area of Quebec. All participants were full-time palliative care physicians, and like most palliative care providers in			=		• •		<u> </u>	
hospitals located in an urban area of Quebec. All participants were full-time palliative care physicians, and like most palliative		-		- ·	-	interviews.	description.	
48 49 50 50 51 52 62 64 64 65 65 65 66 67 68 68 68 68 68 68 68 68 68 68 68 68 68			Quebec, Canada	euthanasia	· ·			
49 50 Quebec. All participants were full-time palliative care physicians, and like most palliative care providers in		2018						
Quebec. All with palliative participants were full-time palliative care physicians, and like most palliative								_
participants were full-time palliative care physicians, and like most palliative care providers in					·			=
care physicians, and like most palliative	51				•			care)
like most palliative					-			
55 care providers in								
I Care providers in I								
					care providers in			

2							
3 4				Canada, the			
5				majority of them			
6				(16 out of 18) were			
7				family physicians. As			
8				expected, all			
9				participants			
10				expressed			
11				discomfort with			
12				euthanasia as an			
13				aspect of end-of-life			
14 15				care. All but one			
16							
17				denied the influence			
18				of religious or			
19				political positions in			
20				shaping their views.			
21	40	e. I. I	2 (0 11 11	e .: 1.1
22	19.	Eight physicians	3 were from	Collectively, by the	In-depth	Qualitative	Emotional theme
23	Jessica	who offered	greater	end of December	semi	thematic analysis	of basic emotions,
24	Shaw et	MAID in British	Vancouver, 3	2016, the 8	structured		especially positive
25 26	al., 2018	Columbia in 2016,	were from	physicians in this	interview		emotions
27		Canada	Victoria, and 2	study had assessed	via phone		(example, sense of
28			worked in a small	332 people who	call/email		fulfilment)
29			community on	were seeking MAID			
30			Vancouver Island.	and had completed			
31			Seven were family	135 assisted deaths			
32			doctors and 1 was				
33 34			a general				
35			internist. Their				
36			ages ranged from				
37			37 to 64 years.				
38			There were 2 men				
39			and 6 women; 6				
40			worked full-time				
41			and 2 worked				
42 43			part-time.				
43 44			pare error				
45							
46							
47	20.	10 nurses who	Four worked in	Nurses were eligible	In-depth	van Manen's	Emotional theme
48	Judith	worked in home	hospice home	to participate in this	interviews	approach to	of role-assigned
49	Schwarz,	hospice, critical	care, three were	study if they	done at	phenomenology	emotions
50	2004	care, and	advance practice	believed that a	least twice	phenomenologica	(example, feeling
51 52		HIV/AIDS care	nurses who	competent patient	for 7	l interpretation	of human-human
53		settings, USA	worked with	had made a serious	participants	and analysis	response and
54			persons with	request for their		(phenomenologic	connectedness)
55			AIDS, two worked	help in dying.		al enquiry)	,
56				. , ,		. ,,	
57		<u> </u>	<u> </u>	<u> </u>			

2							
3			in critical care,				
4			and one was a				
5			clinical nurse				
6 7			specialist in the				
8			care of patients				
9			with spinal cord				
10			injuries. Two of				
11			the ten nurses				
12							
13			were male, all				
14			were Caucasian,				
15 16			middle-aged, well				
17			educated (three				
18			PhDs; five				
19			Masters of				
20			Science in				
21			Nursing), and				
22			clinically				
23			experienced (6-				
24 25			35 years)				
26							
27	21.	22	26 to 67 years	Physicians had	Semi-	descriptive	Emotional theme
28	Marie-	conscientiously	(mean: 45 years),	received requests,	structured	thematic analysis	of basic emotions
29	Eve	objecting	12 of them were	had discussions with	interviews.		(for example
30	Bouthillie	physicians in	male (54.5%). 14	patients regards to	eight open-		emotional labor,
31	r and	Quebec, Canada	Family physicians,	MAiD, and	endedquest		burden and fear of
32	Lucie		2 oncology and 1	conscientiously	ions		psychological
33 34	Opatrny		each from	objected to	Interviews		repercussions)
35	2019		psychiatry,	participate.	ranged in		
36			neurology,		length from		
37			nephrology,		15 min to 1		
38			intensive care,		h, with a		
39			geriatrics and		mean		
40			pneumology. 14		length of 24		
41			from catholic		min		
42 43			background.		(median		
44					length = 21		
45					min). think		
46					back to		
47					their first		
48					medical aid		
49							
50					in dying		
51 52					request (as		
53					some		
54					physicians		
55					had 		
56					received		

2 3 4 5 6 7 8 9 10 11 12 13 14 15					more than one request) and describe the reasons which motivated their refusal.		
16 17 18 19 20 21 22 23 24 25 26 27 28 29	22. Gamondi et al., 2017	23 palliative care physicians across Switzerland	65% German, 30% French and 5% Italian speaking	Regularly received assisted suicide requests. The involvement of Swiss physicians is mostly confined to the decision-making phase; medical certification of diagnosis and mental capacity.	Semi- structured interviews.	thematic analysis	Emotional theme of role-assigned emotions (example professional role-related feeling of ambiguity, fear of being stigmatized as physicians, feeling of walking a tight rope.)
30 31 32 33 34 35 36 37 38 39 40 41 42 43	23. Rosanne Beuthin, 2018	female, of Anglo- European ancestry, age mid- fifties, living in an urban center, Canada	Doctorate in nursing and was employed as a consultant under an end-of-life Program to enact a new MAiD program.	daily journal entries made over a 6 month period, from the first day of immersion in the role and culture of MAiD from late May to October 2016	Raw autobiograp hical text held scattered floods of ideas and released emotions into a thick created Story.	autoethnographic approach-reflective analysis	Emotional theme of reflective emotions (example, feeling of embodiment, compassionate care and sensemaking reflective emotions. Exploring tensions around language, attitudes)
44 45 46 47 48 49 50 51 52 53 54 55 56	24. Anne Bruce and Rosanne Beuthin, 2019	15 RNs/NPs/LPNs from British Columbia, Canada.	Participants worked in diverse settings including acute care, community-home care, and specialty areas including emergency	Eight nurses had directly aided with MAiD and cared for the patient at home or in a care setting. Seven had been involved indirectly with patients such as providing assisted	Semi- structured interviews- (1) tell me about your first experience of being asked to participate	narrative inquiry and thematic analysis	Emotional theme of reflective emotions (example fear of desensitization with deeper questioning) along with complex emotions of "compassion

2							
3			room and	dying information	in a		satisfaction" as
4 5			palliative care.	upon request and	medically		well as
6				listening to patients	assisted		compassion
7				and families as they	death and		fatigue
8				explored pursuing	how you		
9				MAiD	came to the		
10					decision to		
11					participate		
12					or not and		
13 14					(2) tell me		
15					about the		
16					MAiD		
17					experience		
18					itself. What		
19					was most		
20					challenging		
21 22							
23					,		
24	25.	seven nurses,	Health care	Engaged in	one-on-	Foucauldian	Emotional theme
25	Alison	social workers,	professional	discussions and	one, semi-	Discourse	of reflective
26	Townsley	and personal	enrolled through	assessments of	structured	Analysis	emotions
27	2018	support workers,	purposive	patients requesting	interviews	perspective.	(example,
28	2010	Canada	sampling.	MAiD.	with health	Interview data is	emotions
29 30		Cariada	Sumpling.	IVIAID.	care	analyzed by	emerging from
31					professiona	situating the	engagement of the
32					Is	health care	individual in terms
33				Y (13	professional as an	of power,
34						effect, as a	
35						producer, and as	knowledge and individual identity)
36						_ ·	individual identity)
37 38						a challenger of	
39						power-knowledge	
40						systems.	
41						Philosophical	
42						theories of	
43						Giorgio Agamben	
44						are applied to the	
45 46						data to challenge	
46 47						Foucauldian	
48						principles, and to	
49						bolster the	
50						discussion of	
51						defining of the	
52						body that	
53						deserves to live,	
54							

2 3 4						and the body that	
5						deserves to die.	
6	26.	37 health care	Health care	19 physicians (10	One-to-one	Grounded theory	Emotional theme
7	Buchbind	providers in	providers from	internal medicine, 4	semi	approach	of role-assigned
8 9	er et al.,	Vermont, USA.	Hospital and	palliative care, 3	structured	арргоаст	emotions
9 10	2019	vermont, osa.	community-based	neurology, 2	interviews		(example pride,
11	2019			oncology), 12 had	litterviews		
2			practices. Most				burden etc.)
3			were women	participated in Act			
4			(68%) and the	39 (The patient			
5			largest subgroup	Choice and control			
6			specialized in	at End-of-Life Act)			
7			internal or family	as prescribing			
8			medicine (53%).	physicians, the			
9			Most of the	remainder had			
1			nurses and social	initiated but not			
2			workers were	completed the Act			
3			women (89%) and	39 protocol (n = 3),			
4			most worked for	participated as a			
5			hospice and home	second physician to			
6			health agencies	confirm the			
7			(61%).	patient's diagnosis,			
8 9			, ,	prognosis, and			
0				decisional capacity			
1				(n = 3), or counseled			
2				patients (n = 1). The			
3				mean age of nurses			
4				and social workers			
5				(n=18, 9			
6				_ ·			
7 8				hospice/home			
9				nurse, nurse		4	
0				practitioner 5,			
1				inpatient palliative			
2				care 2, hospice			
3				social worker 2) was			
4				52.5, with most			
5				working for hospice			
6				and home health			
7				agencies (61%).			
8				While all			
0				professionals in this			
1				group engaged in			
2				clinical care for			
3				patients pursuing			
4				Act 39, specialty			
5				clinic nurse			
5				chine nuise			

2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 31 31 31 31 31 31 31 31 31 31 31 31	27. Allyson Oliphant, 2017	4 physicians. 4 nurses and 6 HCPs (allied health care professional social workers (1), spiritual care providers (1), pharmacists (1), genetic technologists (1) and psychologists (2).) of team ADRAS in Hamilton, ON.	Of the data available, 2 were semi-retired family physicians, One is an intensive care physician with a background in cardiology, and the second is an Emergency Room physician with training in palliative care.	practitioners were more likely to assist with navigating access to the aid in dying. Participating health care professionals worked in ten of Vermont's 14 counties All participants are members of the ADRAS (assisted dying resource and assessment service) who support the practice of MAiD. Every participant had a capacity to be flexible.	One to one semi-structured interviews.	Grounded theory approach	Emotional theme of reflective emotions (example, emotions related to professional identity, sense making, feeling of obligation to serve)
32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56	28. Laura Sheridon 2017	nine palliative care nurses in southwestern Ontario, Canada	3 males, 6 females. 3 participants worked in residential hospices where MAiD was not supported as an end-of-life option, six participants worked in the community providing home care where MAiD is an option in end-of-life planning. Two participants had	Participants in the study indicated that nurses may act as a liaison between physicians and nurse practitioners who have the authority to assess patient eligibility and provide the intervention of MAiD and the patient, notifying them of an inquiry about or a request for MAiD	One-to-one semi structured interview.	interpretive description qualitative methodology	Emotional theme related to role-assigned emotions (example, emotional expressions ("hard conversations") related to nursing role, struggle related to moral conflicts.

2							
3			previous inpatient				
4			hospital				
5			experience in				
6 7			emergency care				
8			and in intensive				
9							
10			care specialties.				
11	29.	19 physicians,	Half of the	Average 6.9 MAiD	In-depth	inductive	Emotional theme
12	Khosnoo	Canada. Quebec	participants were	cases.	semi-	thematic analysis	of role-assigned
13	d et al.,	not included.	palliative care	cases.	structured	approach	emotions
14	-	not included.	1 ·			арргоасп	
15	2018		specialists (n = 8),		telephone-		(example burn
16			with the		based		out, negative
17			remaining		interviews.		effect on inter-
18			representing				professional
19 20			Family Medicine				relationships vs.
21			(n = 4),				increased feeling
22			Anesthesia (n =				of respect)
23			2), Hematology (n				
24			= 1), and				
25			Obstetrics &	6			
26			Gynecology (n =				
27			1). The majority				
28			of participants				
29			· ·	\sim			
30			practiced in an				
31 32			urban setting (n =				
33			13).				
34	30.	0 physicians	Participants	experience with	In norson	intorprotivo	Emotional them of
35		8 physicians,	•	·	In-person	interpretive	
36	Beuthin	Canada.	included general	MAiD provision	or	descriptive	reflective
37	et al.,		practitioners	ranged from 12 to	telephone-	methodology and	emotions,
38	2020		(GPs) and Non-	113 assisted deaths.	based semi-	thematic analysis	(example complex
39			specialist	Only one physician	structured		emotions of
40			physicians from	was dedicated to	interviews.		compassion
41			urban and rural	full-time provision.			satisfaction,
42			communities				embodied
43 44			working in acute				awareness, soul-
45			and palliative				searching)
46			care. Ages ranged				0,
47			from 33 to 62				
48							
49			years (average				
50			age 49), with an				
51			equal number of				
52			men and women.				
53			The majority				
54			identified no				
55 56			active religious				
56			- 0		I		

2							
3			affiliation, and				
4			ethnicity was				
5			withheld to				
6							
7			protect				
8			anonymity. Years				
9			of experience				
10			ranged from 6 to				
11			38 years (average				
12			of 23).				
13			01 23).				
14	21 Vori	23 physicians of	22 physician	11 identifying	using 1	Thomatic analysis	Emotional theme
15	31. Keri-		23 physician	11 identifying	using 1	Thematic analysis	
16	Lyn	Rural area,	participants	themselves as	semi-		of role-assigned
17	Durant	northwestern	ranged in age	acting both as	structured		emotions
18	and	Ontario, most of	from 26 to 63,	assessor and	focus group		(example, feeling
19	Katherin	subarctic Ontario.	with a mean age	provider, 1 as	and 18		of impact on inter-
20	e Kortes-		of 43 years.	assessor only, 4 as	semi-		professional
21				• •			-
22	Miller		Physicians worked	providing referrals	structured		relationships,
23	2020		in a variety of	upon request, and 7	interviews		feeling of
24			settings, with 14	without any	comprising		unpreparedness.
25			in an urban	direct/indirect	9 set of		
26			setting – in family	experience. These	questions		
27			practice, as a	seven were included	'		
28			hospitalist or	in the study because			
29			-				
30			other specialist, in	they expressed a			
31			the emergency	desire to participate			
32			department, in	and reported that			
33			palliative care,	their practice and	V ,		
34			and in long-term	the community had			
35			care. Nine	been impacted by			
36				the legislation.			
37			participants	•			
38			declared a rural	There was also a		4	
39			practice, and self-	variance in terms of			
40			identified as rural	exposure to death			
41			generalists,	in practice, with an			
42 43			working on a First	estimated total			
44			Nations' reserve,	between 2 and 250			
44			•				
45 46			in a community,	deaths per annum			
47			at a satellite				
47			clinic, or 'All of				
49			the above'.				
50							
51	32.	secondary	Respondents	Twenty-two	One-to-one	Thematic analysis	Emotional theme
52	Snijdewi	analysis of in-	were recruited	respondents	semi-	-	of reflective
53	nd et al.,	depth	both by the	worked as family	structured		emotions
54	-	асриі	·	-			
55	2016		network of	physicians, and six	interviews.		(example, those
56			physicians				related to meaning
50							

interviews with 28 Dutch physicians who had experience with a complex case of EAS well as via a national interviews with working for SCEN worked as medical specialists (three elderly care physicians, a psychiatrist, an internist and a lung specialist). Next to	of suffering, blurring emotional boundaries)
5 physicians who physicians who had experience with a complex case of EAS well as via a specialists (three elderly care physicians, a psychiatrist, an internist and a lung	
physicians who had experience Euthanasia in the with a complex case of EAS well as via a physicians, a psychiatrist, an internist and a lung	
had experience Euthanasia in the physicians, a with a complex case of EAS well as via a psychiatrist, an internist and a lung	
8 with a complex Netherlands) as psychiatrist, an case of EAS well as via a internist and a lung	
g case of EAS well as via a internist and a lung	
11 Ouestionnaire this six of the	
12 Nine of the ground autoples	
13	
respondents were worked as SCEN female. The physicians. All had	
16 respondents' age experience with EAS	
17 ranged from 36 to requests and the	
18	
68 years performance of EAS.	
$\frac{20}{33}$ $\frac{33}{8}$ Pesut $\frac{1}{2}$ 59 registered $\frac{1}{2}$ \frac	Emotional theme
21 33. Pesat 39 registered 11 = 9 (15%) were 24 of the 59 Semi- Qualitative 22 et al., nurses and nurse conscientious participants had structured approach gu	
23 2020 practitioners in objectors, conducted more interviews by Interpreti	=
24 Canada Spiritual or than 25 conducted Description.	
Religious conversations with on immersion, o	' ' '
Affiliation: n = 33 patients about telephone coding cons	.
27 (56%) Noither: n = MAID and 11 of the Question comparative	
28	=
29 analysis, and but not Religious: been involved with (i) Can you construction	·
31 n = 11 (19%) more than 25 tell us how thematic and	
patients who went the process interpretive	feelings of
Home & on to receive MAiD. of MAiD account.	Emotions of
Community: n = Conversion Transprints	frustration,
35 32 (54%): Acute	· ·
36 your 10	'
(170/), Long torm	
context; (ii) the interview	
40 Hospice: n = 4	out)
41 (7%): Clinic: n = 2	
42 (5%	
43 practice	
44 supports	
45 are available to	
47	
48 assist you in	
49 caring for	
50 MAID	
51 patients?	
52 (iii) Tell us	
53 54 about your	
55 experiences	
56 with MAiD?	

2							
3					The average		
4					length of		
5 6					interviews		
7					was 55 min.		
8							
9	34.	40 oncology	48% in	30% had received	Recipients	Denzin's process	Emotional theme
10	Deborah	nurses who	hospital/multi-	requests for	were re	of interpretive	of basic emotions
11	Volkar et	received requests	hospital settings.	assisted suicide, 6	questedto	interactionism	(example
12	al., 2001	for assisted death	9 female, 1 male.	(1%) engaged in	submit a	with an emic,	emotional labor)
13 14		in USA.	Mean age 45 y.	assisted suicide, and	written	ideographic	along with
15			4	20 (4.5%) admitted	account or	approach. That is,	reflective
16				to intentionally	story of	individual	emotions of
17				injecting a drug to	receiving a	experience is	feeling lack of
18				end a patient's life.	request for	considered to be	control (or lack of
19				·	assistance	unique; discovery	it) and moral
20					in dying	of an individual's	distress).
21 22					from a	epiphany and	,
23					terminally	associated	
24					ill patient	meanings is the	
25					with	research focus	
26					cancer.		
27				4	earreer.		
28	35.	23 palliative care	54% of physicians	All the participants	Semi-	Braun and	Emotional theme
29 30	Mathews	providers (13	and 90% of nurses	described having	structured	Clarke's version	of role-assigned
31	et al.,	physicians and 10	were female with	discussions with	interview	of Thematic	emotions
32	2021	nurses) who	a mean age of 43	patients regarding	based on	analysis	(example Role-
33		practiced for 6	years and 42.6	MAiD and 7/23	pre-		driven emotional
34		months or more	years	participants (4	determined		themes of
35		before and after	respectively.	nurses and 3	interview		Emotional,
36 37		the introduction		physicians)	guide		psychological and
38		of MAiD, in		described directly		•	resource burden
39		inpatient and		witnessing assisted		5	along with theme
40		community-based		death. 8/13			of emotional
41		settings that		physicians made	•		labor)
42		supported		referrals for MAiD, 4			,
43		assisted death in		conducted			
44 45		southern Ontario,		assessments, and 3			
46		Canada.		physicians were			
47		-		MAiD providers; 3			
48				physicians identified			
49				as conscientious			
50				objectors. None of			
51 52				the nurses			
53				identified			
54				themselves as			
55				conscientious			
56				5511561611110415			

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3		objectors, although		
 =		some expressed		
) 5		moral or religious		
7		conflict around		
3		MAiD.		
)				

Table 3: Codes and Themes table (corresponding Table-2 study number in parenthesis):

A) Over-arching theme of basic emotions:

Theme 1: Emotional labor (positive/negative emotions) Codes:

"rewarding" "liberating", "Well please let someone else do this question", "blood had frozen in my veins",

I just felt just totally cold all over. I had no idea of what to do. I realized there was no help I could get from anywhere . . . I . . . felt as though I was . . . impotent to help them. "If possible, I would run away. But I see it as the last part of my care. I have taken care of that patient for years and now at the moment . . . when she needs me most . . . I would be a coward to run away then. (1)

"I felt very lonely" "heroic feelings", "tense", "scary", "terribly creepy", "felt pressured to succeed", "suffer a loss yourself when someone like that dies" "terribly manipulated", "felt slightly put upon, angry" 'let off steam' (2)

"feeling of ambivalence", "intense", "gradually feel less secure, less fearful", "surprisingly grateful". "very demanding and emotionally distressing" (3) "very demanding, generally like to avoid", "drastic" (5), "moral pressure", "uncertain, complex" (6), "very hard" (7), "feeling choked up or shedding a tear" "Feeling positive emotions of peace and amazement were more surprising and often shared cautiously in public", "had difficulty finding effective words for the paradoxical experience of witnessing death that is, both "sad" and "beautiful." (11). "felt reluctant as it is difficult to predict" (12). "feeling of enrichment", "feeling of sorrow and intrusive thoughts", "feeling like weathering the storm", "empathy and emotional closeness", "personal compromise" (13). "do not feel competent" (16).

Theme 2: Conscience based emotions.

codes:

"making pluses and minuses about it . . . but . . . 'What's it doing to me? I'm going to kill someone tonight.' [respondent began to cry],

"I have to do no harm, and I just feel that if you're assisting someone in dying . . . it's against what I've been trained . . . It's not up to me to decide when the patient dies . . ." (1);

"killing another person is not the solution. It's in the ten commandments"

"sense of guilt. I feel as if I'm an executioner. Who am I to have the right to do this?" (2);

"Conscientiously, I find it hard to come to terms with euthanasia" (3);

Clarity of conscience- "a sort of trap that can't be avoided. That in spite of everything you can offer, a terminal stage can be so heavy, perhaps too heavy for a patient. In fact, I always see it as an emergency exit. When I am talking about it with a patient I say, "yes we will consider it, if you don't want to go on any longer and if I have nothing more to offer you to make it better"(5);

"I am a Christian so I have strong feelings because of my belief and my background, believe that no human being should be in the position to hasten death." (10);

cannot bear the idea of killing one of my patients", I do not feel competent to deal with the topic...especially for my personal psychological health, "challenges my belief, I do not understand how it can be meaningful" (16)

"rewarding work", "honor", "bit overwhelming", "proud", "incredible" "feeling like being on call all the time (19), "emotional burden", "fear of psychological repercussions", "uncomfortable", fear of stigmatization (21), "fear of stigma/isolation, feeling of ambiguity" (22), "feeling courageous" (23), "satisfying and gratifying" "roller coaster", "transformational feelings of beautiful death" (24), just feel coldness, or whatever. You just feel drained ..."(28), "unexpected rewards", "enriching capacity of caring", (30), , "anxiety, shock, self-doubt", "deep inside...conflict" (34); "walking quiet a tight rope", was as prepared...but went outside and felt like I was about to throw up", "actually, find them. . . they're such beautiful experiences with family. It's the shared experience with the family that you're with that you have an opportunity to help." (35)

"to see somebody lying there, to whom you brought a cup of tea that morning. And you know that everybody who gets a heart attack can die as well, but this was no heart attack. You know that, of course. So, somebody has been killed, just like that. . . That makes it different." (17)

"conflicted, trying to reconcile their own personal moral stance with facilitating the end of someone's life" (28)
"What would my family think that I'm working on a unit that does that [Medical Assistance in Dying]? Do I hide it from them. . .what if people find out that we do it? Are people going to come up here and start protesting? People will see that as evil." (35)

B) Overarching theme of reflective emotions.

Theme 1: relational

"feeling of trust and sympathy in physician patient relationship strong" (14)

"human centered, compassionate care" (23), "for somebody to approach you is almost an honor that they trust you enough to have this conversation, and to have to sort of shut them down, or acknowledge how they're feeling" (empathy) (28), "intimate, emotional engagement-rediscovering the art of medicine", (30), "indelible nature of the experience shared" (34) "as soon the topic [Medical Assistance in Dying] came up, that I was a conscientious objector and the person said that you're not on my side, even though she was getting the service [MAID] . . . I was seen as somebody who was not helping her" (35)

Theme 3: Sense making process and related emotions. (Theme of Growth)

"You grow with the problems of the patients" (1)

" stay closer to their own beliefs" " long road to becoming aware of one's own views" (2)

"meaning full experience" "almost closer than when someone is having a baby" (5)

"[EAS] is not an act, it's a process towards which we both grow"
(6), "Being in process, holding an in-between space of
uncertainty, reflection, and active sense-making" (11); "pure
moment of autonomous self-consciousness" "I am working and
sense making as I go along, being sure that I keep breathing",

Theme 2: Discourse based (control over a natural process of dving)

"interesting discourse presented itself through idea of using stages to determine someone's chances of survival, and the need for professionals to have something finite and concrete to measure", "discourse that emerged through conversations with participants was how control (or masterhood) equates to people's sense of wellbeing" "MAiD itself presents a paradox insofar as one can be too sick to access this form of assistance that is exclusively designed to bring death to the most critically ill people" "The most dominant discourse that emerged from this data set was participants aligning what is right and good within the confines of the law." (25); "medicalization of a social problem" (32); "degree of control over dying process" (34).

Theme 4: Process influenced themes (suffering---relief--death) "Invisible suffering made it harder for the people close by to empathize and come to terms with the patient's request and his/her death" (6);

"for me, a lot of talk, talk about death and dying, talk about life, about saying goodbye, really seeing and feeling what is happening in this last phase of life and reflect on that. But not everybody is capable of talking and reflecting this way, while everybody is

going to die. So that's my problem" (7);

"imagine self" and "imagine other" cognitive route. Use of cognitive reflection (8);

"feeling of embodiment, become the face of MAiD", "bearing witness" (23); "worries of becoming desensitized and ongoing deeper questioning" (24); "their thoughtful silence after speaking or listening represented and solicited from me respect for the dead and the dying, seething inner anger, and perhaps the quietude that one experiences when their physical body feels the effects of being a challenger and resister in the strongest way possible" "Kind of letting them have control over what they can have control over" "beautiful journey of self-reflection", "grappling with identity" (25); "embodied awareness", "soul searching" (30); "silent knowing" (34)

"very difficult for me to let...go, to be so aware of saying farewell, and now I notice that as time passes it gets harder and harder for me" (14); "sense of urgency to hasten death" (23);

"boundaries of EAS has shifted over time, making feel stretched, tense and insecure" "not feeling competent if suffering is existential" (32);

"it's been a bit of a challenge to delineate what we're doing in relationship to the request for assisted dying and what normal care still continues to be" "struggle with the rules of a complex legislated and reporting process that determines it" (33)

C) Overarching theme of emotions related to professional values:

Theme 4: Role-assigned emotions

Nurses: "predominantly tend to be conformist (following existing conventions rather than using critical reflection) when faced with ethical dilemmas. Combined with the emphasis of the medical responsibility in euthanasia care, and combined with the strong inclination of nurses to respect the patients' wishes, it seems logical that nurses interpret the gravity of the process in emotional terms"(3); ""unchartered territory," where "there was almost no foundation" for providing this option, and "this is a whole new role for all of us. (being pioneers)" "duty to provide care" is being touted as "you don't have a choice" and the information isn't there [about] how to object if you don't agree with" (11); "moral distress", "burden", see somebody lying there, to whom you brought a cup of tea that morning. And you know that everybody who gets a heart attack can die as well, but this was no heart attack. You know that, of course. So, somebody has been killed, just like that... That makes it different" (16); "identifying the moral line", "human-human response and connectedness because of the role played", "fear the potential for abuse, and the possibility that other health-care professionals might too readily accept a patient's fleeting wish to die" (20); "taken for granted, feeling terrible" "their own suffering is invisible" (24); "walking alongside patients" like the experience of being able to make [death] a better experience. That celebration of life rather than the mourning of death" (27); "feeling of having hard conversations" (28); "Nurses seeking to provide the compassionate care consistent with such a momentous moment in patients' lives, without suitable supports, find themselves caught between the proverbial rock and hard place" "powerful experience" "mad as a hell", "overwhelmed" "...don't find the provisions so emotionally draining, but it's more the logistics and it's a lot of work as a nurse" (33); there's a sense of ceremony [before Medical Assistance in Dying], So, those all have impacts in terms of resources" (35).

social worker: "feeling of being a gatekeeper" (4); "sense of preparedness", feeling that this option is 'pro-self-determination which is our job"(9); "inner debate, cannot make peace with that, felt a huge shift in my ethics", "dying process has a lot to give" "missed opportunity to deepen oneself spiritually", "missed opportunity to forgive"(15); feeling of advocacy and self-determination in sync with hospice and social work values, and we will advocate for the patients . . . to get them whatever they want . . . I believe in self-determination, but I think it's (PAS) a sad commentary on our society." "Our job is to meet the patients where they are" (10); "felt like higher commitment", "felt like a failure if patient chose EAS" (16).

physicians: "heavy responsibility" (5); "implicit ethical tension due to pressure to decide", "It is the right time for EAS] Only if someone is totally at peace with himself, his life and his death, and if I see and feel that too.'(7); "feeling of duty" (12);

"professional compromise" (13); "fears prosecution", "burden, not wanting to abandon the patient" (14); extremely personal choice, I feel that part of some of the resistance at times can be related to [the fact that] that this is something new" "feeling of being torn between professional values and patient values (18); "significant administrative burden" (21); "struggle to reconcile to professional values", sense of responsibility to not create barriers" "walking a tight rope" (22); "tremendous pride", "burden as well" (26); duty to serve. "if not me than who" (27); "interprofessional lack of trust" "excessive workload and lack of financial satisfaction" (29); "burgeoning relationship between palliative care and MAiD", "positive because master of destiny", "uncomfortable discussing it" (31); "Good palliative care takes a lot of time and interdisciplinary resources. . when a patient is requesting MAID, most of the resources have been sucked up by that one case ... And all of the high-quality palliative care that we do falls by the wayside for the other patients." (35)



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3 Section and Item Countries Countri	otion
4 Topic # Checklist item repo	re item is
5 TITLE 55	
6 Title 1 Identify the report as a systematic review.	
ABSTRACT	
Abstract 2 See the PRISMA 2020 for Abstracts checklist.	
10 INTRODUCTION	
Rationale 3 Describe the rationale for the review in the context of existing knowledge.	6
Objectives 4 Provide an explicit statement of the objective(s) or question(s) the review addresses.	and p.6
METHODS §	
Eligibility criteria 5 Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	3
Information sources 6 Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	9, plementary endix 1
	plementary endix 1
Selection process 8 Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many regiewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools gised in the process.	
Data collection process Data collection process 9 Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of dutomation tools used in the process.	10
Data items 10a List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	7
List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	7
	10, olementary endix 2
33 Effect measures 12 Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	applicable
Synthesis methods 13a Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	-11
Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	-11
40 appe	-11 blementary endix 3
13d Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used (s)	-11
13e Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	applicable
	applicable
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Supplementary appendix 4: PRISMA and ENTREQ checklist.

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Section and Topic	Item #	Checklist item 021-05	Location where item is reported	
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting bias 8).	high risk, p.20	
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	p.5, supplementary appendix 3	
RESULTS	<u> </u>	20		
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Figure 1	
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Figure 1, p.7	
Study characteristics	17	Cite each included study and present its characteristics.	Supplementary appendix 3	
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Supplementary appendix 2	
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Not applicable	
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Supplementary appendix 2	
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	p.11-14. Supplementary appendix 3	
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Not applicable	
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Not applicable	
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Not applicable	
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Table 1	
DISCUSSION				
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.17-20	
	23b	Discuss any limitations of the evidence included in the review.	p.17-20	
	23c	Discuss any limitations of the review processes used.	p.17-20	
	23d	Discuss implications of the results for practice, policy, and future research.	p.17-20	
OTHER INFORMATION G				
Registration and	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p. 11	
protocol	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.11	
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	none	
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the Review.	p.21	
Competing interests	26	Declare any competing interests of review authors. For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml	p.21	

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	Section and Topic	Item #	Checklist item	Location where item is reported
5	Availability of data, code and other materials		Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	p.21
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From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic views. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

Fighancing transparency in reporting the synthesis of qualitative research: FNTRFO Checklist (Tong, et al., 2012)

⁴ Enhancing transpar	ency in reporting the synthesis of qualitative research: ENTREQ Checklist (Tong, et al., 2012) ^v nlo
Item No.	Guide and Description	Report Location
8 1. Aim	State the research question the synthesis addresses	Backg ound, p.6
9 2. Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis)	Data analysis, p.10 Data analysis, p.10
3. Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved)	searc strategy screening and eligibility criteria SPIDER, p.6
4. Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type)	Eligibītity criteria, p.7
5. Data sources 6 7	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources	searck strategy, p.8 guest. Protecte
6. Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits)	Supplementary appendix 1 and p.6-9
7. Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies) For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml	p.9 stgdy selection process, Fig 1 PRISMA flow diagram

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Supplementary appendix 4: PRISMA and ENTREQ checklist.

пристепситу прре	maix 4: PRISMA and ENTREQ checklist.	pen-2
8. Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions)	Table a in supplementary appendix 3, Charagteristics of included studies
9. Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development)	Fig 1 - PRISMA flow diagram
10. Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings)	Table , CERQual approach
11. Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting)	Appræsal of the methodological limitations of included studies, Table 1, CERQual approach
12. Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required	p.10, independently done by the three researchers and consensus achieved.
13. Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale	Table 1, CERQual approach
14. Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software)	Data extraction and analysis, p.10
15. Software	State the computer software used, if any	None gised
16. Number of reviewers	Identify who was involved in coding and analysis	/ guest. Pro
17. Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts)	p.10 et et et
18. Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary)	Table in supplementary appendix 3.
19. Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml	Inductive process, p.10

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5 5 6 7	20. Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation	p.12-153 p.12-153 SS Discussion, p.17-20
8	21. Synthesis	Present rich, compelling and useful results that go beyond a summary of the primary	Discussion, p.17-20
9	output	studies (e.g. new interpretation, models of evidence, conceptual models, analytical	ر تا
10		framework, development of a new theory or construct)	20
11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 40 40 40 40 40 40 40 40 40 40 40 40		interpretation Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct)	July 2022. Downloaded from http://bmjopen.bmj.com/ on April 27, 2024 by guest. Protected by copyright.
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Emotional Impact on Health Care Providers Involved in Medical Assistance in Dying (MAiD): A systematic review and qualitative meta-synthesis.

Journal:	BMJ Open
Manuscript ID	bmjopen-2021-058523.R1
Article Type:	Original research
Date Submitted by the Author:	23-Apr-2022
Complete List of Authors:	Dholakia, Saumil; Ottawa Hospital General Campus, Department of Mental Health Bagheri, Alireza; Lakehead University, Research affiliate Center for Healthcare Ethics Simpson, Alexander; Centre for Addiction and Mental Health, Chair in Forensic Psychiatry
Primary Subject Heading :	Ethics
Secondary Subject Heading:	Qualitative research
Keywords:	MEDICAL ETHICS, MEDICAL LAW, International health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

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Title: Emotional Impact on Health Care Providers involved in Medical Assistance in Dying (MAiD): A systematic review and qualitative meta-synthesis.

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Key words: Ethics-Medical, Health Personnel, Euthanasia, Right to Die.

Word count: 3996 (excluding title page, abstract, references, figures and tables, acknowledgement, contributory, competing interests, data-sharing and funding statements)

Title: Emotional Impact on Health Care Providers involved in Medical Assistance in Dying (MAiD): A systematic review and qualitative meta-synthesis.

Background:

Medical Assistance in Dying (MAiD) traverses challenging and emotionally overwhelming territories: Health Care Providers (HCPs) across jurisdictions experience myriad of affective responses secondary to possible tensions between normative and interwoven values, such as sanctity of life, dignity in death and dying, and duty to care.

Objective: To determine the emotional impact on HCPs involved in MAiD.

Methods: Inclusion restricted to English language qualitative research studies from 4 databases (OVID Medline, EMBASE, CINAHL, and Scopus), from beginning until April 30, 2021, and grey literature up to August 2021 were searched. Key author, citation, and reference searches were undertaken. We excluded studies without rigorous qualitative research methodology. Included studies were critically appraised using Joanna Briggs Institute Critical appraisal tool. Analysis was conducted using thematic metasynthesis. The cumulative evidence was assessed for confidence using the Confidence in the Evidence from reviews of qualitative research (CERQual) approach.

Results: The search identified 4522 papers. Data from 35 studies (393 physicians, 169 nurses, 53 social workers, 22 allied healthcare professionals) employing diverse qualitative research methodologies from 5 countries were coded and analyzed. The thematic meta-synthesis showed three descriptive emotional themes — (1) Polarized emotions including moral distress (n=153), (2) Reflective emotions with MAiD as a 'sense-making process' (n=251), and (3) Professional values-driven emotions (n=352).

Discussion: This research attempts to answer the question- 'what it means at an emotional level', for a MAiD practitioner. Legislation allowing MAID for terminal illness only influences the emotional impact: MAiD practitioners under this essential criterion experience more polarized emotions, whereas those practicing in jurisdictions with greater emphasis on allaying intolerable suffering experience more reflective emotions. MAiD practitioner's professional values and their degree of engagement influences the emotional impact, which may help structure future support networks. English language literature restriction and absence of subgroup analyses limits the generalizability of results.

Other: Funding source: none.

Key words: Ethics-Medical, Health Personnel, Euthanasia, Right to Die.

Strengths and Limitations of this study:

Strengths:

- An eligibility criteria and subsequent search strategy that focusses on emotional impact of MAiD
 on HCPs with qualitative research methodology.
- Use of Joanne Brigg's critical appraisal tool for assessment of risk of bias and use of the CERQual
 approach for assessing the methodological limitations, relevance, coherence and adequacy of the
 evidence after completion of meta-synthesis.

Limitations:

- Qualitative signals of absence of sub-group analysis, eligibility criteria limited to published Englishlanguage literature and fast-moving pace of research on emotional impact of MAiD on HCPs likely contributes to significant publication bias.
- Generalizability of evidence limited by presence of selection bias in included studies.

Medical Assistance in Dying (MAiD) poses ethically complex challenges that can be a major source of distress to participating Health Care Providers (HCPs) —especially since MAiD may involve navigating conflicting personal and professional values. These values are contextual, dynamic and often not in alignment with each other; for example, professional values of duty to care and reducing suffering in case of terminal illness through MAiD may conflict with the moral value of preserving sanctity of human life, as the later may involve forbidding any action that hastens a patient's death in the dying process (1, 2). In the context of assisted death, a HCP often has to navigate value-conflicts between respect for autonomy and patient right to self-determination vs. respect for individual human life, and human life in general. Except for Switzerland, all other countries require HCPs to be at the forefront in discussing and executing eligible requests for assisted death within their defined jurisdictions (3).

Assisted death in selected jurisdictions-overview and current status

The number of jurisdictions across the world with medically assisted death legislation continues to grow. Switzerland, Netherlands, Belgium, Luxemburg, Canada, besides jurisdictions in the USA (Oregon, Vermont, California, Washington State, Colorado, the district of Columbia, Hawaii, Maine and New Jersey) along side the State of Victoria, Tasmania and South Australia in Australia and Columbia in South America, and most recently Spain and New Zealand, have legalized medically assisted death in some form (3, 4). Assisted death legislations in Canada, the State of Victoria in Australia and the Benelux countries includes both assisted suicide and euthanasia. Jurisdictions in the USA and Switzerland allow only assisted suicide. Broadly speaking, the 'Benelux' countries (Belgium, Netherlands and Luxemburg) have less restrictive rules in place for MAiD than the American jurisdictions that permit this practice. For example, Benelux countries allow advanced directives, and terminal of illness is not a requirement for MAiD eligibility in Belgium and Netherlands. Jurisdictions in the USA, on the other end, have strict eligibility criteria that the

illness must be terminal and there must be some timeline to foreseeability of natural death—commonly 6 months in most jurisdictions.

Intact decision-making capacity translating to ability to give informed consent for MAiD, voluntariness of request and suffering from a terminal illness are the mainstay of the eligibility criteria for MAiD, with each criterion receiving variable emphasis, depending on the legislative jurisdiction. For example, "reasonable foreseeability of natural death" criterion was removed from Canada's MAiD eligibility criteria following recent changes in the legislation (5-8).

HCPs and MAiD—current knowledge and knowledge gaps.

From an ethics perspective, amongst the HCPs, the physician's role in providing MAiD is perhaps the most ambiguous. Historically, medicine as a profession is rooted in the ethical principle of 'first, do no harm' while providing care. While this is true, medical futility and the sense of powerlessness and loss of control at end-of-life are a reality in modern medical practice, which is often reflected as physician ambivalence to participate in MAiD (9-11).

While this sense of moral ambiguity may distance physicians from the practice of MAiD, nurses also share the complex attitudes and polarized feelings towards MAiD (12). This complexity is often due to the dual role that nurses play in most health care systems around the world: on one end, they act as a strong advocate for patient's wishes, whereas on the other end, they only have a supportive role in medical decision-making process. A recent synthesis of qualitative studies describing registered nurses' experiences with MAiD from Belgium, the Netherlands, and Canada showed that while the nurses played a central role in providing important 'wrap-around' care for patients and family, their participation in MAiD required significant moral work (13).

A recent scoping review exploring the challenges faced by HCPs while handling MAiD requests found lack of clear guidelines/protocols, role ambiguity, difficulties in evaluating capacity/consent, conscientious

objection, lack of inter-professional collaboration and difficulties in assessing nature and severity of suffering as major barriers in developing comprehensive care models for implementation of MAiD (14). Furthermore, the scoping review also pointed out that HCPs need substantial degree of time and emotional commitment to participate in a MAiD request. A scoping review and thematic meta-synthesis of qualitative studies exploring HCPs' attitudes towards assisted death practices in Belgium, Netherlands, Israel, Australia, Germany and the USA showed that their attitudes were shaped by a deep sense of moral responsibility and contextual care-relationships (15).

This empirical evidence provides valuable insights on experiences and attitudes of HCPs towards MAiD; however, the nature and extent of emotional impact remains unexplored. Preliminary evidence suggests that the shift away from the medicine's fundamental values of cure/control of disease to hastening death with the aim of alleviating intolerable suffering can have significant emotional effects on participating HCPs. These can range from feeling overwhelmed with a sense of powerlessness on one end, to a rewarding and a positive experience on the other (16, 17).

Objectives: To determine the emotional impact on HCPs involved in MAiD.

Methods:

Search strategy, screening and eligibility criteria:

The inclusion and exclusion criteria were developed in line with SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) (18). In order to ensure qualitative richness of themes, we included all qualitative research studies and excluded surveys, personal anecdotes, attitudes and experiences without in-depth qualitative analysis published on this topic.

Relevant definitions: For the sake of this review, we define a Health Care Provider as a person "lawfully entitled under the law of a province to provide health services in the place in which the services are

provided by that person"(19). This definition includes pharmacists, nurses, nurse practitioners, social workers, spiritual health practitioners, psychotherapists and clinical psychologists who are legally authorized to practice within their respective scope of practice. We included 'Assisted suicide assistant' and provider in 'Right to die' societies in Switzerland as unique MAiD care-providers who contact the eligible participant and liaise with the physician and pharmacist in the conduct of MAiD.

For the sake of this review, the term 'MAiD' refers to (20):

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

Eligibility criteria:

- 1) Includes worldwide published literature on the research question in English language, inclusive of all age groups; articles published up to April 30, 2021.
- 2) Includes all qualitative studies evaluating the emotional impact through qualitative research methodologies like grounded theory, semi-structure interviews, narrative inquiry or others, and describes/mentions:
 - a. 'HCPs' and 'MAiD' as defined above

- o. The emotional impact on HCPs in terms of emotions /affective responses experienced or expressed while accessing, discussing, participating or caring for the patient who has made a valid MAiD request.
- Excludes case studies, anecdotes or studies without a description or mention of a rigorous qualitative research methodology.

Search strategy:

An iteratively developed search strategy was developed and piloted with the help of 3 librarians with expertise in systematic review search strategies. Considering the inter-disciplinary nature of the objective, the search strategy was conducted on OVID Medline), CINAHL, EMBASE and SCOPUS databases. The search terms included three main domains—MAiD, HCPs and qualitative research methodology and their synonyms. Full search strategy on the 4 databases is available in supplementary appendix 1.

In addition to database searches, the study team conducted a grey literature search (21) which was informed by search methods outlined by Godin et al (22), using the same search terms and their synonyms. Grey literature was retrieved between December 10, 2018, and March 1, 2019, and updated on August 10, 2020, and August 10, 2021, from:

- (1) Databases including Google scholar, the Canadian electronic library and the Canadian Institute for Health Information and
- (2) OpenGrey, BASE (Bielefeld Academic Search Engine) and the OAIster catalogue of open access resources that includes digital thesis sources like the WorldCat.

The grey literature search strategy and results are included in supplementary appendix 1. For the purpose of feasibility, reports from the year 2000 and beyond were retrieved. In addition, backward citation tracking was conducted by hand searching the reference lists of all included papers.

Study selection process:

All identified records were imported into the reference management software, Zotero and duplicates removed by the lead researcher (SD). 20% of the title and abstracts of peer reviewed records were independently screened by two reviewers (AS and AB) based on the eligibility criteria; SD screened the remaining 80% for eligibility and reviewed the results with AS and AB in regular team meetings. Given that a substantial portion of grey literature did not include abstracts, the grey literature screening process was initiated at the full-text phase. SD consulted the keywords of yielded academic records if the title and abstract lacked clarity in relation to core concepts and reviewers AB and AS independently assessed any records for any discrepancy and/or uncertainty regarding their inclusion. The researchers met at the beginning, middle and end of the screening process to ensure consistency. SD, AS and AB independently screened the full texts of the academic and grey literature, applying the same inclusion and exclusion criteria in successive team meetings to resolve any discrepancies.

Patient and Public involvement: No patients involved.

Assessment of risk of bias:

We used the Joanna Briggs Institute Critical appraisal tool for use in systematic reviews: checklist for qualitative research to critically appraise the included studies over 10 constructs. These constructs range from congruency to philosophical construct to theoretical and cultural location of the researcher (23). The results of the assessment of risk of bias were independently reviewed by AB and AS and are presented in detail in supplementary appendix 2.

The search results and reasons for exclusion at each stage of screening were recorded and represented in the adapted Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) flow diagram in Figure 1.

Data Analysis:

Data Extraction and Data analysis:

We adopted a thematic synthesis approach to analyze and synthesize data. Thematic synthesis is an adaptation of thematic analysis and provides a set of established methods and techniques that help synthesize qualitative research outcomes, especially when there is heterogeneity in the outcome variables (24). This approach is especially useful in our case since it enables us to examine the meaning, significance and social constructions around the emotional experience of a HCP involved in MAiD. SD independently coded each line of text according to its meaning and content. Codes were listed as 'free' codes, without any hierarchical structure. AB and AS cross-checked the coded data for any discrepancy. Subsequent thematic synthesis was done by SD, AB and AS in the following 2 stages:

Stage 1: Identifying the similarities between the codes.

All relevant qualitative data from the selected studies were extracted manually from the results, discussion and conclusion section and are represented in Table 2 of supplementary appendix 3. The codes were inductively grouped into descriptive themes so that patterns could be identified.. The use of line-by-line coding enabled us to undertake translation of concepts from one study to another. Based on the similarities and differences of emerging codes, descriptive themes were generated, and each theme was entered as boxes and codes from each study illustrated in those boxes, so that constant comparison analysis process could be done (see Table 3 in supplementary appendix 3).

Stage 2: Development of analytic themes.

In this last stage, the descriptive themes were further interpreted using reciprocal translation and constant comparison methods to develop analytic themes. At this stage, the meaning of the patterns of

Once thematic synthesis was completed, each researcher independently evaluated the cumulative evidence from individual studies for methodological limitations, relevance, coherence and adequacy using the Confidence in the Evidence from reviews of qualitative research (CERQual) approach (see table 1) (25). All researchers met during regular research-review meetings to resolve any discrepancies and achieve consensus over the assessment.

This systematic review was a part of an academic capstone project and was not registered with any international database. The review protocol is available from the research team on request.

In addition to employing the PRISMA Checklist for systematic reviews, we used the Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) checklist to improve the reporting of our meta-synthesis (see supplementary appendix 4).

Results:

Characteristics of included studies:

35 qualitative research studies were included in the review. The included literature was based in 5 countries: The United States of America [7], The Netherlands [9], Canada [14], Belgium [1], Switzerland [3], and one study was an international study with participants from the United States of America and Netherlands. The data included 393 physicians, 169 nurses, 53 social workers in hospice care, 11 allied health care professionals (7 personal support workers, 1 pharmacist, 1 genetic technologist and 2 psychologists) and 8 directors of socio-medical institutions and 3 socio-cultural animators (applied sociologists who work along side communities at grass roots to develop and facilitate programs that

support action for local and social change). A detailed description of the included studies is included in Table 2 of supplementary appendix 3.

Thematic synthesis:

Stage 1: Descriptive themes:

Three descriptive emotional themes were derived from the thematic synthesis:

<u>Dimension 1: Strong, internalized and polarized emotions (studies referenced 26-36)</u>: These included three subordinate categories/genres of:

- Positive emotions of 'reward', 'relief', 'active openness', 'overwhelming but uplifting' feelings;
- Negative emotions of 'powerlessness', 'guilt', 'emotional exhaustion', 'vicarious suffering' and fear of a slippery slope and losing control and

Individual conscience-based emotions of 'moral shudder' and moral distress. This emotional dimension was strongly embedded in the cultural and political milieu and the interpersonal communication strategies used by the HCP.

<u>Dimension 2: Reflective, discourse-based emotions (studies referenced 26,30,36,37-45)</u>: These included emotions of 'growing with the patient's experience', MAiD as a 'sense-making process', 'de-tabooing the philosophical meaning of death through MAiD' and various degrees of 'dynamic conflict' secondary to a reflective sense of insecurity. These emotions were descriptively laid on a platform of 'interpretative therapeutic engagement', where they seemed to aid in the larger philosophical and societal discourse around MAiD (46).

<u>Dimension 3: Emotions that resonate with professional values (studies referenced 28,30,34,39,47-61)</u>:

These included emotions that resonated with professional values like 'competency and perfection',

'intimate care', 'colloque singuliar' (singular language of trust and conscience in context of therapeutic relationship) and various degrees of commitment ranging from 'contractual' to 'sacrificial'.

Table 1 illustrates some of the quotes demonstrating of the descriptive emotional themes.

Table 1: Descriptive themes and illustrative quotes:

	T .		
Descriptive Theme		Illustrative quotes	Country/Reference
Strong, internalized, and polarized emotion theme	Positive emotions.	I think when you see the patients that we see, it's very clear that you're doing an incredible service. And that's wonderful. There isn't a single moment when I see these patients that I don't think, "Oh my God, I'm so happy to be here to help you." So that's tremendously reinforcing"	Canada/Shaw et al., 2018, p.e397.
	Negative emotions	"It was terribly creepy, I never went anywhere with as much lead in my shoes as that morning when I took my bag with the medication in it (T, male)."	Netherlands/ van Marwijk H et al. 2007, p611.
	Moral distress	"There is just a standard that I have. I could not live with myself if I knew that I broke one of the Ten Commandments. I don't feel that I have the right to do that. I will say that there have been times when I would have liked to do that And there have been times when I've thought about it, and maybe I got right up to the edge. But I wouldn't – I couldn't go over the line"	USA/Judith Schwarz, 2004, p.229
Reflective emotion's theme		"I shy away from saying suicide or euthanasia. The act of it, however we name it, calls for the most profound respect as the consequence is that a heart stop beating, lungs stop breathing, forever. I am working and sense making as I go along, being sure that I keep breathing."	Canada/ Beuthin R., 2018, p1684
Professional values-driven emotional theme		"Patients have the right to make as many decisions as they are able to make for themselves, and we respect those even though they may not be the same decisions that we might make and we will	

advocate for the patients to get them	
whatever they want I believe in self-	
determination, but I think it's (PAS) a sad	
commentary on our society." (Social	
Worker)	

Stage 2: Analytic themes

Analytic themes in thematic synthesis typically 'go beyond' the findings of the primary studies and generate additional concepts, understandings or hypothesis. At this stage, we used the descriptive themes to answer the review question as to how and why did the HCPs participating in MAiD experience such complex emotions. Each reviewer, initially independently and then as a group, inferred the factors that likely influence the experience of the descriptive themes by questioning how HCPs participating in MAiD represent themselves, or their emotions in the context of their larger health care environment. This process was repeated until the new themes were sufficiently abstract to explain all our initial descriptive themes. Altogether, this process resulted in generation of 2 analytical themes:

1. Legislative emphasis on terminal illness as a necessary inclusion criterion for MAiD influences the emotional impact: In jurisdictions that legislate MAiD with the central aim to alleviate intolerable suffering in context of terminally ill medical conditions (example the USA), the HCPs experience strong polarized emotions that are modulated by their individual cultural/religious background. The extent of emotional impact ranges from positive emotions of reward/relief on one end, to negative (burden, emotional exhaustion) and conscientious based moral distress on the other. This is in sharp contrast to the emotional impact on HCPs in jurisdictions that legislate MAiD with an emphasis on alleviating intolerable suffering without terminal illness being a necessary requirement (for example Benelux countries, Switzerland, and more recently, Canada). The HCPs in these jurisdictions experience the emotional impact of MAiD as a 'sense-making' process—this

allows them to reflect on the emotional dissonance between basic emotions and emotions that conform to legislative rules.

2. Values associated with the HCPs' profession and their degree of engagement in the MAiD process are strong influential factors that shape the emotional impact of MAiD. For example, because of their everyday involvement with patients and emphasis on professional values of helping others, compassion and patient advocacy, the emotional impact on nurses involved in MAiD (studies referenced 28, 30, 34-36, 39, 41, 42, 45, 53, 55, 57, 60, 61) demonstrated strong, polarized positive as well as negative emotions. As one nursing participant noted, "...it's the hardest nursing. I've worked [in the emergency department], I've worked medicine floor, this is the hardest nursing there is, having somebody pass away, you actually feel something pulled out of you when that person passes. There's something missing. ... If you take care of somebody for an extended time and they pass away, you just feel, I just feel coldness, or whatever. You just feel drained (36, p57).

Appraising the quality of evidence-the GRADE CERQual approach:

Evidence from qualitative evidence syntheses is increasingly incorporated into decision-making processes and the GRADE CERQual approach allows the user to make a transparent assessment of how much confidence decision-makers and other users can place in individual review findings from syntheses of qualitative evidence. In order to ascertain the degree of confidence, we graded the evidence in terms of adequacy, relevance, coherence as well as methodological limitations using the GRADE CERQual approach (25). Table 2 illustrates a summary of the findings and the GRADE CERQual profile.

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2							
Summary finding 5 6 7 8 9 10 11 12 13 14	Studies contributing substantially to the summary theme (studies numbered as per Table 2 in supplementary appendix 3)	Methodological Limitations	Coherence	Adequacy	Relevance	GRADE evidence	Explanation of CERQual assessment
16HCPs 17 experienced 18 strong, 19 20 internalized, 21 often polarized 22 and deeply 23 24 personal basic 25 emotions that 26 were modulated 27 by the HCP's 28 29 cultural and/or 30 religious 31 background. 32 33 Level embedded: 34 35 cultural/religious 36 37 38 39	1,2,3,5,13,18, 19,21, 24,26,28.	Minor methodological limitations concerning location of the researcher theoretically/ culturally, And influence of the researcher on the research and vice versa	Moderate concerns regarding coherence	Minor concerns regarding adequacy	No or very minor concerns regarding relevance	High	Variability in experiences of participants posed a challenge with respect to coherence, however, this also added to the richness of results. Hence, we have graded the confidence in quality of findings as high.
40 Influenced by the 41 socio-political 42 environment as 43 44 well as the social 45 discourse on 46 suffering and 47 48 death, HCPs 49 shared emotions 50 of personal 51 growth/sense- 52 making and 54 relational 55 experiences of 56	2,5,6,8,11,14, 23,25, 28,30, 32, 34.	Moderate/min or methodological limitations concerning location of the researcher theoretically/ culturally, and influence of the researcher on the research	No or very minor concerns regarding coherence	No or very minor concerns regarding adequacy	No or very minor concerns regarding relevance.	High	Paper 6 did not approach the ethics committee and hence does not have ethics committee approval. Apart from this study, all studies in this group

1

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2							
3 deeper		and vice versa					contributed to
compassion and							the summary
6 sympathy. HCPs							findings in
⁷ also experienced							terms of
emotional							coherence,
10 dissonance over							adequacy and
11personal							relevance.
¹² emotions and							Hence, we
13 14 emotions							have graded
15expressed to							the
¹⁶ conform to							confidence in
17 18 legislative rules.							the quality of
10		O_{λ}					the findings to
20 Level embedded:							be high.
21 Socio-political							
22 23HCPs expressed	3,4,5,7,9,10,12,	Moderate	minor	No or very	No or very	Moderate	Most of the
	15, <u>16</u> ,	Methodological	concerns	minor	minor	Wiederate	studies in this
24 emotions aligned 25 26 with their	17,20,22,24,27,	limitations	regarding	concerns	concerns		group had
27individual	29,31, 33,35.	concerning	coherence	regarding	regarding		methodologic
²⁸ professional	25,51, 55,55.	location of the	concrence	adequacy	relevance		al problems of
29 30 values and		researcher		aucquacy	relevance		selection bias
30 beliefs systems		theoretically/c					and lack of
32and, most of the		ulturally, And					generalizabilit
33times, attempted		influence of		\bigcirc			y. For
34 35 to align their		the researcher		1			example,
36 values associated		on the research					paper 16
³⁷ with the MAiD		and vice versa.					selected
38 39ideology; at		Also, selection					participants
40other times,		of participants		•			from a single
41legislation of		Paper 16, one					hospital-based
		single hospital.					setting. The
42 43 44 jurisdictions		amgra maquam					findings are
45helped shape							limited in
							terms of
46 emotional 47 48 experiences. 49							generalizabilit
48 ' 49							y to similar
50							groups in
51							different
52 Level embedded : 53Professional/							settings.
54 _{logal}							Hence, we
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5 6 57		<u>I</u>	I	I	I	l	
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2				
3				down our
4				confidence in
6				the quality of findings to moderate.
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8				moderate.
10				

Discussion:

Difference in MAiD legislation in Benelux and Non-Benelux countries-key features:

The substantive and procedural requirements for MAiD across global jurisdictions rests on 3 main pillars: patients' right for self-determination expressed through voluntariness of request and a valid, informed consent process, foreseeableness of natural death due to terminal medical illness and subjective nature of individual suffering (62,63). The key difference between the legislations for MAiD in Benelux countries and countries like the USA is the differential emphasis on eminent or foreseeableness of death. The MAiD legislations in Belgium, Netherlands, Switzerland, and, more recently Canada have a more permissive legal framework that allows people to access MAiD as a service to end their intolerable suffering that has no prospect of improvement but is not necessarily terminal.

MAID Legislation and its shaping effect on the emotions of the involved HCP:

An important take home message from this evidence synthesis is how legislations have a shaping effect on emotional responses. The HCPs who practice in the Benelux countries and Switzerland seem to experience more reflective emotions over strong polarizing emotions expressed by HCPs who practice in non-Benelux countries like the USA. Canada seems to have a unique, transitional position—with the emphasis of the legislation going the Benelux countries' way, the HCPs emotional experiences show a mixture of emotions driven by their professional values as well as the ongoing societal discourse on MAiD. This observation conforms to Michel Foucault's position on how law acts as an element in the expansion

of power(s) (64); legislatures along with other platforms of knowledge expression modulate every fiber of human society. Our thematic synthesis points out that the Law that limits application of MAiD to terminally illnesses provide for a broader range of emotional expression. Thus, legislation on MAiD across the globe provides the HCP with a locus of administrative control which then decides how the emotional discourse around MAiD is shaped; the question is—how do we want the emotional discourse around MAiD to be shaped?

MAID legislation, societal values, and emotional impact on the involved HCP: A complex relationship.

On one end, attitudes of physicians towards MAiD has shown reflective trends to legislative standards; countries like Belgium and Netherlands find much stronger physician support than their USA counter parts (65). On the other end, public support towards MAiD has been reflective of the prevailing societal cultural and religious practices; central and eastern European countries have shown a decline in support with corresponding increase in religiosity as opposed to western European countries (66,67). While an assisted-death legislation with its rules and safeguards provides an obligatory, 'top-down' framework to embed MAiD within health care, it does not necessary reflect the integration of MAiD within the value-based relationships that have traditionally defined an individual's health care (68). Hence, although a MAiD legislation to integrate MAiD into health care is a likely reflection of a consensus position of a society, it does challenge the moral environments within which HCPs practice medicine, thereby influencing the emotional impact on HCP. HCPs subsequent attempt to align themselves with their own professional values, legislative standards and public perceptions can lead to intense emotional responses, both, within their internal, personal and their external professional spaces.

Emotional discourse amongst HCPs involved in MAiD: HCP role and ethics of Care

The right to choose when and how to die has always been a contentious issue across various societies (69-71). Public discourse on MAiD are shaped through societal emphasis on individual as well as contextual factors associated with assisted death—these often range from religious beliefs regarding sanctity of human life and personal meaning of death to loss of autonomy associated with illness-related intolerable suffering. With advancing medical technologies, the potential to prolong life has increased significantly (72,73), and the HCPs assumes a central position to shape the discourse around assisted death.

In countries where MAiD is legalized but is restricted to terminal illnesses with imminent chance of death, the position of a HCP continues to be one that of a provider of 'Care'. Here, the moral dimension of 'Care' continue to be defined as 'everything we do to maintain, continue or repair our world so that we can live in it as well as possible' (74). The value of care in health care systems have been traditionally associated with attentiveness, responsibility, nurturance, compassion and meeting others' needs (75). While emotional responses to legal requests of hastening death is affected by policies, professional identity, commitment to patient autonomy, personal values and beliefs, the patient-clinician relationship and will vary on a case-by-case basis (76), this systematic review raises an important question—How does legalizing MAiD with emphasis on alleviating intolerable suffering without the context of a terminal illness change the moral dimensions of Care?

Conclusion:

HCPs involved in MAiD experience a myriad of emotions that includes positive/negative emotions, reflective, 'sense-making' emotions and/or professional value driven emotions. Emphasis on terminal illness only as an essential criterion, MAiD practitioner's individual professional values and their degree of engagement influence this rich and diverse emotional discourse.

Limitations of the review:

This review is limited by its focus of emotional impact on HCPs only and the obvious selection bias in the included studies—those who could and volunteered to express their emotions are represented in the review. The review is also limited with absence of sub-group analysis with respect to HCPs' age, years of experience and the influence of gender on the results. Restriction to English language studies likely carries a high risk of publication bias.

There are several gaps in our understanding of the emotional impact on HCPs involved in MAiD that would benefit from further research. Intolerable suffering is a common eligibility requirement for assisted death, although HCPs often struggle to understand and assess the nature and normative function of suffering. Is it the very nature of the emotional tone of suffering which is overwhelming or is it more to do with what lies underneath that makes suffering 'intolerable'? Is there room for humanistic narratives around meaning behind and endurance of one's suffering? Such questions confront MAiD practitioners and an indepth exploration of this nebulous concept of intolerable suffering in context of assisted death may help HCPs navigate their emotional experience while providing MAiD.

Ethics statement: This is a systematic review and meta-synthesis of already published and accessible research data and does not require ethics committee or Institutional board approval.

Acknowledgements: The authors acknowledge the valuable contribution of Erica Lenton, Heather Cunningham (Library services, Gerstein's library, University of Toronto) and Fiona Inglis (Library services, Center for Addiction and Mental Health, University of Toronto) for consultations and assistance with devising the search strategy.

Contributorship Statement: The authors confirm contribution to this systematic review and metasynthesis as follows:

study conception and design: Dr. Saumil Dholakia, Dr. Alireza Bagheri, Dr. Alexander Simpson.

- development of eligibility criteria: Dr. Saumil Dholakia, Dr. Alireza Bagheri and Dr. Alexander
 Simpson.
- search strategy developed by Erica Lenton, Heather Cunningham (Library services, Gerstein's library, University of Toronto) and Fiona Inglis (Library services, Center for Addiction and Mental Health, University of Toronto) in close consultation with Dr. Saumil Dholakia and reviewed by Dr. Alireza Bagheri and Dr. Alexander Simpson.
- Study selection and data extraction process by Dr. Saumil Dholakia and independently reviewed by Dr. Alireza Bagheri and Dr. Alexander Simpson.
- Dr. Saumil Dholakia performed the assessment of risk of bias, which was independently reviewed by Dr. Alireza Bagheri and Dr. Alexander Simpson.
- All three authors were involved equally in performing the qualitative meta-synthesis and
 CERQual assessment.
- Draft manuscript preparation: Dr. Saumil Dholakia with multiple reviews, feedback and edits in form as well as content by Dr. Alireza Bagheri and Dr. Alexander Simpson.
- All authors reviewed the results and approved the final version of the manuscript.

Competing interests: The authors disclose no competing interests.

Funding Acknowledgment: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Data sharing: Data set "Codes and themes-qualitative analysis_MAiD_HCP_emotional impact" submitted and published at ZENODO and is available at DOI: 10.5281/zenodo.6778236

No unpublished data.

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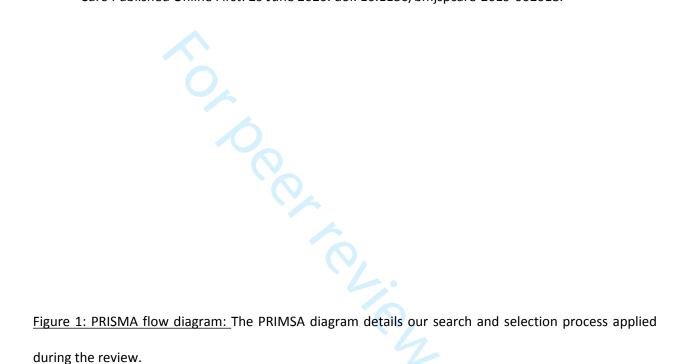
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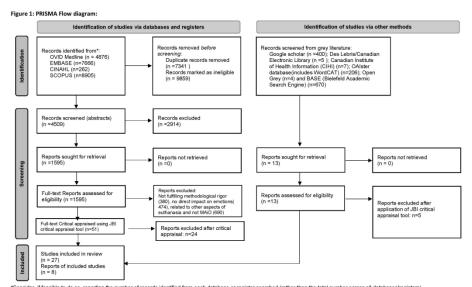
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Consider, it reasilise to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers). ""If automation tools were used, indicate how many records were excluded by a human and how many were excluded by a utomation tools."

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit http://www.prisma-statement.org/

Caption: Figure 1: PRISMA flow diagram: The PRISMA diagram details our search and selection process applied during the review.

296x210mm (250 x 250 DPI)

Supplementary appendix 1:

Database: Ovid MEDLINE(R) ALL <1946 to October 04, 2021>

Search Strategy:

- 1 euthanasia, active/ or euthanasia, active, voluntary/ or hospice care/ or suicide, assisted/ (14808)
- 2 terminally ill/ (6684)
- 3 Right to die/ (4950)
- 4 Terminal care/ (29907)
- 5 advance care planning/ or advance directives/ (9125)
- 6 ((dying or death or euthan* or suicide or terminal* ill*) adj5 (assist* or hasten*)).tw,kf. (5952)
- 7 Palliative care/ (58012)
- 8 exp Practice Patterns, Physicians'/es [Ethics] (812)
- 9 physician's role/ (30584)
- 10 Health Personnel/ (52294)
- 11 ((health care provider or clinician* or doctor* or physician* or nurse or social work* or oncologist* or palliative physician or nursing or psychiatrist* or psychologist* or psychotherapist*) adj3 (experience* or emotion* or feeling*)).tw,kf. (23976)
- 12 (Interview: or experience:).mp. or qualitative.tw. (1655368)
- health personnel/ or allied health personnel/ or anesthetists/ or caregivers/ or case managers/ or "coroners and medical examiners"/ or emergency medical dispatcher/ or epidemiologists/ or faculty, medical/ or faculty, nursing/ or health educators/ or health facility administrators/ or medical chaperones/ or medical laboratory personnel/ or medical staff/ or exp nurses/ or nursing staff/ or occupational therapists/ or personnel, hospital/ or pharmacists/ or physical therapists/ or physician executives/ or exp physicians/ (431546)
- 14 (ethnograph* or grounded theory or qualitative research or thematic analysis or semi-structured interview* or narrative inquiry or focus* group or content analysis or discourse or lived life experience*).tw,kf. (156494)
- 15 aid in dying.mp. (243)
- 16 death with dignity.mp. (607)
- 17 Bill C-14.mp. (24)
- 18 Bill C-7.mp. (2)
- 19 MAID.mp. (458)
- 20 physician assisted death.mp. (309)
- 21 physician assisted dying.mp. (142)
- 22 (assisted suicide or physician assisted suicide).tw,kf. (3163)
- 23 Qualitative Research/ (67825)
- 24 1 or 2 or 3 or 4 or 5 or 6 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 (55486)
- 25 7 or 8 or 9 or 10 or 11 or 13 (527655)
- 26 12 or 14 or 23 (1692068)
- 27 24 and 25 and 26 (5490)
- 28 limit 27 to dt=19460101-20210430 [January 1st, 1946 to April 30th, 2021] (5441)
- 29 limit 28 to english language (5073)
- 30 limit 29 to abstracts (4876)

Grey Literature databases (December 10th 2018 to March 1st, 2019, updated August 2020 and 2021)

Total # Records after de-duplication: 13. Records selected after applying critical appraisal tool 8.

Database	Search strategy	#records screened	# new records and records after de-duplication and
			applying the critical appraisal tool
Google scholar	With the exact phrase: "Medical assistance in dying"; "physician assisted suicide"; With all the words: "emotional impact on health care providers involved in medical assistance in dying"	400	5
Des Lebris/Canadian Electronic Library	Medical assistance in dying	5	0
Canadian Institute of Health Information (CIHI)	Medical assistance in dying	7	0
OAIster database (includes WordCAT)	Medical Assistance in dying, Physician assisted suicide as key word	206	2
OpenGrey	Medical assistance in dying, Physician Assisted suicide as key word	4	0
BASE (Bielefeld Academic Search Engine)	Subject Heading search: "Medical Assistance in dying"	670	1

Selected records:

Google scholar included Results:

- 1. Beuthin R. Cultivating Compassion: The Practice Experience of a Medical Assistance in DyingCoordinator in Canada. *Qualitative Health Research*. 2018;28(11):1679-1691. doi:10.1177/1049732318788850
- 2. Bouthillier M-E, Opatrny L. A qualitative study of physicians' conscientious objections to medical aid in dying. *Palliative Medicine*. 2019;33(9):1212-1220. doi:10.1177/0269216319861921
- Bruce A, Beuthin R. Medically Assisted Dying in Canada: "Beautiful Death" Is TransformingNurses' Experiences of Suffering. Canadian Journal of Nursing Research. June 2019. doi:10.1177/0844562119856234
- 4. Alison A. Townsley. Putting a Bow on Death and Dying-Health Care Professionals' Experiences with Medical Assistance in Dying (MAiD): A Foucauldian Discourse Analysis with Agambian Insights. [Practice Based Research Paper on the Internet]. York University School of Social Work;2018. [Cited February 28,2019] Available from: https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/35613/Alison_Townsley_PRP 2018.pdf?sequence=1
- 5. Gamondi C, Borasio GD, Oliver P, Preston N, Payne S. Responses to assisted suicide requests: aninterview study with Swiss palliative care physicians. BMJ Support Palliat Care. 2019 Mar;9(1):e7. doi: 10.1136/bmjspcare-2016-001291. Epub 2017 Aug 11. Available from https://pubmed.ncbi.nlm.nih.gov/28801317/

OAIster included Results:

- 1. Implementing Medical Aid-in-Dying in Vermont: a Qualitative Study. *J GEN INTERNMED* **34,** 636–641 (2019). https://doi.org/10.1007/s11606-018-4811-1
- Allyson Oliphant. "If Not Me, Then Who?" The Narratives of Medical Aid in Dying (MAiD) Providers and Supporters Around Their Professional Identity and Role in MAiD [Thesis on theInternet]. MacMaster University; 2017. [Cited on February 10, 2019]. Available from http://hdl.handle.net/11375/22146

BASE included results:

1. Sheridan, Laura, "When Patients Ask to Die: The Role of Nurses in Medical Assistance in Dying" (2017). Electronic Thesis and Dissertation Repository. 5041. https://ir.lib.uwo.ca/etd/5041

Database:

Embase <1974 to 2021 April 30>

ı	ase <1974 to 2021 April 30>	
#	Query	Results from search strategy run on October 4, 2021
1	euthanasia, active/ or euthanasia, active, voluntary/ or hospice care/ or suicide, assisted/	18,815
2	terminally ill/	8,339
3	right to die/	4,060
4	terminal care/	38,968
5	advance care planning/ or advance directives/	13,209
6	((dying or death or euthan* or suicide or terminal* ill*) adj5 (assist* or hasten*)).tw,kf.	7,430
7	palliative care/	83,687
8	exp clinical practice/ and medical ethics/	5,575
9	physician's role/	49,149
10	health personnel/	168,037
11	((health care provider or clinician* or doctor* or physician* or nurse or social work* or oncologist* or palliative physician or nursing or psychiatrist* or psychologist* or psychotherapist*) adj3 (experience* or emotion* or feeling*)).tw,kf.	34,589
12	(interview: or experience:).mp. or qualitative.tw.	2,361,122
13	health personnel/ or allied health personnel/ or anesthetists/ or caregivers/ or case managers/ or "coroners and medical examiners"/ or emergency medical dispatcher/ or epidemiologists/ or faculty, medical/ or faculty, nursing/ or health educators/ or health facility administrators/ or medical occupational therapists/ or personnel, hospital/ or pharmacists/ or physical therapists/ or physician executives/ or exp physicians/	1,402,853
14	(ethnograph* or grounded theory or qualitative research or thematic analysis or semi-structured interview* or narrative inquiry or focus* group or content analysis or discourse or lived life experience*).tw,kf.	203,129
15	aid in dying.mp.	293
16	death with dignity.mp.	655
17	Bill C-14.mp.	32
18	Bill C-7.mp.	4
19	MAID.mp. For peer review only - http://bmjopen.bmj.com/site/about/guidelines	667

1	BMJ Open	
20	physician assisted death.mp.	365
21	physician assisted dying.mp.	171
22	(assisted suicide or physician assisted suicide).tw,kf.	3,620
23	qualitative research/	98,864
24	1 or 2 or 3 or 4 or 5 or 6 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22	73,993
25	7 or 8 or 9 or 10 or 11 or 13	1,525,230
26	12 or 14 or 23	2,406,823
27	24 and 25 and 26	8,659
28	limit 27 to (abstracts and english language and yr="1946 - 2021")	7,666
MY		



CINAHL search strategy: Monday, October 4, 2021 3:59:32 PM

# Query	Limiters/Expanders	Last Run Via	Results
S25 S22 AND S23 AND S24	Limiters - Published Date:	Interface - EBSCOhost	Display
19460401-20210430;		Research Databases Search Screen - Advanced Search	
Exclude MEDLINE records; Publ	lication Type: Abstract; Language: English	Database - CINAHL	
Expanders - Apply related word	ds; Apply equivalent subjects		
Search modes - Boolean/Phrase	e		
S24 S10 OR S12 OR S21	Expanders - Apply related	Interface - EBSCOhost	Display
words; Apply equivalent subjec	ts	Research Databases Search Screen - Advanced Search	
Search modes - Boolean/Phrase	e	Database - CINAHL	
S23 S6 OR S7 OR S8 OR S9	Expanders - Apply related	Interface - EBSCOhost	Display
OR S11	words; Apply equivalent subjects	Research Databases Search Screen - Advanced Search	
	•		
	Search modes - Boolean/Phrase	Database - CINAHL	
Forp	peer review only - http://bmjopen.bmj.com/sit	te/about/guidelines.xhtml	

1 2	S22	(S1 OR S2 OR S3 OR S4	Expanders - Apply related words; Apply equivalent	Interface - EBSCOhost Research Databases Search	Display
3	OR S5	OR S13 OR S14 OR S15 OR S16 OR	subjects	Screen - Advanced Search	
4 5 6 7 8	S17 OF	R S18 OR S19 OR S20)	Search modes - Boolean/Phrase	Database - CINAHL	
9	S21	qualitative research Expande	rs - Apply related	Interface - EBSCOhost	Display
10 11 12	words	; Apply equivalent subjects		Research Databases Search Screen - Advanced Search	
13	Search	modes - Boolean/Phrase		Database - CINAHL	
14 15					
16	S20	TX (assisted suicide or	Expanders - Apply related	Interface - EBSCOhost	Display
17 18		ian assisted suicide)	words; Apply equivalent	Research Databases Search	Display
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Search modes - Boolean/Phrase	Search		
Scarett modes Booleany i mase	Database	e - CINAHL	
S19 physician assisted dying Expander	rs - Apply related	Interface - EBSCOhost Research Databases Search	Display
words; Apply equivalent subjects		Screen - Advanced Search	
Search modes - Boolean/Phrase		Database - CINAHL	
S18 physician assisted death E	xpanders - Apply related	Interface - EBSCOhost Research Databases Search	Display
words; Apply equivalent subjects		Screen - Advanced Search	
Search modes - Boolean/Phrase		Database - CINAHL	
S17 MAID Expanders - Apply related subjects Search modes - Boolean/Phrase	d words; Apply equivalent	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
Search modes - Booleany Fili ase		Database - CINAHL	
S16 Bill C-7 Expanders - Apply related subjects	d words; Apply equivalent	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
Search modes - Boolean/Phrase		Database - CINAHL	
S15 Bill C-14 Expanders - Apple equivalent subjects	y related words; Apply	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
Search modes - Boolean/Phrase		Database - CINAHL	
S14 death with dignity Expander words; Apply equivalent subjects	rs - Apply related	Interface - EBSCOhost Research Databases Search	Display
Search modes - Boolean/Phrase		Screen - Advanced Search Database - CINAHL	
S13 aid in dying Expanders - Apple equivalent subjects Search modes - Boolean/Phrase	y related words; Apply	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
Search modes Booleany i mase		Database - CINAHL	
S12 TX (ethnograph* or grounded theory or qualitative research or	Expanders - Apply related words; Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen - Advanced	Display
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thematic synthesis or semi-structured interview* or narrative inquiry or focus* group or content analysis or discourse or lived life experience*)

Search modes -Search

Boolean/Phrase

Database - CINAHL

S11 health personnel or allied health personnel or anesthetists or caregivers or case managers or "coroners and medical examiners" or emergency medical dispatcher or epidemiologists or faculty, medical or faculty, nursing or health educators or health facility administrators or medical chaperones or medical laboratory personnel or medical staff or nurses or nursing staff or occupational therapists or personnel, hospital or pharmacists or physical therapists or physician executives or physicians

Expanders - Apply related words; Apply equivalent subjects

Search modes -

Boolean/Phrase

Interface - EBSCOhost Research Databases Search Screen - Advanced Search

Database - CINAHL

S10 TX (interview: or experience:) or qualitative

Expanders - Apply related words; Apply equivalent subjects

Search modes -Boolean/Phrase Interface - EBSCOhost Research Databases Search Screen - Advanced Search

Database - CINAHL

TX ((health care provider or clinician* or doctor* or physician* or nurse or social work* or oncologist* or palliative physician or nursing or psychiatrist* or psychologist* or psychotherapist*) N3 (experience* or emotion* or feeling*))

Expanders - Apply related words; Apply equivalent subjects

Search modes -Boolean/Phrase Interface - EBSCOhost Research Databases Search Screen - Advanced Search

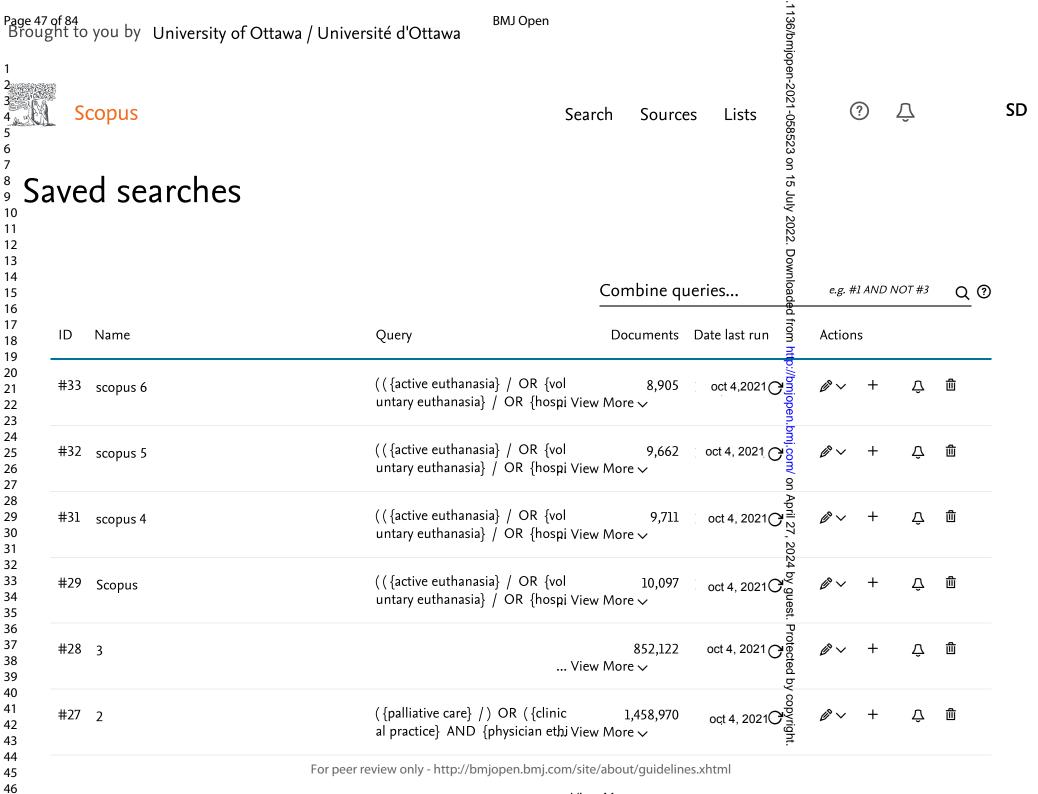
Database - CINAHL

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

	BMJ Open	Late from EDCCOlevel	Page 44
S8 health personnel or healthcare professionals or healthcare workers	Expanders - Apply related words; Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
	Search modes - Boolean/Phrase	Database - CINAHL	
S7 physician role Expanders - Apply equivalent subjects	related words; Apply	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
Search modes - Boolean/Phrase		Database - CINAHL	
S6 practice patterns, physicians AND medical ethics	Expanders - Apply related words; Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
	Search modes - Boolean/Phrase	Database - CINAHL	
SE TV//discondents on the W		Later from EDCCOlored	D'a da
TX ((dying or death or euthan* or suicide or terminal* ill*) N5 (assist* or hasten*))	Expanders - Apply related words; Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
	Search modes - Boolean/Phrase	Database - CINAHL	
advance care planning or end of ife planning or advance directive or advance care plan or advance decision or	Expanders - Apply related words; Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
advance helth care plan	Search modes - Boolean/Phrase	Database - CINAHL	
terminal care or palliative care or end of life care or hospice	Expanders - Apply related words; Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	Display
	Search modes - Boolean/Phrase	Database - CINAHL	
52 terminally ill Expanders - Apply equivalent subjects	related words; Apply	Interface - EBSCOhost Research Databases Search	Display
Search modes - Boolean/Phrase		Screen - Advanced Search	
		Database - CINAHL	
S1 euthanasia or assisted suicide or	or death with dignity	Expanders - Apply related	subjects

Total Number of records from CINAHL search strategy: 262.





ID	Name	Query	BMJ Open	Documents	Date last run 1136/bn	Action	S		Page 48 of 8
#26	1	({active euthanas ntary euthanasia}		127,545	oct 4, 2021 Gen-2021-	Ø~	+	Ţ	ш
#25	terminally ill terminal care	{terminally ill} O e}	R {terminal car	72,266	058523 on	Ø~	+	Ţ	⑪
#24	qualitative research	{qualitative resear	rch}	570,500	oct 4, 2021 Oty 2022	<i>></i>	+	Ŷ	<u> </u>
#23	physician assisted suicide	{physician assiste	d suicide}	1,365	oct 4, 2021 🖰 💆	ØV	+	Û	⑪
#22	physician assisted dying	{physician assiste	d dying}	90	oct 4, 2021 O ht	ØV	+	Û	ш
#21	physician assisted death	{physician assiste	d death}	153	oct 4, 2021	ØV	+	Û	⑪
#20	MAiD	{MAiD}		11,549	oct 4, 2021	<i>®</i> ~	+	Û	⑪
#19	Bill C-7	{Bill C-7}		38	oct 4, 2021 O April 27,	ØV	+	Û	ш
#18	Bill C-14	{Bill C-14}		120	oct 4, 2021 2 by gu	ØV	+	Û	⑪
#17	death with dignity	{death with digni		2,743 ⁄ More >	oct 4, 2021 (3)	ØV	+	Û	⑪
#16	aid in dying	{aid in dying}	Viev	823 / More 🗸	oct 4, 2021 O by 8	ØV	+	Û	⑪
#15	qualitative methods	TITLE-ABS-KEY (OR "grounded th review only - http://b	neory" OR "the	439,839	oct 4, 2021027 13.	<i>®</i> ~	+	Ŷ	â

49 o f (8)4	Name	Query BMJ Open View	v More ✓ Documents	.1136/bn	Actions		
#14	health care provider	TITLE-ABS-KEY ("allied health p ersonnel" OR anesthetists OR	1,203,712	oct 4, 2021 O ct 4, 2021 O ct 4, 2021 O ct 4, 2021	<i>₿</i> ∨ +	Û	ŵ
#13	qualitative interview qualitative study	TITLE-ABS-KEY ("qualitative inte rview" OR "qualitative study")	119,016	٩	<i>₽</i> ∨ +	Ŷ	⑪
#12	health care provider experience	(("health care provider" OR clin ician* OR doctor* OR physicia	85,449	oct 4, 2021 O 2022	<i>Ø</i> ∨ +	Ŷ	⑪
#11	health personnel	{health personnel} /	195,852	oct 4, 2021 O not 4, 2021 O not 4, 2021 O not 4	Ø∨ +	Ŷ	血
		View	v More 🗸	d ed			
#10	physicians role	{physician's role} /	31,290	oct 4, 2021 () from http://www.news.news.news.news.news.news.news.n	<i>®</i> ∨ +	Ţ	쉡
#9	clinical practice physician ethics	{clinical practice} AND {physicia n ethics}	25	oct 4, 2021 Onen.	<i>₿</i> ∨ +	Ŷ	⑪
#8	palliative care	{palliative care} /	185,455	oct 4, 2021 O	<i></i>	Ŷ	血
#7	assisted death	((dying OR death OR euthan* OR suicide OR "terminal* ill*"	v More > 12,119	oct 4, 2021 7 27, 20	<i>&</i> ∨ +	Ţ	ı̈́
#6	advance care planning	{advance care planning} / OR {a dvance directives} /	27,184	oct 4, 2021 O guest.	<i>&</i> ∨ +	Ţ	ŵ
#5	right to die	{right to die} /	8,046	oct 4, 2021 Protecte	<i>₿</i> ∨ +	Ŷ	⑪
#3	active euthanasia	{active euthanasia} / OR {volunt ary euthanasia} / OR {hospice c	38,053	oct 4, 2021 Opyright	<i>8</i> ∨ +	Ŷ	⑪
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Page 49 of **8**4 Name

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of 84						ВМЈ Ор	en				.1136/bmjopen-2021-0585 2 3		
Гable 2: Criti	cal ap _l	praisal of st	udies using 1	Гhe Joanna Bri	ggs Institute	e Critical appra	isal tool fo	or Qualitativ	ve Research:		ר-2021-05852		
Study (location, number and category of Participants)	JBI Check list	b/w philosophy	Q2: Congruity b/w research method and question	Q3:congruity b/w Research method &Data collection	Q4:congruity b/w Research method & analysis	Q5: congruity b/w Research method & Results	Q6: Statement Locating the researcher	Q7: Influence Of Researcher addressed	Q8: Adequate Representa- tion of Participants	Q9:ethical approval	Q10: Conclusion Elows from Enalysis 2022	Appraisal	R for exclusion
1.Voorhees et a and Netherland physicians 23		Υ	Y	Y	Y	Υ	Υ	N	Y	Υ	Downbaded	Include	
2.Van Marwjik e Netherlands 22 Primary care ph		Y	Υ	Υ	Y	Y	N	N	Υ	Unc	from ht	Include	
3. Denier Yyonn 2010. Belgium N n=18		Y	Υ	Y	Υ	Y	N	N	Υ	Υ	from http://bmjopen.bmj.com/	include	
4. Elizabeth Nor al. 2012 USA-social work		Y	Υ	Y	Υ	Y	N	N	Υ	Unc	open.br	include	
5. JJ Georges et 2008. Netherlar GPs		Y	Υ	Y	Υ	Υ	N	N	Υ	Unc	n y .com/	Include	
6. Snijdewind et 2014 (Netherlands, 20 physicians)		Y	Y	Y	Y	Υ	N	N	Y	N	en April 21%,	include	
7. Katja ten Cate 2017-33 physici netherlands		Y	Υ	Y	Υ	Υ	N	N	Y	Y	7 ₇ , 2024	Include	
8. Donald G Var al., 2012. Nethe 15 physicians		Υ	Υ	Y	Υ	Υ	N	N	Υ		by guest.	include	
9. Veronica Lorra Fausto Melchor USA Hospice so worker 8	, 2018.	Y	Y	Y	Υ	Y	Υ	Υ	Υ			include	
10. Pamela Millo al., 2008 Oregoi	n SW-8	Υ	Υ	Y	Υ	Υ	N	N	Υ	Unc	ed by	Include	
11. Deborah Vo al., 2001. USA C Nurse-40		Y	Y	Y	Y	Υ	N	N	Y	Unc	Protected by≽copyright	Include	

12.michael Young et al., 2008 Canada nurses-22	Υ	N	Y	Y	Y	N	N	Υ	Y	-2021-058523 on 15	exclude	Study done at a time assisted death not
										23 on 15 July		legal, so does not meet inclusion criteria.
13. Rosanne Beuthin et al., 2018 Canada nurses-17	Υ	Y	Y	Υ	Υ	N	N	Y	Υ	ly 2022	include	
14.eva Bolt et al., 2017 Netherlands paediatrician-8	Y	Y	YOA	Y	Y	N	N	Υ	NR		Include	
15.Dolores Angela Castelli Dransart et al., 2017 Switzerland-20 nurse, 1 physician, 8 directors, 3 socio- cultural animators.	Y	Y	Y	Deer	Y	N	N	Y	Y	. Downlogded from http://bmjopsp.bmj.c	Include	
16. Marianne Dees et al., 2012 Netherlands-phy-28	Y	Y	Y	Y	Y	N	N	Υ	Υ	∷∦bmjop	include	
17. Theresa Harvath et al., 2006. USA hospice social workers-20	Y	Y	Y	Y	Y	N	N	Υ	Υ	вр.bmj.c	include	
18. Ina Otte et al., 2017. Switzerland GP's-20	Y	Y	Y	Y	Y	N	N	Υ	Υ	am/ on Apsil	include	
19. Ada van de Scheur, Arie van der Arend, 1998 Netherlands Nurse-20	Y	Y	Y	Y	Y	N	N	Y	Unc	27,	include	
20.Belanger E.et al., 2019 Canada-palliative care physicians-18	Υ	Y	Y	Y	Υ	N	N	Υ	Υ	2024 by guest	include	
21. Jessica Shaw et al., 2018. canada phy-8	Y	Y	N	Y	Υ	N	N	Υ	Unc		Include	
22. Judith Schwartz 2004. USA nurses-10	Υ	Y	Y	Y	Y	N	N	Y	Υ	Protected by	include	

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										njopen-2		
23. Dobscha SJ et al., 2004. USA phy-35	Y	N	Y	Y	Υ	N	N	Y	Υ	.1136/bmjopen-2021-0585 <u>2</u> 3	Exclude	No theme of emotional impact.
24. Galusko et al., 2015, Germany 19 specialized palliative care physicians.	Y	Y	Y	Y	Υ	N	N	Υ	Υ	23 on 15	Exclude	Desire to hasten death- definition ambiguous
25. Susanne Brauer et al., 2015. Switzerland, 12 physicians	Y	Y	Y	Υ	Υ	N	N	N	N	勁clear 到y 2022.	Exclude	Opinions known, but no emotional ipact theme
26. Linda (b) Oregon phy-35	N	Y	YOA	Υ	Υ	N	N	Υ	Υ		Exclude	Physician opinion of patients req
27.Deborah-texas nurses-36	N	Y	N	Deer	Υ	N	N	Y	Unc	Downloaded from http	Exclude	No of the nurses participated in assisted suicide in any way
28. D Van Rooyan, Dutch nurses-7	N	N	Y	Y	, 6 h	N	N	Y	N		Exclude	More with withdrawal of treatment does not meet criteria
29. vanderspank canada Nurses	N	N	Y	Y	Y	N	N	Y	Y	://bmjopen.blgj.com/ on April	Exclude	SR on nurses experience with withdrawal of treatment- does not meet criteria
30. Joanne Wolfe USA 324 Oncologists	Y	N	N	Y	Υ	N	N	N	Y	27, 2024 by guest. P	Exclude	Telephone based survey interviews.
31. Booij et al., 2012 Netherlands 15 physicians	Υ	N	Y	Y	Y	N	N	N	Υ	guest. Protected by	Exclude	No particular description of emotional impact
32. Denier et al., 2010 Belgium 18 Nurses	Υ	N	Y	Υ	Υ	N	N	Υ	Υ	y çopyright.	Exclude	More about communicati

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										.1136/bmjopen-2021-0 5 <u>8</u> 52		
										021-0		inclusion criteria.
39. Bernadette 2006 Belgium	Υ	N	Υ	Υ	N	N	Υ	Υ	Υ)5852	Exclude	As above.
40. Veerport et al 2006 USA	Υ	N	Υ	Υ	N	N	Υ	Υ	Υ	350n	Exclude	As above
41. Wright et al., 2017 Canada	Y	N	Y	Y	N	N	Υ	Y	Υ	15 July 2022	Exclude	Data collected in 2012-2013 when MAiD illegal.
42. Curry et al., 2000 USA, Connecticut 909 physicians.	Y	N	YOp	Y	N	N	N	N	Υ		Exclude	Assisted suicide illegal, Plus experiences and no emotional impact
43. Susan Price 2001 USA, 11 nurses and 10 physicians. North Carolina	Y	N	Y	Y	N	N	Y	Y	Υ	Downloaded from http://bmjopen.bm	Exclude	Assisted suicide illegal in North Carolina, hence does not meet inclusion criteria
44. France Norwood 2009 Netherlands	Y	N	Y	Y	N	N	Y	Y	Y	πj.com/ on Apgil	Exclude	No emotional impact. Evaluates absence of abuse
45. Smith et al., 2013 USA, South Mississippi	Y	N	Υ	Υ	N	N	Y	Y	Y	27, 2024 by	Exclude	Assisted death illegal in mississippi and hence does not meet inclusion criteria
46. Beuthin et al., 2020 Canada 8 physicians.	Y	Υ	Υ	Υ	N	N	Υ	Υ	Y	\$ Prote	include	
47. Khosnood et al., 2018 19 physicians, Canada	Υ	Υ	Υ	Υ	N	N	Υ	Υ	Υ	guest, Protected by co	Include	

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 Grey Literature databases (December 10th 2018 to March 1st, 2019, updated August 2020 and August 2021)

Total # Records after de-duplication: 13. Records selected after applying critical appraisal tool: 8.

Database	Search strategy	#records	# new records selected after applying
		screened	after de-duplication and applying critical
	X		appraisal tool
Google scholar	With the exact phrase: "Medical assistance in dying"	400	Downloaded
	; "physician assisted suicide"; With all the words:		'nlo
	"emotional impact on health care providers involved		ade
	in medical assistance in dying"		+
Des Lebris/Canadian	Medical assistance in dying	5	0 0
Electronic Library	· NA		htt
Canadian Institute of Health	Medical assistance in dying	7	0 0 0
Information (CIHI)	CV;		p://bmjopen.bm
OAIster database (includes	Medical Assistance in dying, Physician assisted	206	2 8
WordCAT)	suicide as key word	1	2 .co
OpenGrey	Medical assistance in dying, Physician Assisted	4	0 On Apr
	suicide as key word		₹pri
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Selected records:

Google scholar included Results:

1. Beuthin R. Cultivating Compassion: The Practice Experience of a Medical Assistance in Dying Coordinator in Canada. Quantum Health Research.

2018;28(11):1679-1691. doi:10.1177/1049732318788850

- 2. Bouthillier M-E, Opatrny L. A qualitative study of physicians' conscientious objections to medical aid in dying. *Palliative Medicine*. 2019;33(9):1212-1220. doi:10.1177/0269216319861921
- 3. Bruce A, Beuthin R. Medically Assisted Dying in Canada: "Beautiful Death" Is Transforming Nurses' Experiences of Suffering. Canadian Journal of

Nursing Research. June 2019. doi:10.1177/0844562119856234

4. Alison A. Townsley. Putting a Bow on Death and Dying-Health Care Professionals' Experiences with Medical Assistance in Dying (MAiD): A Foucauldian

Discourse Analysis with Agambian Insights. [Practice Based Research Paper on the Internet]. York University School of Social Work: 2018. [Cited February 28,2019] Available from: https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/35613/Alison Townsley PRP 2018.

5. Gamondi C, Borasio GD, Oliver P, Preston N, Payne S. Responses to assisted suicide requests: an interview study with Swiss palliative care physicians.

BMJ Support Palliat Care. 2019 Mar;9(1):e7. doi: 10.1136/bmjspcare-2016-001291. Epub 2017 Aug 11. Available from https://pubmed.ncbi.nlm.nih.gov/28801317/

OAIster included Results:

- Implementing Medical Aid-in-Dying in Vermont: a Qualitative Study. J GEN INTERN MED 34, 636-641 (2019). https://doi.org/10.1007/s11606-018-1. 4811-1
- Allyson Oliphant. "If Not Me, Then Who?" The Narratives of Medical Aid in Dying (MAiD) Providers and Supporters Arou&d Their Professional Identity 2. and Role in MAiD [Thesis on the Internet]. MacMaster University; 2017. [Cited on February 10, 2019]. Available from http://hdl.h@ndle.net/11375/22146

BASE included results:

Sheridan, Laura, "When Patients Ask to Die: The Role of Nurses in Medical Assistance in Dying" (2017). Electronic Thesis and Dissertation Repository. 1. 5041. https://ir.lib.uwo.ca/etd/5041



Table 2: Description of articles included in qualitative meta-synthesis:

4							
5	Study	Number and	Description of	Extent of	Method of	Method of	Emotional theme
7		country of origin	participants	engagement in the	interview	analysis	explored
8		of participants		MAiD process			
9							
10	1.	23 physicians, 18	@40% from	Physician assisted	40-70 min,	Modified 5-step	Themes related to
11	Voorhees	from USA (5 from	primary care,	dying discussions.	one-one	framework-	reflective
12	et al.,	Oregon), and 18	majority >40		semi	familiarization,	emotions and
13	2014	from Netherlands	years		structured	identifying a	sense of growth
14 15					interviews	theme, indexing,	along with themes
16						charting, mapping	emotional labor
17						and	and conscientious-
18						interpretation.	based emotions.
19							
20	2.	22 primary care	Variable range of	Discussing and	4 focused	Content analysis	Themes related to
21	Marwijk	physicians,	experience, 5	performing assisted	groups,	within a coding	reflective
22 23	et	Netherlands	PCPs participated	death	homogeniz	frame of three	emotions and
24	al.,2007		in the Support		ed as per	themes of (1)	sense of growth
25			and Consultation		age and	emotional	along with themes
26			Regarding		gender.	experience; (2)	emotional labor
27			Euthanasia			coping (dealing	and conscientious-
28			(SCRN)			with and	based emotions.
29						managing the	
30 31						event) and (3)	
32						role of the	
33					O .	physician.	
34							
35	3. Denier	18 nurses from 5	Registered nurses	Discussing and	1.5h in-	Grounded theory	Themes related to
36	et al.,	provinces of	(13 women, 5	performing assisted	depth	design	role-assigned
37 38	2010	Flanders, Belgium	men) of geriatric,	death	interviews,		emotions along
39			oncology, internal		think back	6	with themes of
40			medicine, and		to a		emotional labor.
41			palliative care. All		specific,		
42			had positive		recent case		
43			attitude, except		of caring for		
44 45			one who was		a patient		
45 46			conscientiously		requesting		
47			objecting.		euthanasia		
48					and to		
49					recount the		
50					way in		
51					which they		
52 52					experience		
53 54					d this		
J4		<u> </u>	1		<u> </u>	ı	ı

				process as a whole		
4. Norton et al., 2012	9 social worker hospice practitioners in Oregon, USA.	Represent several health systems in Oregon	involved in discussions with family of those participating in assisted death ('add on') and 'context interpreters'	Focused group	Thematic analysis	Themes related to role-assigned emotions (for example advocacy and feeling of being a 'gate-keeper')
5. Georges et al, 2008	30 general physicians in Netherlands.	71% male, 29% female, 46% had restrictive and 14% had permissive attitudes towards euthanasia.	89% had received explicit requests and were involved in discussions, and 64% had participated in EAS	In-depth interviews	Constant comparative method of analysis	Emotional theme of reflective emotions (example, feeling of sense of growth)
6.Snijde wind et al., 2014	28 General Physicians in Netherlands	Physicians who had received a request from someone suffering from dementia or a psychiatric illness, or who was "tired of living," as these are cases that are often regarded as complex.	Involved in decision making of assisted death for respective patients.	In-depth interviews	Open coding and inductive analysis	Emotional theme of reflective emotions (example, reflecting on individual meaning of suffering)
7. Katja ten Cate et al., 2017	15 General Practitioners in Netherlands	8 GPs with liberal attitude, 5 with conservative attitude and 2 with neutral attitude towards assisted death. Mean age 51.2 years.	1-2/>2 assisted deaths performed.	In-depth interviews	several phases of coding (axial and selective coding); codes were refined, sub codes and overarching codes were assigned and relationships between codes were explored. Interviews were also analysed as a whole, to look for	Emotional theme of reflective emotions (example, reflecting on feelings of what is happening during the last stage of life)

2 3 4 5 6						patterns and inconsistencies in reasoning.	
7 8 9 10 11 12 13 14 15 16 17 18 19 20	8. Donald G Van Tol et al., 2012	15 physicians in Netherlands	Fourteen of them were general practitioners. Seven of them were also active as a consulting doctor, one was a nursing home doctor who was also working as a consulting doctor.	Physicians were consulting doctors of Euthanasia and have successfully completed a formal training program.	In-depth semi- structured interviews	Grounded theory approach by Glaser and Strauss and Glaser	Emotional theme of reflective emotions (example 'imagine self', cognitive reflection)
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38	9. Melchor Lorraine 2018	8 social workers in California, USA.	75% female with 60% having an average 5 years of experience in hospice care.	assist patients and family with the death and dying process, may connect them to additional community resources, and offer counseling to improve and maintain emotional, psychological, social, and physical well-being	In-depth semi- structured interviews	Open coding, axial coding, selective coding, and conditional matrix stages of data analysis.	Emotional theme of role-assigned emotions (example, feeling of pro-self-determination and advocacy).
39 40 41 42 43 44 45 46	10. Miller et al., 2002	8 social workers in Oregon, USA	2 men, 6 women, age range of 27- 64, 3-22 years' experience in hospice care	Active engagement in end-of-life care and assisted suicide discussions.	interviews	Ethnographic study and constant comparative method of analysis	Emotional theme of role-assigned emotions (example advocacy and self- determination)
47 48 49 50 51 52 53 54 55 56	11. Beuthin et al., 2018	17 Nurses in Canada	NPs, RNs, and LPNs, from urban and rural areas across Vancouver Island, British Columbia, working across	15 nurses had direct experience with MAiD, 7 were involved in some aspect of assisted death in the patient's journey (e.g., providing	In-depth semi structured interviews	Descriptive narrative enquiry and thematic analysis	Emotional theme of reflective emotions (example, a sensemaking process)

12. Bolt et al., 2016	8 pediatricians in Netherlands	settings including acute care, residential care, primary care clinics, and community and palliative care. 8 pediatricians who were interviewed were 5 men and 3 women, aged 44–62y, working in four academic and three general hospitals	information, acting as witness to the medical assessment, providing care before or after, etc.) 25% had received an explicit request for Physician-assisted death, with 7% in the last two years, and the requests were mostly made by parents (25%) and sometimes by patients (6%)	Semi- structured interviews	Qualitative Analysis Guide of Leuven method was used for the analysis. Mixed method approach.	Emotional theme of role-assigned emotions (example, feeling of duty)
13. Dolares Angela Castelli Dransart et al., 2017.	1 physician, 8 directors of sociomedical institutions or organizations, 10 head nurses, 8 nurses, 10 nursing assistants or care assistants, and 3 sociocultural animators, Switzerland confronted with assisted suicide requests.	27 men, 13 women, mean age 52y.	14 had been faced with suicide or assisted suicide in their personal life, beside the situation of assisted suicide at work. None of the respondents interviewed had physically provided the lethal substance to perform the assisted suicide (a task assigned to Right to Die associations), nor were they directly involved in the decision-making process that enabled the assisted suicide to take place (except for one physician). In fact, the vast majority of these professionals	Semi- directive interviews conducted at workplace.	Grounded theory using 3 types of coding-open, axial and selective.	Emotional theme of role assigned emotions (example, feeling of professional compromise)

2							
3				(except for two)			
4 5				declared that not			
6				only did they			
7				appreciate the fact			
8				that Right to Die			
9				associations			
10				assumed the task of			
11				delivering the lethal			
12 13				substance and			
14				physically assisting			
15				the requestor, but			
16				they also did not			
17				want to be led to do			
18				it themselves in the			
19 20				future			
21							
22	14.	28 physicians in	20 males, 8	once in 3-5 years'	In-depth	Thematic analysis	Emotional theme
23	Mariann	Netherlands	females, 22 GPs, 1	experience with	interviews		of reflective
24	e Dees et		elderly care 2 GP	assisted death.	with		emotions
25	al., 2012		trainees and 1		patients		(example,
26 27			psychiatry		who had		relational and
28					explicitly		feeling of trust in
29					requested		physician-patient
30					assisted		relationship)
31					death, their		
32					most		
33 34					involved		
35					relatives		
36					and their		
37					treating		
38					physicians		
39 40	15	20 hassiss social		The 20 hearing	Carrai	The section and busin	Emotional them of
41	15.	20 hospice social workers and		The 20 hospice	Semi-	Thematic analysis	
42	Harvath			social	structured,		role-assigned
43	et al.,	nurses in Oregon,		workers/nurses	In-depth		emotions
44	2006	USA.		described 33	interviews.		(example, feeling
45				different cases of			of professional
46 47				terminally ill			failure,
48				patients who had			professional
49				requested them to			dilemmas and
50				hasten death			inner debate).
51				through physician			
52				assisted suicide (n =			
53 54				22)			
54			l				

2							
3	16. Ina	20 General	GPs who had	Receive 1-3	In-depth	Thematic analysis	Emotional theme
4 5	Otte et	practitioners	chosen to refuse	requests of	semi-		of basic emotions
6	al., 2016	(GPs) in	to assist a	physician assisted	structured		with conscience-
7		Switzerland., 3	patient's suicide	suicide per year.	interviews.		based
8		declined to	comprise the	2/3 rd of the GPs			avoidance/rejectio
9		participate due to	largest group in	interviewed had			n of MAiD
10		personal	the study and	chosen to refuse			(example, feeling
11		discomfort with	provided the				of moral distress)
12 13		assisted death.	most insights.	to assist a patient's			
14				suicide comprised			
15				the largest group in			
16				the study and			
17				the study and			
18				provided the most			
19 20				insight into their			
21				handling			
22				of requests for PAS.			
23				or requests for this.			
24	17. Ada	20 nurses in	According to	Engagement as per	In-depth	Thematic analysis	Emotional theme
25	van de	Netherlands	different phases	different phases of	semi-		of role-assigned
26 27	Scheur		of Euthanasia:	Euthanasia	structured		emotions
28	and Arie		Observation of a		interviews.		(example, feeling
29	van der		request for				of moral distress)
30	Arend		euthanasia: 17				
31	1998		nurses. 2)				
32			Decision making:				
33 34			14 nurses. 3)		V ,		
35			Carrying out of		4		
36			euthanasia: 12				
37			nurses. 4)				
38			Aftercare: 14				
39			nurses				
40							
41 42	18.	18 university	Participants	majority of the	In-depth	Inductive	Emotional theme
43	Emmanu	affiliated	positioned	palliative care	semi-	methodology of	of role-assigned
44	elle	palliative care	themselves	physicians on staff	structured	Interpretive	emotions
45	Bélanger	physicians in	opposite	at the palliative care	interviews.	description.	(example,
46	et al.,	Quebec, Canada	euthanasia	units of two public			professional
47	2018			hospitals located in			dilemmas and
48 49				an urban area of			conflicting values
50				Quebec. All			with palliative
51				participants were			care)
52				full-time palliative			
53				care physicians, and			
54				like most palliative			
55 56				care providers in			
30		1	1	ı	1	1	

2		T	I	I	I	I	
3 4				Canada, the			
5				majority of them			
6				(16 out of 18) were			
7				family physicians. As			
8				expected, all			
9				participants			
10 11				expressed			
12				discomfort with			
13				euthanasia as an			
14				aspect of end-of-life			
15				care. All but one			
16				denied the influence			
17				of religious or			
18 19				political positions in			
20				shaping their views.			
21							
22	19.	Eight physicians	3 were from	Collectively, by the	In-depth	Qualitative	Emotional theme
23	Jessica	who offered	greater	end of December	semi	thematic analysis	of basic emotions,
24	Shaw et	MAID in British	Vancouver, 3	2016, the 8	structured		especially positive
25	al., 2018	Columbia in 2016,	were from	physicians in this	interview		emotions
26 27		Canada	Victoria, and 2	study had assessed	via phone		(example, sense of
28			worked in a small	332 people who	call/email		fulfilment)
29			community on	were seeking MAID			
30			Vancouver Island.	and had completed			
31			Seven were family	135 assisted deaths			
32			doctors and 1 was				
33 34			a general		V /		
35			internist. Their		4		
36			ages ranged from				
37			37 to 64 years.				
38			There were 2 men			_	
39			and 6 women; 6				
40 41			worked full-time				
41			and 2 worked				
43			part-time.				
44							
45							
46	20	10 nursos wha	Four worked in	Nurses were aliaible	In donth	van Manan's	Emotional thans
47	20.	10 nurses who		Nurses were eligible	In-depth	van Manen's	Emotional theme
48 49	Judith	worked in home	hospice home	to participate in this	interviews	approach to	of role-assigned
50	Schwarz,	hospice, critical	care, three were	study if they	done at	phenomenology	emotions
51	2004	care, and	advance practice	believed that a	least twice	phenomenologica	(example, feeling
52		HIV/AIDS care	nurses who	competent patient	for 7	l interpretation	of human-human
53		settings, USA	worked with	had made a serious	participants	and analysis	response and
54			persons with	request for their		(phenomenologic	connectedness)
55 56			AIDS, two worked	help in dying.		al enquiry)	
56 57							

ſ			in critical care,				
			and one was a				
			clinical nurse				
			specialist in the				
			care of patients				
			with spinal cord				
)			injuries. Two of				
,			the ten nurses				
			were male, all				
1			were Caucasian,				
;			middle-aged, well				
,			educated (three				
1			PhDs; five				
3			Masters of				
<u>'</u>			Science in				
			Nursing), and				
2			clinically				
3			experienced (6–				
١.			35 years)				
			, ,				
,	21.	22	26 to 67 years	Physicians had	Semi-	descriptive	Emotional theme
3	Marie-	conscientiously	(mean: 45 years),	received requests,	structured	thematic analysis	of basic emotions
)	Eve	objecting	12 of them were	had discussions with	interviews.		(for example
)	Bouthillie	physicians in	male (54.5%). 14	patients regards to	eight open-		emotional labor,
	r and	Quebec, Canada	Family physicians,	MAiD, and	ended ques		burden and fear of
2	Lucie		2 oncology and 1	conscientiously	ions		psychological
1	Opatrny		each from	objected to	Interviews		repercussions)
	2019		psychiatry,	participate.	ranged in		
5			neurology,		length from		
,			nephrology,		15 min to 1		
3			intensive care,		h, with a		
)			geriatrics and		mean		
)			pneumology. 14		length of 24		
,			from catholic		min		
			background.		(median		
ļ					length = 21		
;					min). think		
,					back to		
					their first		
					medical aid		
					in dying		
					request (as		
2					some		
					physicians		
					had		
. 1						i l	
					received		

				more than one request) and describe the reasons which motivated their refusal.		
22. Gamondi et al., 2017	23 palliative care physicians across Switzerland	65% German, 30% French and 5% Italian speaking	Regularly received assisted suicide requests. The involvement of Swiss physicians is mostly confined to the decision-making phase; medical certification of diagnosis and mental capacity.	Semi- structured interviews.	thematic analysis	Emotional theme of role-assigned emotions (example professional role-related feeling of ambiguity, fear of being stigmatized as physicians, feeling of walking a tight rope.)
23. Rosanne Beuthin, 2018	female, of Anglo- European ancestry, age mid- fifties, living in ar urban center, Canada	Doctorate in nursing and was employed as a consultant under an end-of-life Program to enact a new MAiD program.	daily journal entries made over a 6 month period, from the first day of immersion in the role and culture of MAiD from late May to October 2016	Raw autobiograp hical text held scattered floods of ideas and released emotions into a thick created Story.	autoethnographic approach-reflective analysis	Emotional theme of reflective emotions (example, feeling of embodiment, compassionate care and sensemaking reflective emotions. Exploring tensions around language, attitudes)
24. Anne Bruce and Rosanne Beuthin, 2019	15 RNs/NPs/LPNs from British Columbia, Canada.	Participants worked in diverse settings including acute care, community-home care, and specialty areas including emergency	Eight nurses had directly aided with MAiD and cared for the patient at home or in a care setting. Seven had been involved indirectly with patients such as providing assisted	Semi- structured interviews- (1) tell me about your first experience of being asked to participate	narrative inquiry and thematic analysis	Emotional theme of reflective emotions (example fear of desensitization with deeper questioning) along with complex emotions of "compassion

2							
3			room and	dying information	in a		satisfaction" as
4			palliative care.	upon request and	medically		well as
5 6				listening to patients	assisted		compassion
7				and families as they	death and		fatigue
8				explored pursuing	how you		
9				MAiD	came to the		
10					decision to		
11					participate		
12					or not and		
13					(2) tell me		
14 15					about the		
16					MAiD		
17							
18					experience		
19					itself. What		
20					was most		
21					challenging		
22					?		
23 24	25.	seven nurses,	Health care	Engaged in	one-on-	Foucauldian	Emotional theme
25	Alison	social workers,	professional	discussions and		Discourse	of reflective
26			1 ⁻		one, semi-		
27	Townsley	and personal	enrolled through	assessments of	structured	Analysis 	emotions
28	2018	support workers,	purposive	patients requesting	interviews	perspective.	(example,
29		Canada	sampling.	MAID.	with health	Interview data is	emotions
30					care	analyzed by	emerging from
31					professiona	situating the	engagement of the
32 33					ls	health care	individual in terms
34					Y /	professional as an	of power,
35					4	effect, as a	knowledge and
36						producer, and as	individual identity)
37						a challenger of	
38						power-knowledge	
39						systems.	
40					•	Philosophical	
41 42						theories of	
43						Giorgio Agamben	
44						are applied to the	
45						data to challenge	
46						Foucauldian	
47						principles, and to	
48						bolster the	
49						discussion of	
50 51						defining of the	
52						body that	
53							
54						deserves to live,	

					and the body that deserves to die.	
26.	37 health care	Health care	19 physicians (10	One-to-one	Grounded theory	Emotional theme
Buchbind	providers in	providers from	internal medicine, 4	semi	approach	of role-assigned
	*	=			арргоасп	_
er et al.,	Vermont, USA.	Hospital and	palliative care, 3	structured		emotions
2019		community-based	neurology, 2	interviews		(example pride,
		practices. Most	oncology), 12 had			burden etc.)
		were women	participated in Act			
		(68%) and the	39 (The patient			
		largest subgroup	Choice and control			
		specialized in	at End-of-Life Act)			
		internal or family	as prescribing			
		medicine (53%).	physicians, the			
		Most of the	remainder had			
		nurses and social	initiated but not			
		workers were	completed the Act			
		women (89%) and	39 protocol (n = 3),			
		most worked for	participated as a			
		hospice and home	second physician to			
		health agencies	confirm the			
		(61%).	patient's diagnosis,			
			prognosis, and			
			decisional capacity			
			(n = 3), or counseled			
			patients (n = 1). The			
			mean age of nurses			
			and social workers	4		
			(n=18, 9			
			hospice/home			
			nurse, nurse		4	
			practitioner 5,			
			inpatient palliative			
			care 2, hospice			
			social worker 2) was			
			52.5, with most			
			working for hospice			
			and home health			
			agencies (61%).			
			While all			
			professionals in this			
			group engaged in			
			clinical care for			
			patients pursuing			
			Act 39, specialty			
			clinic nurse			

			practitioners were more likely to assist			
			with navigating			
			access to the aid in			
			dying. Participating			
			health care			
)			professionals			
			worked in ten of			
) =			Vermont's 14			
			counties			
27.	4 physicians. 4	Of the data	All participants are	One to one	Grounded theory	Emotional theme
Allyson	nurses and 6 HCPs	available, 2 were	members of the	semi-	approach	of reflective
Oliphant,	(allied health care	semi-retired	ADRAS (assisted	structured		emotions
2017	professional	family physicians,	dying resource and	interviews.		(example,
	social workers (1),	One is an	assessment service)			emotions related
2	spiritual care	intensive care	who support the			to related to
<u> </u>	providers (1),	physician with a	practice of MAiD.			professional
·	pharmacists (1),	background in	Every participant			identity, sense
3	genetic	cardiology, and	had a capacity to be			making, feeling of
,	technologists (1)	the second is an	flexible.			obligation to
3	and psychologists	Emergency Room				serve)
)	(2).) of team	physician with				
)	ADRAS in	training in				
,	Hamilton, ON.	palliative care.				
28. Laura	nine palliative	3 males, 6	Participants in the	One-to-one	interpretive	Emotional theme
Sheridon	care nurses in	females. 3	study indicated that	semi	description	related to role-
2017	southwestern	participants	nurses may act as a	structured	qualitative	assigned emotions
)	Ontario, Canada	worked in	liaison between	interview.	methodology	(example,
)		residential	physicians and	•		emotional
,		hospices where	nurse practitioners who have the			expressions ("hard
		MAiD was not supported as an				conversations")
		end-of-life option,	authority to assess			related to nursing role, struggle
		six participants	patient eligibility and provide the			related to moral
		worked in the	intervention of			conflicts.
		community	MAiD and the			connects.
		providing home	patient, notifying			
		care where MAiD	them of an inquiry			
		is an option in	about or a request			
!		end-of-life	for MAiD			
		planning. Two				
		participants had				

2							
3			previous inpatient				
4			hospital				
5 6			experience in				
7			emergency care				
8			and in intensive				
9			care specialties.				
10			care specialties.				
11	29.	19 physicians,	Half of the	Average 6.9 MAiD	In-depth	inductive	Emotional theme
12	Khosnoo	Canada. Quebec	participants were	cases.	semi-	thematic analysis	of role-assigned
13	d et al.,	not included.	palliative care	cases.	structured	approach	emotions
14	2018	not included.	specialists (n = 8),		telephone-	арргоаст	(example burn
15	2010		with the		Ī		
16					based		out, negative
17 18			remaining		interviews.		effect on inter-
19			representing				professional
20			Family Medicine				relationships vs.
21			(n = 4),				increased feeling
22			Anesthesia (n =				of respect)
23			2), Hematology (n				
24			= 1), and				
25			Obstetrics &	$\mathbf{O}_{\mathbf{A}}$			
26			Gynecology (n =				
27			1). The majority				
28			of participants				
29 30			practiced in an				
31			urban setting (n =				
32							
33			13).				
34	30.	8 physicians,	Participants	experience with	In-person	interpretive	Emotional them of
35	Beuthin	Canada.	included general	MAiD provision	or	descriptive	reflective
36		Cariaua.	_	· ·		=	
37	et al.,		practitioners	ranged from 12 to	telephone-	methodology and	emotions,
38	2020		(GPs) and Non-	113 assisted deaths.	based semi-	thematic analysis	(example complex
39			specialist	Only one physician	structured		emotions of
40			physicians from	was dedicated to	interviews.		compassion
41			urban and rural	full-time provision.			satisfaction,
42 43			communities				embodied
44			working in acute				awareness, soul-
45			and palliative				searching)
46			care. Ages ranged				<u>.</u>
47			from 33 to 62				
48			years (average				
49			age 49), with an				
50							
51			equal number of				
52			men and women.				
53			The majority				
54 55			identified no				
55 56			active religious				
56			•			•	

31. Keri- Lyn Durant and Katherin e Kortes- Miller 2020	23 physicians of Rural area, northwestern Ontario, most of subarctic Ontario.	affiliation, and ethnicity was withheld to protect anonymity. Years of experience ranged from 6 to 38 years (average of 23). 23 physician participants ranged in age from 26 to 63, with a mean age of 43 years. Physicians worked in a variety of settings, with 14 in an urban setting – in family practice, as a hospitalist or other specialist, in the emergency department, in palliative care, and in long-term care. Nine participants declared a rural practice, and self-identified as rural generalists, working on a First Nations' reserve, in a community, at a satellite clinic, or 'All of the above'.	11 identifying themselves as acting both as assessor and provider, 1 as assessor only, 4 as providing referrals upon request, and 7 without any direct/indirect experience. These seven were included in the study because they expressed a desire to participate and reported that their practice and the community had been impacted by the legislation. There was also a variance in terms of exposure to death in practice, with an estimated total between 2 and 250 deaths per annum	using 1 semi- structured focus group and 18 semi- structured interviews comprising 9 set of questions	Thematic analysis Thematic analysis	Emotional theme of role-assigned emotions (example, feeling of impact on interprofessional relationships, feeling of unpreparedness.
nd et al.,	analysis of in- depth	both by the	worked as family	structured		emotions
2016	Сери	network of		interviews.		
2016		network of physicians	physicians, and six	interviews.		(example, those related to meaning
2016		network of	physicians, and six	interviews.		(example, those
		•				
nd et al.,	depth	both by the	worked as family	structured		emotions
	-		•			
Snijdewi	analysis of in-	were recruited	respondents	semi-		of reflective
Snijdewi	analysis of in-	were recruited	respondents	semi-		of reflective
		•	•		Thematic analysis	
32.	secondary	Respondents	Twenty-two	One-to-one	Thematic analysis	Emotional theme
		-				
		the above'.				
		clinic, or 'All of				
		at a satellite				
		• •	acatiis per ailliulli			
			deaths ner annum			
		Nations' reserve,	between 2 and 250			
		_				
		=	•			
		generalists,	in practice, with an			
			-			
		practice, and self-	variance in terms of			
		declared a rural	There was also a			
		participants	the legislation.			
			•			
		care. Nine	been impacted by			
		and in long-term	the community had	4		
		=	· · · · · · · · · · · · · · · · · · ·			
		-		V.		
		department, in	and reported that			
		= -				
		•				
		other specialist, in				
		hospitalist or	in the study because			
		=				
		-	•	questions		
		in an urban	direct/indirect	9 set of		
		settings, with 14	without any	comprising		unpreparedness.
2020		•				=
						•
Miller		Physicians worked	providing referrals	structured		relationships.
e Kortes-		of 43 years.	assessor only, 4 as	semi-		professional
Katherin	subarctic Ontario.	with a mean age	provider, 1 as	and 18		=
	· · · · · · · · · · · · · · · · · · ·			• .		
		_	=			
	northwestern	ranged in age	acting both as	structured		emotions
Lyn	Rural area,	participants	themselves as	semi-		of role-assigned
31. Keri-	23 physicians of	23 physician	• =	using 1	Thematic analysis	Emotional theme
31 Keri-	23 physicians of	,	11 identifying	using 1	Thematic analysis	Fmotional theme
		_				
		-				
		• •				
		anonymity. Years				
		protect				
		withheld to				
		ethnicity was				
		•				

2							
3		interviews with	working for SCEN	worked as medical			of suffering,
4 5		28 Dutch	(Support and	specialists (three			blurring emotional
6		physicians who	Consultation for	elderly care			boundaries)
7		had experience	Euthanasia in the	physicians, a			
8		with a complex	Netherlands) as	psychiatrist, an			
9		case of EAS	well as via a	internist and a lung			
10			national	specialist). Next to			
11			Questionnaire.	this, six of the			
12 13			Nine of the	respondents also			
14			respondents were	worked as SCEN			
15			female. The	physicians. All had			
16			respondents' age	experience with EAS			
17			ranged from 36 to	requests and the			
18			68 years	performance of EAS.			
19							
20 21	33. Pesut	59 registered	n = 9 (15%) were	24 of the 59	Semi-	Qualitative	Emotional theme
22	et al.,	nurses and nurse	conscientious	participants had	structured	approach guided	of role-assigned
23	2020	practitioners in	objectors,	conducted more	interviews	by Interpretive	emotions
24		Canada	Spiritual or	than 25	conducted	Description. data	(example,
25			Religious	conversations with	on	immersion, open	emotions related
26			Affiliation: n = 33	patients about	telephone.	coding, constant	to find themselves
27 28			(56%) Neither: n =	MAiD, and 11 of the	Question	comparative	caught between
29			15 (25%); Spiritual	59 participants had	examples:	analysis, and the	the proverbial
30			but not Religious:	been involved with	(i) Can you	construction of a	"rock and hard
31			n = 11 (19%)	more than 25	tell us how	thematic and	place." With
32				patients who went	the process	interpretive	feelings of
33			Home &	on to receive MAiD.	of MAiD	account.	Emotions of
34 35			Community: n =		occurs in	Transcripts	frustration,
36			32 (54%); Acute		your	include emotions	powerfulness of
37			Care: n = 10		practice	evident during	the experience,
38			(17%); Long-term		context? (ii)	the interview	feeling drained
39			care: n = 5 (9%);		What	(e.g., crying).	out)
40			Hospice: n = 4		resources		
41 42			(7%); Clinic: n = 3		and		
43			(5%		practice		
44					supports		
45					are		
46					available to		
47					assist you in		
48					caring for		
49 50					MAiD		
51					patients?		
52					(iii) Tell us		
53					about your		
54					experiences		
55					with MAiD?		
56					WICH WIAID:		

34. Deborah Volkar et al., 2001	40 oncology nurses who received requests for assisted death in USA.	48% in hospital/multi- hospital settings. 9 female, 1 male. Mean age 45 y.	30% had received requests for assisted suicide, 6 (1%) engaged in assisted suicide, and 20 (4.5%) admitted to intentionally injecting a drug to end a patient's life.	The average length of interviews was 55 min. Recipients were re quested to submit a written account or story of receiving a request for assistance in dying from a terminally ill patient with cancer.	Denzin's process of interpretive interactionism with an emic, ideographic approach. That is, individual experience is considered to be unique; discovery of an individual's epiphany and associated meanings is the research focus	Emotional theme of basic emotions (example emotional labor) along with reflective emotions of feeling lack of control (or lack of it) and moral distress).
35. Mathews et al., 2021	23 palliative care providers (13 physicians and 10 nurses) who practiced for 6 months or more before and after the introduction of MAiD, in inpatient and community-based settings that supported assisted death in southern Ontario, Canada.	54% of physicians and 90% of nurses were female with a mean age of 43 years and 42.6 years respectively.	All the participants described having discussions with patients regarding MAiD and 7/23 participants (4 nurses and 3 physicians) described directly witnessing assisted death. 8/13 physicians made referrals for MAiD, 4 conducted assessments, and 3 physicians were MAiD providers; 3 physicians identified as conscientious objectors. None of the nurses identified themselves as	Semi- structured interview based on pre- determined interview guide	Braun and Clarke's version of Thematic analysis	Emotional theme of role-assigned emotions (example Role-driven emotional themes of Emotional, psychological and resource burden along with theme of emotional labor)

	objectors, although		
	objectors, although some expressed		
	moral or religious conflict around		
	conflict around		
	MAiD.		

Table 3: Codes and Themes table: This table represents line-by-line coding (underlined) of each study (numbered in 14parenthesis corresponding to the table 2 above). These codes have been subsequently grouped into descriptive themes in 15their respective boxes.

A) Over-arching theme of basic emotions:

Theme 1: Emotional labor (positive/negative emotions) Codes:

"rewarding" "liberating", "Well please let someone else do this question", "blood had frozen in my veins",

I just felt just totally cold all over. I had no idea of what to do. I realized there was no help I could get from anywhere . . . I . . . felt as though I was . . . impotent to help them. "If possible, I would run away. But I see it as the last part of my care. I have taken care of that patient for years and now at the moment . . . when she needs me most . . . I would be a coward to run away then. (1)

"I felt <u>very lonely</u>" "heroic feelings", "tense", "scary", "terribly creepy", "felt pressured to succeed", "suffer a loss yourself when someone like that dies" "terribly manipulated", "felt slightly put upon, angry" 'let off steam' (2)

"feeling of ambivalence", "intense", "gradually feel less secure, less fearful", "surprisingly grateful". "very demanding and emotionally distressing" (3) "very demanding, generally like to avoid", "drastic"(5), "moral pressure", "uncertain, complex"(6), "very hard"(7), "feeling choked up or shedding a tear" "Feeling positive emotions of peace and amazement were more surprising and often shared cautiously in public", "had difficulty finding effective words for the paradoxical experience of witnessing death that is, both "sad" and "beautiful." (11). "felt reluctant as it is difficult to predict" (12). "feeling of enrichment", "feeling of sorrow and intrusive thoughts", "feeling like weathering the storm", "empathy and emotional closeness", "personal compromise" (13). "do not feel competent" (16).

Theme 2: Conscience based emotions.

Codes:

"making pluses and minuses about it . . . but . . . 'What's it doing to me? I'm going to kill someone tonight.' [respondent began to cry],

"I have to do no harm, and I just feel that if you're assisting someone in dying . . . it's against what I've been trained . . . It's not up to me to decide when the patient dies . . ." (1);

"killing another person is not the solution. It's in the ten commandments"

"sense of guilt. I feel as if I'm an executioner. Who am I to have the right to do this?" (2);

"Conscientiously, I find it hard to come to terms with euthanasia" (3);

Clarity of conscience- "a <u>sort of trap</u> that can't be avoided. That in spite of everything you can offer, a terminal stage can be so heavy, perhaps too heavy for a patient. In fact, I always see it as an emergency exit. When I am talking about it with a patient I say, "yes we will consider it, if you don't want to go on any longer and if I have nothing more to offer you to make it better"(5);

"I am a Christian so I have strong feelings because of my belief and my background, believe that no human being should be in the position to hasten death." (10);

<u>cannot bear the idea of killing one</u> of my patients", I do not feel competent to deal with the topic...especially for my personal psychological health, "<u>challenges my belief</u>, I do not understand how it can be meaningful" (16)

"rewarding work", "honor", "bit overwhelming", "proud", "incredible" "feeling like being on call all the time (19), "emotional burden", "fear of psychological repercussions", "uncomfortable", fear of stigmatization (21), "fear of stigma/isolation, feeling of ambiguity" (22), "feeling courageous" (23), "satisfying and gratifying" "roller coaster", "transformational feelings of beautiful death" (24), just feel coldness, or whatever. You just feel drained ..." (28), "unexpected rewards", "enriching capacity of caring", (30), "anxiety, shock, self-doubt", "deep inside...conflict" (34); "walking quiet a tight rope", was as prepared...but went outside and felt like I was about to throw up", "actually, find them. . . they're such beautiful experiences with family. It's the shared experience with the family that you're with that you have an opportunity to help." (35)

"to see somebody lying there, to whom you brought a cup of tea that morning. And you know that everybody who gets a heart attack can die as well, but this was no heart attack. You know that, of course. So, somebody has been killed, just like that. . . That makes it different." (17)

"conflicted, trying to reconcile their own personal moral stance with facilitating the end of someone's life" (28) "What would my family think that I'm working on a unit that does that [Medical Assistance in Dying]? Do I hide it from them. . .what if people find out that we do it? Are people going to come up here and start protesting? People will see that as evil." (35)

B) Overarching theme of reflective emotions.

Theme 1: relational

"feeling of <u>trust and sympathy</u> in physician patient relationship strong" (14)

"human centered, compassionate care" (23), "for somebody to approach you is almost an honor that they trust you enough to have this conversation, and to have to sort of shut them down, or acknowledge how they're feeling" (empathy) (28), "intimate, emotional engagement-rediscovering the art of medicine", (30), "indelible nature of the experience shared" (34) "as soon the topic [Medical Assistance in Dying] came up, that I was a conscientious objector and the person said that you're not on my side, even though she was getting the service [MAID] . . . I was seen as somebody who was not helping her" (35)

Theme 3: Sense making process and related emotions. (Theme of Growth)

"You grow with the problems of the patients" (1)

"stay closer to their own beliefs" "long road to becoming aware of one's own views" (2)

"meaning full experience" "almost closer than when someone is having a baby" (5)

"[EAS] is not an act, it's a process towards which we both grow"

(6), "Being in process, holding an in-between space of uncertainty, reflection, and active sense-making" (11); "pure moment of autonomous self-consciousness" "I am working and sense making as I go along, being sure that I keep breathing",

Theme 2: Discourse based (control over a natural process of dying)

"interesting discourse presented itself through idea of using stages to determine someone's chances of survival, and the need for professionals to have something finite and concrete to measure", "discourse that emerged through conversations with participants was how control (or masterhood) equates to people's sense of wellbeing" "MAID itself presents a paradox insofar as one can be too sick to access this form of assistance that is exclusively designed to bring death to the most critically ill people" "The most dominant discourse that emerged from this data set was participants aligning what is right and good within the confines of the law." (25); "medicalization of a social problem" (32); "degree of control

over dying process" (34).

Theme 4: Process influenced themes (suffering---relief--death)

"Invisible suffering made it harder for the people close by to empathize and come to terms with the patient's request and his/her death" (6);

"for me, a lot of talk, talk about death and dying, talk about life, about saying goodbye, <u>really seeing and feeling what is happening in this last phase of life and reflect on that</u>. But not everybody is capable of talking and reflecting this way, while everybody is

going to die. So that's my problem" (7);

"imagine self" and "imagine other" cognitive route. Use of cognitive reflection (8);

"feeling of embodiment, become the face of MAiD", "bearing witness" (23); "worries of becoming desensitized and ongoing deeper questioning" (24); "their thoughtful silence after speaking or listening represented and solicited from me respect for the dead and the dying, seething inner anger, and perhaps the quietude that one experiences when their physical body feels the effects of being a challenger and resister in the strongest way possible" "Kind of letting them have control over what they can have control over" "beautiful journey of self-reflection", "grappling with identity" (25); "embodied awareness", "soul searching" (30); "silent knowing" (34)

"very difficult for me to let...go, to be so aware of saying farewell, and now I notice that as time passes it gets harder and harder for me" (14); "sense of urgency to hasten death" (23);

"boundaries of EAS has shifted over time, <u>making feel</u> <u>stretched</u>, <u>tense and insecure</u>" "<u>not feeling competent</u> if suffering is existential" (32);

"it's been a bit of a challenge to delineate what we're doing in relationship to the request for assisted dying and what normal care still continues to be" "struggle with the rules of a complex legislated and reporting process that determines it" (33)

C) Overarching theme of emotions related to professional values:

Theme 4: Role-assigned emotions

Nurses: "predominantly tend to be conformist (following existing conventions rather than using critical reflection) when faced with ethical dilemmas. Combined with the emphasis of the medical responsibility in euthanasia care, and combined with the strong inclination of nurses to respect the patients' wishes, it seems logical that nurses interpret the gravity of the process in emotional terms"(3); ""unchartered territory," where "there was almost no foundation" for providing this option, and "this is a whole new role for all of us. (being pioneers)" "duty to provide care" is being touted as "you don't have a choice" and the information isn't there [about] how to object if you don't agree with" (11); "moral distress", "burden", see somebody lying there, to whom you brought a cup of tea that morning. And you know that everybody who gets a heart attack can die as well, but this was no heart attack. You know that, of course. So, somebody has been killed, just like that. . . That makes it different" (16); "identifying the moral line", "human-human response and connectedness because of the role played", "fear the potential for abuse, and the possibility that other health-care professionals might too readily accept a patient's fleeting wish to die" (20); "taken for granted, feeling terrible" "their own suffering is invisible" (24); "walking alongside patients" like the experience of being able to make [death] a better experience. That celebration of life rather than the mourning of death" (27); "feeling of having hard conversations" (28); "Nurses seeking to provide the compassionate care consistent with such a momentous moment in patients' lives, without suitable supports, find themselves caught between the proverbial rock and hard place" "powerful experience" "mad as a hell", "overwhelmed" "...don't find the provisions so emotionally draining, but it's more the logistics and it's a lot of work as a nurse" (33); there's a sense of ceremony [before Medical Assistance in Dying], So, those all have impacts in terms of resources" (35).

social worker: "feeling of being a gatekeeper" (4); "sense of preparedness", feeling that this option is 'pro-self-determination which is our job"(9); "inner debate, cannot make peace with that, felt a huge shift in my ethics", "dying process has a lot to give" "missed opportunity to deepen oneself spiritually", "missed opportunity to forgive" (15); feeling of advocacy and self-determination in sync with hospice and social work values, and we will advocate for the patients . . . to get them whatever they want . . . I believe in self-determination, but I think it's (PAS) a sad commentary on our society." "Our job is to meet the patients where they are" (10); "felt like higher commitment", "felt like a failure if patient chose EAS" (16).

physicians: "heavy responsibility" (5); "implicit ethical tension due to pressure to decide", "It is the right time for EAS] Only if someone is totally at peace with himself, his life and his death, and if I see and feel that too.'(7); "feeling of duty" (12);

"professional compromise" (13); "fears prosecution", "burden, not wanting to abandon the patient" (14); extremely personal choice, I feel that part of some of the resistance at times can be related to [the fact that] that this is something new" "feeling of being torn between professional values and patient values (18); "significant administrative burden" (21); "struggle to reconcile to professional values", sense of responsibility to not create barriers" "walking a tight rope" (22); "tremendous pride", "burden as well" (26); duty to serve. "if not me than who" (27); "interprofessional lack of trust" "excessive workload and lack of financial satisfaction" (29); "burgeoning relationship between palliative care and MAiD", "positive because master of destiny", "uncomfortable discussing it" (31); "Good palliative care takes a lot of time and interdisciplinary resources. . when a patient is requesting MAID, most of the resources have been sucked up by that one case ... And all of the high-quality palliative care that we do falls by the wayside for the other patients." (35)



Supplementary appendix 4: PRISMA and ENTREQ checklist.

Section and Topic	Item #	Checklist item		Location where item is reported
TITLE				Тороноа
Title	1	Identify the report as a systematic review.		Title
ABSTRACT		7 2		
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	! -	
INTRODUCTION		\bar{\chi}		
Rationale	3	Describe the rationale for the review in the context of existing knowledge.		p.4-6
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.)	p.2 and p.6
METHODS				
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	-	p.6-8
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted the date when each source was last searched or consulted.	identify studies. Specify	p.8-9, supplementary appendix 1
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.		Supplementary appendix 1
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many record and each report retrieved, whether they worked independently, and if applicable, details of automation tools		p.9
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of the process.		p.9-10
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results		p.6-7
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, fund assumptions made about any missing or unclear information.	ng sources). Describe any	p.6-7
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how material each study and whether they worked independently, and if applicable, details of automation tools used in the process.		p.9-10, supplementary appendix 2
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentates	on of results.	Not applicable
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study integrated and comparing against the planned groups for each synthesis (item #5)).	vention characteristics	p.10-11
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summer conversions.	ary statistics, or data	p.10-11
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.		p.10-11 supplementary appendix 3
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was permodel(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used		p.10-11
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis	s, meta-regression).	Not applicable
	13f	Describe any sensitivity amalyses coniducted to-asses/shobjustness of the synthesized tresults lines.xhtml		Not applicable

Supplementary appendix 4: PRISMA and ENTREQ checklist.

	.ррспа	1X 4. I KISIVIA and ENTREQ checkrist.	
Section and Topic	Item #	Checklist item	Location where item is reported
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting bias 8).	high risk, p.20
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	p.5, supplementary appendix 3
RESULTS	•	20	
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the sumber of studies included in the review, ideally using a flow diagram.	Figure 1
3 4	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Figure 1, p.7
Study characteristics	17	Cite each included study and present its characteristics.	Supplementary appendix 3
7 Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Supplementary appendix 2
9 Results of on individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Not applicable
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Supplementary appendix 2
3 4 5	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	p.11-14. Supplementary appendix 3
6	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Not applicable
7	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Not applicable
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Not applicable
0 Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Table 1
2 DISCUSSION			
3 Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.17-20
4	23b	Discuss any limitations of the evidence included in the review.	p.17-20
5 6	23c	Discuss any limitations of the review processes used.	p.17-20
7	23d	Discuss implications of the results for practice, policy, and future research.	p.17-20
OTHER INFORMA	TION	te Control of the Con	
9 Registration and	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p. 11
0 protocol	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.11
1 2	24c	Describe and explain any amendments to information provided at registration or in the protocol.	none
3 Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the eview.	p.21
4 Competing 5 interests	26	Declare any competing interests of review authors. For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml	p.21
6	•		•

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Supplementary appendix 4: PRISMA and ENTREQ checklist.

Availability of data, code and other materials Availability of materials Availability of data, code and other materials Availability of materials Availability of data collection forms; data and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Section and Topic	Item #	Checklist item	Location where item is reported
	 data, code and	27		p.21

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic views. BMJ 2021;372:n71. doi: 10.1136/bmj.n71 For more information, visit: http://www.prisma-statement.org/ 2022. Down

Item No.	Guide and Description	Report Location
1. Aim	State the research question the synthesis addresses	Backgaound, p.6
2. Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. metaethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis)	Data amalysis, p.10
3. Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved)	search strategy screening and eligibility criteria SPIDER, p.6
4. Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type)	Eligibitity criteria, p.7
5. Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources	searck strategy, p.8 guest. Protecte
6. Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits)	Supplementary appendix 1 and p.6-9
7. Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies) For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml	p.9 stady selection process, Fig 1 PRISMA flow diagram

Supplementary appendix 4: PRISMA and ENTREQ checklist.

		02
8. Study	Present the characteristics of the included studies (e.g. year of publication, country,	Table 2 in supplementary appendix 3,
characteristics	population, number of participants, data collection, methodology, analysis, research questions)	Charaထိုsteristics of included studies
9. Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development)	Fig 1 -3 RISMA flow diagram Luly 2022.2.
10. Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings)	Table ₹, CERQual approach
11. Appraisal	State the tools, frameworks and criteria used to appraise the studies or selected	Appræsal of the methodological
items	findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting)	limitagions of included studies, Table 1, CERQual approach
12. Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required	p.10, independently done by the three researchers and consensus achieved.
13. Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale	Table , CERQual approach
14. Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software)	Data Extraction and analysis, p.10
15. Software	State the computer software used, if any	None J ised
16. Number of reviewers	Identify who was involved in coding and analysis	' guest. Pro
17. Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts)	p.10 of
18. Study	Describe how were comparisons made within and across studies (e.g. subsequent	Table 2 in supplementary appendix 3.
comparison	studies were coded into pre-existing concepts, and new concepts were created when deemed necessary)	оругіgh
19. Derivation of	Explain whether the process of deriving the themes or constructs was inductive or	Inductive process, p.10

 Supplementary appendix 4: PRISMA and ENTREQ checklist.

		n- 202
20. Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation	p.12-13
21. Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct)	Discussion, p.17-20
	interpretation Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct)	022. Downloaded fr
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