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

Study	Number and country of origin of participants	Description of participants	Extent of engagement in the MAiD process	Method of interview	Method of analysis	Emotional theme explored
1. Voorhees et al., 2014	23 physicians, 18 from USA (5 from Oregon), and 18 from Netherlands	@40% from primary care, majority >40 years	Physician assisted dying discussions.	40-70 min, one-one semi structured interviews	Modified 5-step framework-familiarization, identifying a theme, indexing, charting, mapping and interpretation.	Themes related to reflective emotions and sense of growth along with themes emotional labor and conscientious-based emotions.
2. Marwijk et al.,2007	22 primary care physicians, Netherlands	Variable range of experience, 5 PCPs participated in the Support and Consultation Regarding Euthanasia (SCRN)	Discussing and performing assisted death	4 focused groups, homogenized as per age and gender.	Content analysis within a coding frame of three themes of (1) emotional experience; (2) coping (dealing with and managing the event) and (3) role of the physician.	Themes related to reflective emotions and sense of growth along with themes emotional labor and conscientious-based emotions.
3. Denier et al., 2010	18 nurses from 5 provinces of Flanders, Belgium	Registered nurses (13 women, 5 men) of geriatric, oncology, internal medicine, and palliative care. All had positive attitude, except one who was conscientiously objecting.	Discussing and performing assisted death	1.5h in-depth interviews, think back to a specific, recent case of caring for a patient requesting euthanasia and to recount the way in which they experienced this	Grounded theory design	Themes related to role-assigned emotions along with themes of emotional labor.

				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)

					patterns and inconsistencies in reasoning.	
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)
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).
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)
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 sense-making process)

		settings including acute care, residential care, primary care clinics, and community and palliative care.	information, acting as witness to the medical assessment, providing care before or after, etc.)			
12. Bolt et al., 2016	8 pediatricians in Netherlands	8 pediatricians who were interviewed were 5 men and 3 women, aged 44–62y, working in four academic and three general hospitals .	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)

			(except for two) declared that not only did they appreciate the fact that Right to Die associations assumed the task of delivering the lethal substance and physically assisting the requestor, but they also did not want to be led to do it themselves in the future			
14. Marianne Dees et al., 2012	28 physicians in Netherlands	20 males, 8 females, 22 GPs, 1 elderly care 2 GP trainees and 1 psychiatry	once in 3-5 years' experience with assisted death.	In-depth interviews with patients who had explicitly requested assisted death, their most involved relatives and their treating physicians	Thematic analysis	Emotional theme of reflective emotions (example, relational and feeling of trust in physician-patient relationship)
15. Harvath et al., 2006	20 hospice social workers and nurses in Oregon, USA.	--	The 20 hospice social workers/nurses described 33 different cases of terminally ill patients who had requested them to hasten death through physician assisted suicide (n = 22)	Semi-structured, In-depth interviews.	Thematic analysis	Emotional them of role-assigned emotions (example, feeling of professional failure, professional dilemmas and inner debate).

16. Ina Otte et al., 2016	20 General practitioners (GPs) in Switzerland., 3 declined to participate due to personal discomfort with assisted death.	GPs who had chosen to refuse to assist a patient's suicide comprise the largest group in the study and provided the most insights.	Receive 1-3 requests of physician assisted suicide per year. 2/3rd of the GPs interviewed had chosen to refuse to assist a patient's suicide comprised the largest group in the study and provided the most insight into their handling of requests for PAS.	In-depth semi-structured interviews.	Thematic analysis	Emotional theme of basic emotions with conscience-based avoidance/rejection of MAiD (example, feeling of moral distress)
17. Ada van de Scheur and Arie van der Arend 1998	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	Engagement as per different phases of Euthanasia	In-depth semi-structured interviews.	Thematic analysis	Emotional theme of role-assigned emotions (example, feeling of moral distress)
18. Emmanuelle Bélanger et al., 2018	18 university affiliated palliative care physicians in Quebec, Canada	Participants positioned themselves opposite euthanasia	majority of 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 providers in	In-depth semi-structured interviews.	Inductive methodology of Interpretive description.	Emotional theme of role-assigned emotions (example, professional dilemmas and conflicting values with palliative care)

			Canada, the majority of them (16 out of 18) were family physicians. As expected, all participants expressed discomfort with euthanasia as an aspect of end-of-life care. All but one denied the influence of religious or political positions in shaping their views.			
19. Jessica Shaw et al., 2018	Eight physicians who offered MAID in British Columbia in 2016, Canada	3 were from greater Vancouver, 3 were from Victoria, and 2 worked in a small community on Vancouver Island. Seven were family doctors and 1 was a general internist. Their ages ranged from 37 to 64 years. There were 2 men and 6 women; 6 worked full-time and 2 worked part-time.	Collectively, by the end of December 2016, the 8 physicians in this study had assessed 332 people who were seeking MAID and had completed 135 assisted deaths	In-depth semi structured interview via phone call/email	Qualitative thematic analysis	Emotional theme of basic emotions, especially positive emotions (example, sense of fulfilment)
20. Judith Schwarz, 2004	10 nurses who worked in home hospice, critical care, and HIV/AIDS care settings, USA	Four worked in hospice home care, three were advance practice nurses who worked with persons with AIDS, two worked	Nurses were eligible to participate in this study if they believed that a competent patient had made a serious request for their help in dying.	In-depth interviews done at least twice for 7 participants .	van Manen's approach to phenomenology phenomenological interpretation and analysis (phenomenological enquiry)	Emotional theme of role-assigned emotions (example, feeling of human-human response and connectedness)

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

				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 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 autobiographical 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 sense-making 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

		room and palliative care.	dying information upon request and listening to patients and families as they explored pursuing MAiD	in a medically assisted death and how you came to the decision to participate or not and (2) tell me about the MAiD experience itself. What was most challenging ?		satisfaction" as well as compassion fatigue
25. Alison Townsley 2018	seven nurses, social workers, and personal support workers, Canada	Health care professional enrolled through purposive sampling.	Engaged in discussions and assessments of patients requesting MAiD.	one-on-one, semi-structured interviews with health care professionals	Foucauldian Discourse Analysis perspective. Interview data is analyzed by situating the health care professional as an effect, as a producer, and as a challenger of power-knowledge systems. Philosophical theories of Giorgio Agamben are applied to the data to challenge Foucauldian principles, and to bolster the discussion of defining of the body that deserves to live,	Emotional theme of reflective emotions (example, emotions emerging from engagement of the individual in terms of power, knowledge and individual identity)

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

			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. 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.	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 related to professional identity, sense making, feeling of obligation to serve)
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.

		previous inpatient hospital experience in emergency care and in intensive care specialties.				
29. Khosnood et al., 2018	19 physicians, Canada. Quebec not included.	Half of the participants were palliative care specialists (n = 8), with the remaining representing Family Medicine (n = 4), Anesthesia (n = 2), Hematology (n = 1), and Obstetrics & Gynecology (n = 1). The majority of participants practiced in an urban setting (n = 13).	Average 6.9 MAiD cases.	In-depth semi-structured telephone-based interviews.	inductive thematic analysis approach	Emotional theme of role-assigned emotions (example burn out, negative effect on inter-professional relationships vs. increased feeling of respect)
30. Beuthin et al., 2020	8 physicians, Canada.	Participants included general practitioners (GPs) and Non-specialist physicians from urban and rural communities working in acute and palliative care. Ages ranged from 33 to 62 years (average age 49), with an equal number of men and women. The majority identified no active religious	experience with MAiD provision ranged from 12 to 113 assisted deaths. Only one physician was dedicated to full-time provision.	In-person or telephone-based semi-structured interviews.	interpretive descriptive methodology and thematic analysis	Emotional them of reflective emotions, (example complex emotions of compassion satisfaction, embodied awareness, soul-searching)

		affiliation, and ethnicity was withheld to protect anonymity. Years of experience ranged from 6 to 38 years (average of 23).				
31. Keri-Lyn Durant and Katherine Kortes-Miller 2020	23 physicians of Rural area, northwestern Ontario, most of subarctic Ontario.	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	Emotional theme of role-assigned emotions (example, feeling of impact on inter-professional relationships, feeling of unpreparedness.
32. Snijdewind et al., 2016	secondary analysis of in-depth	Respondents were recruited both by the network of physicians	Twenty-two respondents worked as family physicians, and six	One-to-one semi-structured interviews.	Thematic analysis	Emotional theme of reflective emotions (example, those related to meaning

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

				The average length of interviews was 55 min.		
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.	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 conscientious	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 some expressed moral or religious conflict around MAiD.			

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