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Nurses' views on legalising assisted dying in New Zealand: A cross-sectional study

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ABSTRACT

Aims: This study investigated New Zealand nurses' views on legalising assisted dying across a range of clinical conditions, nurses' willingness to engage in legal assisted dying, potential deterrents and enablers to such engagement, and nurses' perceptions of the proper role of their professional bodies in relation to legalising assisted dying.

Background: A Bill for legalising assisted dying is currently before the New Zealand parliament. Of the 16 jurisdictions where assisted dying has been specifically legislated, only the Canadian federal statute provides nurses with explicit legal protection for their performance of assisted dying-related tasks. An absence of policy development and planning for safe nursing practice prior to legalisation of assisted dying results in a gap in professional support and guidance.

Design: Exploratory cross-sectional survey.

Respondents: A self-selected sample of 475 New Zealand nurses responded to an anonymous online survey disseminated through the newsletters and websites of relevant medical and nursing professional bodies. A subsample of nurses who expressed support for or ambivalence about legalisation (n = 356): rated their level of support for legalising assisted dying in New Zealand across a range of medical conditions, and their willingness to participate in a range of assisted dying tasks; identified barriers and facilitators to potential participation; and assessed the responsibility of the professional bodies to provide practice supports.

Method: Mixed-method approach using descriptive analysis of quantitative data; qualitative data were analysed thematically.

Results: Nurses supported legalisation at a rate (67%) significantly greater than that of doctors (37%) and for a diverse range of medical conditions. Most supporting nurses were willing to engage in the full range of relevant assisted dying roles. They identified several practical and ethical supports as essential to safe engagement, in particular practice guidelines, specific training, legal protections, clinical supervision and mentoring, and independent review of assisted dying service provision. They saw the facilitation of these supports as primarily the responsibility of their professional bodies.

Implications for policy: Nursing bodies should proactively facilitate workforce awareness and development of assisted dying policy and practice supports in anticipation of legalisation. This can be done through information campaigns and by adapting assisted dying policy, practice materials and systems already developed internationally. Nursing bodies need to engage in formulating legislation to ensure inclusion of explicit protections for participating nurses and to delegate relevant responsibilities to regulatory bodies.

What is already known about this topic?

- While doctors' views on legal assisted dying are well-documented internationally, both where assisted dying is legal and illegal, nurses hold different views from doctors and these views are under-represented in research.
- The language of statutes and practice guidelines where assisted dying is regulated is largely framed to guide doctor participation only, despite evidence that nurses are often delegated tasks in the assisted dying process.
- In some jurisdictions where assisted dying is legal, nurse involvement can include assessing patient eligibility and administering the

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medication, without nurses having legal immunities. In this context, nurses often feel compromised and vulnerable regarding their participation.

What this paper adds

- In the context of a campaign to legalise assisted dying in New Zealand, a majority of nurse respondents (67%) were "strongly" or "mostly" supportive of legalising assisted dying, a rate nearly twice that of doctors.
- Large majorities of supportive nurses were willing to engage in a broad range of activities related to assisted dying, and across a range of clinical diagnoses, if provided with ethical and practice guidelines.
- Nurses supportive of legalising assisted dying believed that nursing professional bodies are best placed to: 1) facilitate the provision of assisted dying implementation guidelines, mentoring, training and accountability systems for safe nursing participation in assisted dying services; 2) provide for those entering nursing to be trained in legal assisted dying options; and 3) lobby for legal immunities in new statutes to facilitate safe nursing participation in assisted dying.

1. Background and introduction

The pace at which legalisation of assisted dying is occurring has increased rapidly in the past decade. There are now at least 16 jurisdictions, mostly in North America and Europe, that have legislated specifically for assisted dying – that is, the legal prescription and/or administration of a lethal dose of medication by an authorised health professional with the intention of ending a patient's life, at the request of a mentally competent patient at end of life where eligibility and procedural requirements are met. Several other jurisdictions have decriminalised assisted dying though court decisions. A momentum in the Oceania region has seen the Australian state of Victoria pass assisted dying legislation in December 2017, a New South Wales Bill defeated by just one vote in November 2017 (New South Wales Parliament, 2017), the right to die organisations in Tasmania and South Australia continuing to resubmit Bills in those states, despite earlier defeats (Australian Broadcasting Corporation, 2017), and a parliamentary committee set up by the Premier in Western Australia to investigate legalising assisted dying there (Kagi, 2017). A New Zealand Bill recently passed its first reading by a margin of 76 'yes' votes to 44 'no' and was referred to a Justice Select Committee in 2018 (New Zealand Parliament, 2017).

Polls in New Zealand (NZ) continue to show that 60–80% of New Zealanders across sex, age group, ethnicity, religion and political persuasion support legal assisted dying (Lee et al., 2017; Rae et al., 2015). A review of relevant literature by Woods and Bickley Asher (2015) assumes eventual legalisation in NZ and discusses what that might mean for nursing practice. These authors concluded that nurses' contribution to the formulation of assisted dying law, establishment of guidelines and protocols, and curricular advances will depend on the profession's understanding of the challenges in legalising assisted dying. The New Zealand Nurses Organisation recognised in 2016 that "…some form of euthanasia may be legal in Aotearoa New Zealand in the near future…" (New Zealand Nurses Organisation, 2016a, p. 3), acknowledged the implications for nurses engaged in end-of-life care in terms of both practice and training, and made this topic a key focus at its 2017 annual conference (New Zealand Nurses Organisation, 2017). Nonetheless, it neither endorses nor rejects assisted dying. Instead, based on extensive member consultation, it has compiled a 'draft' position statement that "advocate(s) for individuals to have the option or choice of AD… [and] is focused on the impact of legislative changes that may affect the day-to-day practice of nurses who work with dying people" (New Zealand Nurses Organisation, 2016b).

The potentially significant role for nurses in legal assisted dying provision derives from their typically closer relationship than other health practitioners with patients and their families, their apparent support for and interest in assisted dying participation (Francke et al., 2016; Gagnon and Duggleby, 2014; Woods and Bickley Asher, 2015), and the often neutral stance towards legal assisted dying of nursing professional bodies (Trowell, 2009). Since legalisation in The Netherlands and Belgium, nurses there have increasingly become involved in various tasks in assisted dying and/or voiced a willingness to (De Beer, 2004; Inghelbrecht et al., 2010; Oliver, 2016). Internationally, nursing roles in assisted dying appear to be expanding, even if informally (Canadian Nurses Association, 2017; Li et al., 2017; Oliver, 2016; Van Bruchem-van de Scheur, 2008). The recent Canadian federal legislation extends authority for eligibility assessments and prescribing to nurse practitioners in circumstances where not enough participating doctors are available, for example in remote areas (Minister of Justice, 2016, sec. 241.2), and those roles have been embraced by Canadian nurse practitioners (Li et al., 2017). However, despite the core involvement of nurses in end-of-life practices, the attitudes of nurses towards legal assisted dying remain under-represented in current research (Terkamo-Moisio et al., 2017).

The New Zealand Nursing Council, in compliance with the Health Practitioner Competence Assurance Act of 2003, sets standards for and monitors the quality of nurse education programmes (Nursing Council of New Zealand, 2015). The scopes of practice are defined as Nurse Practitioner, Registered Nurse and Enrolled Nurse. Scope of registered nurse clinical practice is not specified in detail in the legislation, but includes health assessment, care, and advice for self-management of health. Internationally it is recognised that end-of-life care training is both necessary (Ek et al., 2014) and under-developed (Henoch et al., 2017), despite the fact that "nurses spend more time at the bedside caring for patients at the end-of-life than any other professional group" (Ferrell et al., 2005).

The limited research available relevant to nursing roles demonstrates that, where assisted dying has been legalised, a majority of nurses are interested in engaging in its provision (De Bal et al., 2008; Kouwenhoven et al., 2014). However, the absence of both legislated immunities for nurses and planning for safe practice can deter otherwise willing nurses from participation (De Bal et al., 2008; Elmore et al., 2016; Oliver, 2016; Trowell, 2009). Post-hoc development of policy and guidelines, such as occurs in The Netherlands through regular structured review of assisted dying events by Regional Euthanasia Review Committees (see e.g. van Wersch, 2016), is unlikely to offer *legal* protection for a participating nurse, despite informal 'authorisation' by a doctor. The challenge for nursing leadership is to ensure nurse protections through the development of policy and practice guidelines and input into assisted dying legislation.

2. Aims

Our research surveyed New Zealand nurses and doctors on their views on legalising assisted dying. This paper has four aims, to explore:

1) nurses' views on legalising assisted dying across a range of clinical conditions
2) nurses' willingness to engage in legal assisted dying
3) potential deterrents and enablers to such engagement, and
4) nurses' perceptions of the proper role of their professional bodies in relation to legalising assisted dying.

An earlier discussion of this research that focused primarily on New Zealand doctors' views noted that the majority of doctors opposed legalisation and doctor participation, and that they were significantly less supportive than nurses (Oliver et al., 2017). The present paper focuses particularly on the views of nurses who in principle supported or were ambivalent about legal assisted dying, regarding: their level of support or otherwise for assisted dying; their level of willingness to be involved;

and their views of the roles of the professional bodies. Nurses' opposition to legalising assisted dying was also canvassed.

3. Method

3.1. Design

An online survey including quantitative and qualitative questions was developed from a comprehensive review of international literature on doctors' and nurses' attitudes towards legalising assisted dying, with a set of questions on each of the topics listed above. The 15 multi-choice rating scale questions, most of which asked respondents to rate a level of agreement or value in relation to a series of sub-questions, were supplemented by 12 open-response questions for respondents' independent views, together with a set of demographic questions on respondent attributes, including age, sex, ethnicity, length of practice, area of specialisation, and professional memberships. Multi-choice response options allowed for a full range of views. Likert scales were customised as appropriate to the focus and phrasing of each question. For attitudinal questions, the scales included the options 'strongly agree' to 'strongly disagree' and 'not sure', together with an option to omit the question if preferred for questions deemed 'sensitive' by pilot participants. The draft instrument was pilot-tested with 10 health practitioners (five doctors and five nurses) and minor adjustments made to phrasing where indicated. A copy of the survey instrument is appended to the online version of this paper.

3.2. Sample, setting and recruitment

New Zealand doctors and nurses were invited to take part in an anonymous online survey – *Attitudes of doctors and nurses towards legalising assisted dying in New Zealand* – from late September to early November 2015. An invitation was disseminated through the electronic newsletters and/or websites of 10 relevant New Zealand medical and nursing professional bodies (including Australasian bodies, with invitations to registered New Zealand practitioners only).

This article reports on the responses of 475 self-selected respondents who identified as a nurse. Nurse respondents' age range, sex and ethnicity distributions corresponded closely to the demographics reported in the most recently published summary of NZ nursing workforce statistics (Nursing Council of New Zealand, 2015), except that our sample had 10% more respondents in the 46–60 years band than the total nurse population (51%–41%). In both the nurse population and this sample the majority identified as NZ European. A majority of respondents had extensive professional experience and 37% had 6–40 years full-time equivalent end-of-life care experience (see Table 1; comparable data on full-time equivalent years experience are not available for the national nurse population). Ninety-eight percent of nurse respondents identified as members of the New Zealand Nurses Organisation and 21% were also members of other professional nursing bodies.

Doctor respondents' age range, sex and ethnicity distributions also closely reflected those of the medical profession generally in NZ (Oliver et al., 2017).

3.3. Ethical and cultural considerations

The survey invitation clarified that the survey was voluntary, anonymous and had been approved by the University of Auckland Human Participants Ethics Committee (UAHPEC reference: 015470). Greetings were included in te reo Māori to encourage participation across predominant New Zealand cultures.

3.4. Data analysis – validity and reliability

Quantitative data analysis used response frequency and percentage counts. Qualitative data were analysed applying the thematic analysis approach recommended by Braun and Clarke (Braun and Clarke, 2006; Patton, 2015). Respondents' open comments were coded independently by one of the authors and a research assistant not involved in other aspects of the study. Verbatim quotes (with original spelling and grammar) have been included to represent the diversity of views. Open responses were thematically analysed to reveal emergent response categories. Both quantitative and qualitative data were co-analysed by independent researchers who were not involved in the survey design and data collection. These researchers also cross-checked the reporting of the data for internal validity.

Table 1
Nurse respondent characteristics.

Age				
	< 30	30–45	46–60	> 60
No.	52	104	240	78
%	11	22	51	17

Gender		
	F	M
No.	443	31
%	93.5	6.5

Ethnicity[a]				
	NZ/European	NZ Maori	Pasifika	Other
No.	412	21	5	53
%	87	4	1	11

Experience (FTE years)						
	None	1–5	6–10	11–20	21–40	> 40
No.	0	76	45	117	174	61
%	0	16	10	25	37	13

End-of-life care experience (FTE years)						
	None	1–5	6–10	11–20	21–40	> 40
No.	118	182	76	64	33	0
%	25	39	16	14	7	0

[a] Respondents selected as many as applied.

4. Findings

This section explores emerging themes, patterns and diversity in NZ nurses' support for legalising assisted dying (briefly contrasted with NZ doctors' level of support for legal assisted dying). Response rates are shown as both percentages and respondent numbers.

4.1. Level of agreement with legalising assisted dying

The rate of nurses "strongly" or "mostly" agreeing with legalised assisted dying (67%, n = 318), assuming provision of appropriate guidelines and protocols, was nearly twice the rate of doctors who agreed (37%, n = 110). Only four percent of nurses (n = 19) were "unsure", with the remainder "strongly" (25%, n = 119) or "mostly" (4%, n = 19) disagreeing with legal assisted dying in NZ. These findings are consistent with international research on the level of nursing support for assisted dying in advance of legalisation, and with doctor/nurse attitudinal differences where assisted dying is legal (De Bal et al., 2008).

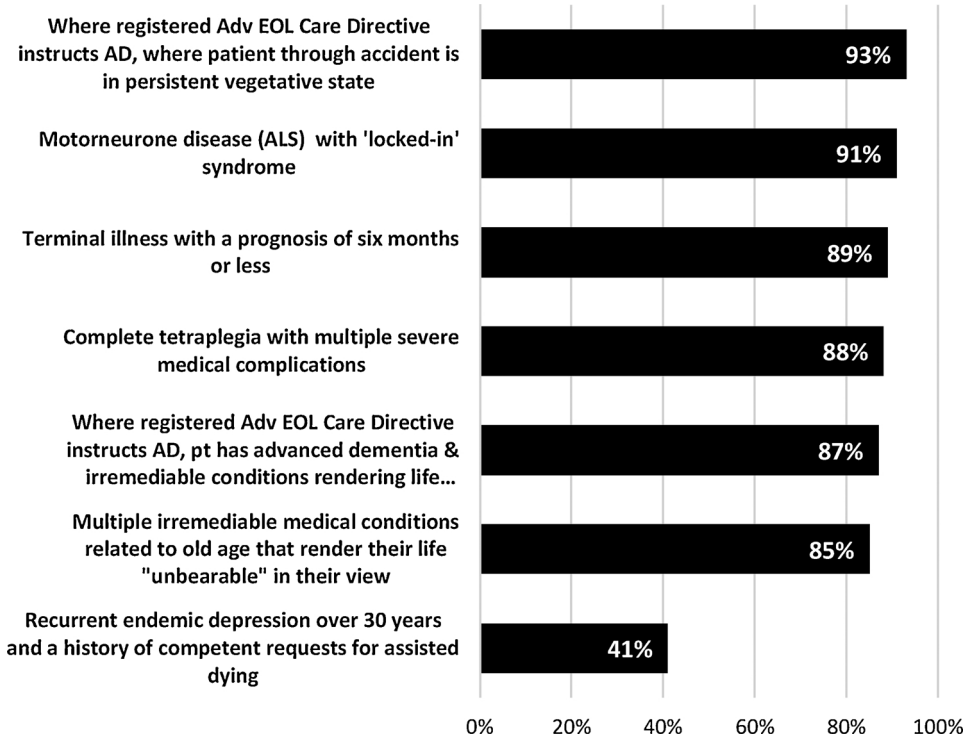

Fig. 1. Agree with the availability of assisted dying (AD) for various circumstances (% "strongly" or "mostly" agree"; n = 356).

4.2. Nurses' reasons for supporting or opposing legal assisted dying

4.2.1. Reasons for supporting

Nurses' stated reasons for supporting legal assisted dying, consistent with European and Canadian studies, reflected the key principles of medical ethics – beneficence, non-maleficence and, in particular, patient autonomy as strongly influential bioethical principles in contemporary health care (Kouwenhoven et al., 2014; Lavoie et al., 2016; Quaghebeur et al., 2009; Vezina-Im et al., 2014). Nurses' main stated reasons for agreeing with legal assisted dying reflected support for a right to autonomous patient decision-making at end of life, irrespective of health practitioners' beliefs (33% [n = 144] of total nurse comments on reasons for supporting or opposing legal assisted dying), alongside philosophical beliefs about personal dignity and a perceived right for people to avoid unnecessary pain and suffering at the end of one's life (23% [n = 100] of total comments). Respondents' comments are presented verbatim, with original spelling and punctuation.

> Assisted dying has been a part of EOL medical care for many years, under different guises and legalising this option would go a long way towards removing that pretence within EOL medical care. Having the option of legalised assisted dying would also empower the dying person, giving them BACK control over whatever time they have remaining.

> …if there is ability to hasten death why should this not be legalised so that one's right to choose can be sacred in the context of our time.

> Due to the many undignified and frankly awful deaths I have seen over the past several years working in various hospitals. A lot of what we is cruel at times (despite best intentions) and can cause a lot of pain for very little benefit (if any).

Other commonly stated reasons reflected a perception that health practitioners do not always respect the autonomy of dying patients and a perceived failure of some health practitioners to acknowledge medical futility, resulting in suffering through prolonging people's lives.

> … the medical profession has lost sight of the fact that people have a natural lifespan and try to keep some patients alive at no benefit to those patients (those that request cessation of treatment etc and the doctors ignore their wishes).

> Prolonging life can often be torturous and result in invasive medical procedures taking place in patients who have minimal quality of life. People should be able to choose their end point if faced with a life limiting condition.

4.2.2. Reasons for opposing

Nurses' most commonly stated reasons for opposing legal assisted dying reflected the following main themes: a belief that undertaking assisted dying functions was not a proper role for health practitioners (10% [n = 43] of total nurse comments on reasons for supporting or opposing legal assisted dying); a belief that vulnerable people will be pressured to end their lives prematurely (10%, n = 43); professional experience with and/or belief in the adequacy of good palliative care (9%, n = 39); moral/ethical (non-religious) objections to legal assisted dying (9%, n = 38); 'slippery slope' arguments – that legalising assisted dying will result in doctors and nurses providing non-voluntary euthanasia (7%, n = 30); and a belief that there is spiritual value in suffering (7%, n = 30).

> Suffering is just as much a part of life as joy is and it is possible to learn and grow from it, particularly spiritually.

> It [legalising AD] makes health professionals obliged to assist death, and this could have psychological/moral issues for them. Good palliative care should negate the need for this issue. I feel more resources should be put into palliative care.

4.3. Scope of agreement with legal assisted dying

The remainder of this article explores the views of the 75% of total nurse respondents (n = 356; the 'sub-sample') who either supported legal assisted dying "strongly" or "mostly" or were ambivalent or unsure. (That is, these topics were not canvassed amongst the 25%

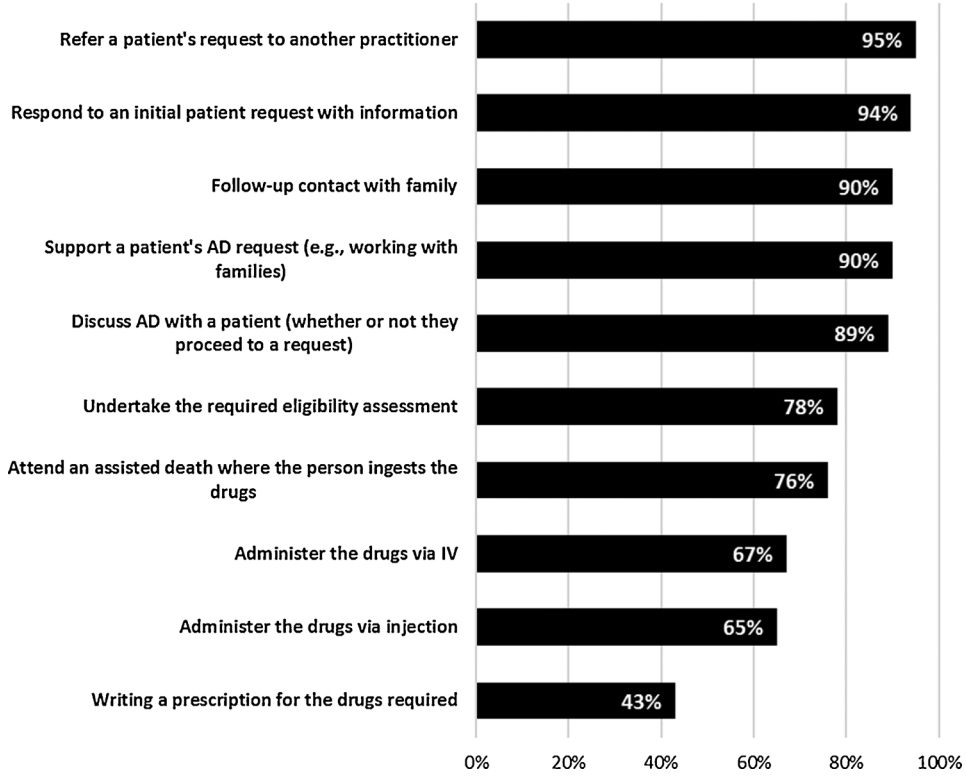

Fig. 2. Nurses' willingness to participate in activities of legal assisted dying service provision (% "very" or "probably" willing; n = 356).

(n = 119) of total respondents who "strongly" disagreed with legalising assisted dying, as those survey questions were not relevant to those strongly opposed.)

The majority of sub-sample nurses supported the availability of legal assisted dying across a broad range of medical conditions (see Fig. 1). Fig. 1 shows that the level of support was consistently strong across diverse medical conditions but decreased markedly in response to more ethically complex or ambiguous medical situations, such as endemic and persistent depression.

4.4. Willingness to participate

One third of nurses' open comments on this topic noted that nurses cannot prescribe currently, but 43% (n = 30) of those comments indicated willingness to undertake prescribing if it were legally authorised for their profession (see Fig. 2).

> I do not have prescribing rights, thats the only reason for [question] 8 answer 'unsure'.

> I have answered the question regarding prescribing as a 'not willing' only due to my RN status.

This finding is consistent with previous international research (De Bal et al., 2008), and the new Canadian federal legislation that incorporates a nurse practitioner role in assisted dying service provision (Minister of Justice 2016, sec. 241.2). Two thirds (n = 238) of sub-sample nurses were willing to administer assisted dying either by injection or intravenous line.

Nurses' willingness to participate in legal assisted dying generally was moderated by two factors – a concern for the safety of both the patient and the nurse, and the need for advanced training and supervision *prior* to undertaking those activities.

> The safety legislation ensuring the wishes of the individual are respected and carried out is what will determine my willingness to assist.

> I suspect careful assisted dying wouldn't often go wrong. but if it did, there could be spectacular consequences. I'd like to know my privacy and safety would be protected.

> I would need advanced training in this. …. It should not be forced on anyone as it may not fit in with an individual's beliefs. You would definitely need clinical supervision.

Sub-sample nurses indicated strong support for assisted dying as an option for their own end-of-life care (82%, n = 292) or that of a family member (83%, n = 295). This support was markedly stronger on both measures among nurses than doctors (64% and 70% respectively). These views reflect those of Swiss palliative care doctors and nurses, where many of those opposed to assisted dying in principle nonetheless considered it for themselves (Gamondi et al., 2017).

4.5. Deterrents to and facilitators of engagement in legal assisted dying

4.5.1. Deterrents

Deterrents to participating in legal assisted dying indicated most often by sub-sample nurses (n = 356) were related to the pragmatics of assisted dying provision, in four related areas: a lack of professional guidelines for safe and competent practice (92%, n = 328); lack of training for the tasks involved (85%, n = 303); lack of professional supports (87%, n = 310); and concerns about litigation or professional reprimand (77%, n = 274).

> Unclear guidelines, need to be robust and protection of the vulnerable paramount.

> I would need to be absolutely certain there would be no complaint by family, employer etc, and crystal clear guidelines would need to be provided along with a transparent pathway for actioning the request.

> An overall sense that an organisation did not have the correct policies or that they were not well entrenched and followed, leaving doubt.

Nearly half (46%, n = 164) would also be deterred by pressure from employers to decline participation. The least frequently mentioned deterrent to participation was a personal philosophical objection to assisted dying (26%, n = 93). The strong support from sub-sample nurses that an assisted death "should be available to people when resident in hospitals, hospices and aged care facilities" (87%, n = 310) highlights the tension nurses and doctors in Switzerland and the United States have experienced with the policies of residential facilities that contractually prohibit assisted dying services on their premises and/or the participation of employees in assisted dying service provision (Gamondi et al., 2017; Oliver, 2016). Those prohibitions have occurred particularly with faith-based providers.

It is noteworthy, however, that regardless of their position on legalising assisted dying, most sub-sample nurses were unfamiliar with the protections included in statutes overseas where legal assisted dying is available, or with the considerable literature on the effectiveness of those protections. Sixty-two percent of sub-sample nurses (n = 221) said they knew "very little about" protections embedded in existing laws for conscientious objection or immunity from prosecution. Fifty-two percent (n = 185) knew "very little about" safeguards for patients included in assisted dying laws in other countries (eligibility, waiting times, procedural requirements). Only 27% (n = 96) had read detailed information on assisted dying or attended a session where legal assisted dying implementation was discussed, and only four percent (n = 14) rated themselves "well informed" on these matters.

4.5.2. Facilitators

The facilitators of assisted dying participation identified most often as "essential" or "desirable" by sub-sample nurses were: authorised guidelines from professional bodies (99%, n = 354); a support or mentoring organisation for nurses who wish to participate in assisted dying provision (99%, n = 354); training in assisted dying practice for health practitioners (99%, n = 354); an independent Review Committee to check compliance with protocols (98%, n = 349); freedom to refer an assisted dying request to another professional (97%, n = 346); and immunity from civil or criminal prosecution where legal requirements are adhered to in good faith (96%, n = 341).

> If assisted dying is legalised then Prof Organisations will really have an obligation (regardless of their preferred stance) to ensure that health practitioners who wish to participate do so in a safe manner for themselves and pt/families.

> Education and training should be touched on in undergraduate courses but actual papers should be available at a post grad level to do. not a nursing council responsibility to train but a tertiary provider responsibility, with input from medical and nursing council.

> Essential nursing profession is involved in every and all facets of this subject and at all levels - Government and policy through to patient and family care and support, including regulating and research.

The great majority of sub-sample nurses also saw as "essential" or "desirable" supports for individual conscientious objection to assisted dying engagement (90%, n = 320).

> Support information and training for those apposed to assisted dying so they are able to cope with choices made by patients and other health professionals.

4.6. Role of the professional bodies

As illustrated in Fig. 3, more than 90% of sub-sample nurses viewed it as the responsibility of their professional bodies to ensure provision for essential safe practice supports such as authorised guidelines, training and mentoring, provision of clear position statements on assisted dying, and training in safe implementation of assisted dying tasks. Other supports sought by nurses were ensuring the availability of indemnity insurance and legal assistance, should it be needed.

> When assisted dying becomes legal, the professional bodies need to support it and the rights for patients to self determine.

> The [care provider] organisation should have some sort of system for ensuring they meet all the requirements for protocols, supports etc from an outside agency … I think the implementation of this requires a outside body with authority in these matters to be involved … don't know if that even exists. I think this is necessary for not only staff but for the public.

> I think the training and guidelines come from the sector combined and not the professional bodies in isolation.

Nearly one fifth of open comments to this question suggested there should be a task-specific independent body, rather than one of the professional bodies, providing oversight to produce a coherent assisted dying implementation response across settings or professions.

> If there were to be an independent review body I would see that they would also have a role in providing education rather than the professional body. Alternatively, the provision of education, support and mentoring could best be established regionally perhaps by the regional training hubs.

A few sub-sample nurses noted that there might be a perceived conflict of interest for the professional bodies, but nonetheless believed those bodies had a responsibility to ensure the availability of appropriate education.

> I do not think the nursing council should issue an official stance on the issue - it's role would be to support its members in carrying out the process in accordance with any new legislation. It should have a responsibility to ensure its members are well educated on the matter and aware off all legal and ethical issues relating to any new legislation.

5. Discussion

5.1. Developing the nurse role in legal assisted dying

The majority of nurse respondents were supportive in principle of legalising assisted dying and were willing to engage in a broad range of activities related to that option as part of end-of-life care. Moreover, nurses were willing to support legal assisted dying for a diverse range of medical circumstances and were much more supportive in principle of assisted dying and willing to participate than NZ doctors (Oliver et al., 2017). As the role of nurses in assisted dying internationally is expanding, notably in Belgium, Canada, and The Netherlands (Bilsen et al., 2014; Canadian Nurses Association, 2017; Li et al., 2017; Van Bruchem-van de Scheur, 2008), it is appropriate in contemplating potential legalisation in NZ, or elsewhere, to consider the potential role/s for nurses in legal assisted dying. Such consideration should include both the scope for authorised engagement in core assisted dying tasks (e.g. eligibility assessment, prescribing and delivery of assisted dying) and the implications for safe practice and professional supports.

The New Zealand Medical Association has consistently declared its opposition to doctors' assisted dying participation (Baddock, 2018; Child, 2016). In contrast, the New Zealand Nurses Organisation has recently promoted legislative reform that explicitly allows for people to decide the manner of their death in end-of-life contexts and also protects nurses from prosecution for participating in legal assisted dying. Its recent draft position statement, based on extensive member consultation, states that: "As patient advocates, NZNO can no longer take a neutral stance in relation to AD. NZNO has chosen to take a principled approach to AD, and advocate for individuals to have the option or choice of AD. Accordingly, our concern is focused on the impact of

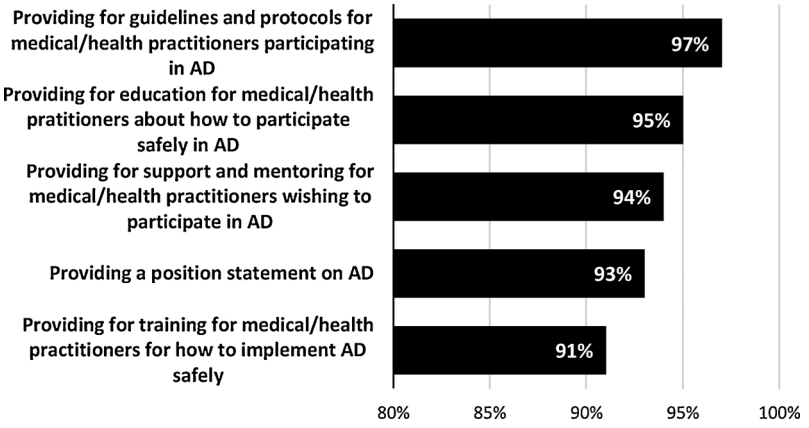

Fig. 3. Roles and responsibilities of professional bodies if assisted dying is legalised in New Zealand (% "essential" or "desirable"; n = 356).

legislative changes that may affect the day-to-day practice of nurses who work with dying people" (New Zealand Nurses Organisation, 2016b, p. 1). This position potentially allows for nurses to take an individual stance on assisted dying engagement.

5.2. Facilitating safe nurse engagement

International research shows that the main barrier to patient access to the option of legal assisted dying is an absence among health professionals in capacity, capability and willingness to engage (Gagnon and Duggleby, 2014; Oliver, 2016). Those barriers to engagement appear due to several related factors, in particular (i) a lack of either accredited training and education for the assisted dying provider tasks and roles, (ii) a lack of practice standards and guidelines authorised by the relevant medical and nursing professional bodies, as noted in previous research (Oliver, 2016; Van Wesemael et al., 2009), and (iii) a lack of statutory immunities and other protections for participation in compliance with the law.

Sub-sample nurse respondents identified two critical areas where they wanted support – the provision of effective and sufficient practice guidelines and standards for participating nurses, and legal immunities. Because nurses will inevitably be required to undertake auxiliary assisted dying tasks in their ordinary roles in end-of-life care, input into the legislation needs to advocate for specific criminal *and* civil immunity for actions complying with the statute, including protection against professional censure, for all tasks designated to nurses (Oliver, 2016). Across jurisdictions, only the federal Canadian statute provides a degree of legal protection for nurses (Minister of Justice, 2016, sec. 241.2). Nurses in other jurisdictions often feel deeply compromised and vulnerable about assisted dying participation (Elmore et al., 2016), on the one hand wanting and/or being required by medical staff to undertake assisted dying tasks, on the other hand recognising the legal and professional risks of doing so *or* of refusing to do so (Oliver, 2016).

To ensure safety for participating nurses, the nursing profession needs to inform any statute so that nurses are appropriately authorised for *all* tasks that they might be engaged in relating to the assisted dying process. Given many sub-sample respondents' apparent willingness to undertake assisted dying roles, including prescription and administration of lethal medications, those authorisations might potentially be included in specified situations, as in the Canadian federal statute. The Québec and Canadian federal experience since 2016 provides some valuable information in this area (Canadian Nurses Association, 2017; Li et al., 2017), where the nursing professional bodies across the Canadian provinces and federally have now published safe practice guidelines for nurses (see for example, Canadian Nurses Association, 2017; College of Nurses of Ontario, 2017).

Clear policy and safe practice guidelines at the institutional level are also necessary to protect nurses against professional censure for their participation when statutory and regulatory requirements are complied with. Such protections could enhance workforce capacity, leading to better service access and experiences for dying people and their families, while avoiding conflict amongst end-of-life care practitioners.

Woods and Bickley Asher (2015) concluded from their international literature review of potential nurse roles in assisted dying that "Nurses need to be fully informed about, and contribute to, proposed assisted dying legislation…and should therefore be ready to influence law, policy and future nursing practices." (p. 13). Our sub-sample nurses believed that information on the status of assisted dying implementation, regulation and monitoring in other jurisdictions would ideally be provided to them through formal professional education and that nursing bodies were best placed to ensure nurses are fully informed on relevant issues. This suggests that the profession as a whole will benefit from evidence on nurse engagement where assisted dying is legal, what the impacts have been of that engagement, and therefore what statutory protections will be needed. The 2016 New Zealand Nurses Organisation submission to the Health Select Committee also suggested that it is a responsibility of the relevant professional bodies to ensure that nurses are supported for that eventuality.

Similar to most recent international findings of nurses attitudes (Terkamo-Moisio et al., 2017), our study showed nearly one third of the total NZ nurse respondents, however, "mostly" or "strongly" disagreed with the prospect of legal assisted dying, based primarily on 'slippery slope' arguments and concerns for the lack of safeguards for both clinicians and people seeking assisted dying. In contrast, the willingness of sub-sample nurses to participate in assisted dying activities was attributed above all to a commitment to respect for patient autonomy, including end-of-life treatment choices, even when that may conflict with the nurse's personal beliefs. Moreover, again consistent with international research (Vezina-Im et al., 2014), willingness to participate in a range of assisted dying tasks was strongest where there was little ethical ambiguity in the patient's circumstances (e.g., terminal illness, versus long-standing endemic depression), *and* premised on strong professional supports. Thus, assuming an inevitable role for nursing in legal assisted dying, nurse respondents who were willing to participate expected their professional bodies to both promote assisted dying implementation guidelines and training for current practitioners and also provide assurance that those entering nursing are trained in legal assisted dying roles.

Development of practice guidelines by nursing bodies *in advance* of legal assisted dying coming into force could mitigate risk that nurses might tacitly be expected to undertake assisted dying tasks without relevant ethical and practical preparation. The Vermont legislation, enacted to take effect immediately (Vermont General Assembly, 2013), resulted in hospitals and clinicians "scrambling to figure out whether they will take part in the law, and … state officials scurrying to prepare guidelines" (USA Today, 2013). In Australia, Doolan and Bradley

(2017) want to see nursing roles in assisted dying "embedded in practice to ensure that nurses integral to the care of a patient who has requested VE [voluntary euthanasia] are consulted and included in the decision-making processes" (p. 1). Guidance for developing implementation supports is available from the supports developed for clinical practice in the Netherlands (Government of the Netherlands, 2017), Québec (College des Medecins du Quebec, 2015) and federal Canada (Canadian Nurses Association, 2017; College of Physicians and Surgeons of Ontario, 2015). Those guidelines variously clarify definitions, stipulate review processes, and address other procedural, ethical and decision-making issues. The development of effective practice guidelines and standards needs to take into account all usual nurse roles in end-of-life care, including those not acknowledged in the existing assisted dying statutes (e.g. acting under the instruction of a doctor to set up equipment) (Oliver, 2016). Ideally a statute for assisted dying should delegate responsibility for developing safe practice measures to the appropriate combination of professional bodies, in particular the regulatory bodies, as pertinent to each jurisdiction.

For nurses to determine appropriate roles in legal assisted dying, both individually and for the nursing profession, in advance of legalisation, more research is needed on nurses' actual and preferred roles where assisted dying is already legal, including abstention from engagement and the enablers and barriers to sound ethical engagement decisions by individual nurses. It would also be highly valuable to investigate the ideal nurse role in assisted dying from the perspective of patients.

Conflicts of interest

Author PM is a member of the End of Life Choice Society of New Zealand. Author PO is a member of End of Life Choice Society of New Zealand for the purpose of obtaining information on the group's activities for research purposes.

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Appendix A. Supplementary data

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