



NURSES' ATTITUDES TO EUTHANASIA: A REVIEW OF THE LITERATURE

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This article provides an overview of the scarce international literature concerning nurses' attitudes to euthanasia. Studies show large differences with respect to the percentage of nurses who are (not) in favour of euthanasia. Characteristics such as age, religion and nursing specialty have a significant influence on a nurse's opinion. The arguments for euthanasia have to do with quality of life, respect for autonomy and dissatisfaction with the current situation. Arguments against euthanasia are the right to a good death, belief in the possibilities offered by palliative care, religious objections and the fear of abuse. Nurses mention the need for more palliative care training, their difficulties in taking a specific position, and their desire to express their ideas about euthanasia. There is a need to include nurses' voices in the end-of-life discourse because they offer a contextual understanding of euthanasia and requests to die, which is borne out of real experience with people facing death.

Introduction

The enormous progress made in science and technology has resulted in medicine being able to extend human life significantly.¹ However, medicine has not always been able to guarantee a better quality of life within this increased quantity of life. A number of important ethical questions are situated in this tension between length and quality of life. One pressing question being debated world-wide concerns the ethical acceptability and desirability of legalizing euthanasia.

This article is a literature review of nurses' attitudes to euthanasia. Nurses' voice is of immense importance, since nurses are involved longer and more intensely than any other professional group in the care of dying persons and their families. They occupy a privileged position for knowing about the experiences of patients who request euthanasia.² The Belgian Act on Euthanasia came into force on 23 September 2002,³ making Belgium only the second country in the world, after the Netherlands, to have

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decriminalized euthanasia under certain conditions. Nurses can anticipate being confronted more often and more urgently with euthanasia. However, little is known about nurses' attitudes to euthanasia and its legalization. It is important to know not only whether nurses support changes in the law to allow euthanasia, but also what conditions they believe the law should specify. The practical experiences of nurses can make a valuable contribution to the debate about euthanasia. Moreover, insight into nurses' attitudes would be useful when drawing up clinical practice guidelines. The present review is the first to collect in an orderly fashion the scarce international research data and to compare these findings with each other as far as possible.

Data and analysis

Using the electronic databases Medline, BIOETHICSLINE and Cinahl, scholarly research articles published in Dutch, French, German and English journals were systematically investigated. Manual searches for relevant references were conducted. A combination of the following keywords was used: euthanasia, nursing, attitudes, views, opinions and characteristics. For inclusion, the study sample had to consist of nurses, and researchers had to focus on the nurses' attitudes to euthanasia, its legalization and/or the factors that may be related to these attitudes.

The search strategy was limited to publications between 1990 and 2002 because the euthanasia debate has become prominent only since the 1990s. Before 1990 no significant empirical study was published to the best of our knowledge. Attitudes towards the ethics and legality of euthanasia have gradually been changing over the last decade. All selected articles describe nurses' attitudes towards euthanasia as an illegal act, making them not comparable with potential studies reporting on nurses' attitudes to euthanasia after legalization. In 2002 the act on euthanasia came into force in Belgium as well as in the Netherlands, probably influencing nurses' attitudes to euthanasia.

In selecting the literature, predetermined inclusion criteria were applied. These criteria were logically derived from the operating definition of euthanasia. In accordance with official legal terminology, euthanasia is defined as the administration of lethal drugs with the explicit intent of shortening a patient's life at that person's explicit request.³ The necessary criteria for euthanasia are: the patient has attained the age of majority or is an emancipated minor, and is legally competent and conscious at the moment of making the request; the request is voluntary, well considered and repeated, and is not the result of any external pressure; and the patient is suffering from a terminal illness. Other situations are not implied in the definition.

Publications were selected on the basis of these inclusion criteria. After reading the abstracts, 15 usable publications were identified: eight quantitative studies,^{2,4-10} five qualitative studies,¹¹⁻¹⁵ one review article,¹⁶ and one survey article dealing with a number of quantitative studies.¹⁷ These articles formed the basis for this literature review. The settings were Australia, Canada, Finland, Israel, Japan, the Netherlands and the USA. Euthanasia is illegal throughout these countries, with the exception of the Netherlands. Euthanasia was not legal when the Dutch study¹⁴ was taking place; however, it was not a punishable offence if the 'due care' requirements were fulfilled. Some study samples were composed of a mix of nursing specialties, while others dealt with one specific practice setting (e.g. palliative care, oncology). Characteristics of the

primary empirical studies are schematically presented in Tables 1 (quantitative studies) and 2 (qualitative empirical studies).

Data analysis started with reading repeatedly through the different articles to obtain an overall sense of the studies' content. Important items involving attitudes of nurses were gathered together and were classified into three categories: negative/positive/no opinion. The analysis continued by looking for reasons and arguments for respondents' opinions in each category. Theme headings were formed under which the articles were placed. Factors significantly influencing opinion formation were analysed. Possible differences between subgroups of nurses were examined. The researcher who performed the literature search also analysed the data. The process of data collection and analysis was carefully evaluated and commented on by two experts in nursing ethics research.

Different criteria are required to evaluate qualitative research from those used for quantitative work. A good quantitative study has to measure the phenomena of interest accurately. It needs to generalize beyond the particular context in which the research has been conducted. It is judged in terms of validity and reliability, both of which were mentioned in only a few studies, so the quality of the results needs to be questioned. The aim of a good qualitative study is to access the phenomena of interest from the participants' perspective. Evaluative criteria should be based on trustworthiness. Specific strategies are used to increase the worth of qualitative projects: triangulation, peer debriefing and member checking were appropriate in this review. Only The¹⁴ outlined these strategies. Reliability is thus questionable because other studies did not describe these strategies.

Results

An overview of the findings from the empirical studies is provided, highlighting: (1) the percentage of nurses who were for or against euthanasia and the arguments that nurses applied in support of their positions; (2) nurses' views about their involvement in euthanasia; (3) the factors that influenced opinion formation; and (4) relevant comments from the nurses themselves.

For or against

Many studies examined whether nurses believe that euthanasia should be legalized and/or whether they think it is ethically acceptable. The studies show a wide range in the reported percentages, which can be explained, in part, by the composition of the sample. Certain participant characteristics seem to impact significantly on their views about euthanasia (see below). The percentage of nurses who were in favour of legalization ranged from 14%,^{4,9} 47%,¹⁰ 62%,⁷ and 63%⁶ to 78%.⁵ The percentages of nurses who considered euthanasia to be ethically acceptable were 23%,^{4,9} 31%,⁸ 62%¹¹ and 70%⁷ respectively.

Arguments for

The arguments in support of nurses' position on euthanasia and/or its legalization were: quality of the patient's life, respect for the patient's autonomy, and dissatisfaction with the current situation.

Table 1 Overview of the quantitative empirical studies

Study	Design and data collection	Data analysis	Sample	Setting (country)	Setting (specialty)	Reliability	Validity
Asai <i>et al.</i> , 2001 ⁴	<ul style="list-style-type: none"> Postal survey Self-administered questionnaire based on version of Kuhse and Singer 	<ul style="list-style-type: none"> Unpaired <i>t</i>-tests 95% CI Chi² test Logistic regression 	<ul style="list-style-type: none"> <i>n</i> = 903 (659 physicians; 244 nurses) RR nurses = 67% (145/217) Not random Members of Palliative Care Association 	Japan	Palliative care	?	<ul style="list-style-type: none"> Back-translated questionnaire, reviewed by author of original questionnaire
Kitchener, 1998 ²	<ul style="list-style-type: none"> Postal survey Self-administered questionnaire 	<ul style="list-style-type: none"> Percentages 95% CI Chi² test Logistic regression 	<ul style="list-style-type: none"> <i>n</i> = 2000 RR = 61% (1218/2000) Random Listed on 1996 printed register compiled by the Nurses Board 	Australian Capital Territory	Community care, critical care, geriatric care, oncology, palliative care, mental health care, other	?	?
Kuhse and Singer, 1993 ⁵	<ul style="list-style-type: none"> Postal survey Self-administered questionnaire 	<ul style="list-style-type: none"> Frequencies and percentages 	<ul style="list-style-type: none"> <i>n</i> = 1942 RR = 49% (943/1942) Random Members of Nursing Council 	Australia (Victoria)	Mixed (not specified)	?	?

Table 1 (Continued)

Study	Design and data collection	Data analysis	Sample	Setting (country)	Setting (specialty)	Reliability	Validity
Musgrave <i>et al.</i> , 2001 ⁶	<ul style="list-style-type: none"> Correlational Self-administered questionnaire Nurses' Attitudes Regarding Physician-Assisted Dying questionnaire: 4 vignettes 	<ul style="list-style-type: none"> Frequencies and percentages Means Chi² test Power analysis: ? 	<ul style="list-style-type: none"> <i>n</i> = 123 (71 oncology; 52 maternity/nursing) RR = unknown Not random 	Israel	Oncology; maternity-nursing departments	Test-retest reliability in community health nurses: k-values: vignette 1: 0.75 vignette 2: 0.87 vignette 3: 0.59 vignette 4: 0.64 Not calculated because of time constraint	<ul style="list-style-type: none"> Back-translated questionnaire, reviewed by author of original questionnaire
Musgrave and Soudry, 2000 ⁷	<ul style="list-style-type: none"> Correlational Three-part self-administered questionnaire (Likert scale) 	<ul style="list-style-type: none"> Descriptive statistics Spearman's rank-order correlation Chi² test 	<ul style="list-style-type: none"> <i>n</i> = 200 RR = 69% (139/200) Not random Participants attending international conference 	Israel, but participants from 27 different countries	Nurse-midwives	Not calculated because of time constraint	<ul style="list-style-type: none"> Content validity
Richardson, 1994 ⁸	<ul style="list-style-type: none"> Postal survey Self-administered questionnaire (Likert scale) 	<ul style="list-style-type: none"> Frequencies and percentages One-way analysis of variance 	<ul style="list-style-type: none"> <i>n</i> = 200 RR = 74% (148/200) Random Members of Oncology Nurses' Society 	USA	Oncology	Internal consistency Cronbach's alpha = 0.89	?

Table 1 (Continued)

Study	Design and data collection	Data analysis	Sample	Setting (country)	Setting (specialty)	Reliability	Validity
Tanida <i>et al.</i> , 2002 ⁹	<ul style="list-style-type: none"> Postal survey Self-administered questionnaire based on version of Kuhse and Singer 	<ul style="list-style-type: none"> Percentages 95% CI Chi² test 	<ul style="list-style-type: none"> <i>n</i> = 244 RR = 67% (145/217) Members of Palliative Medicine Association 	Japan	Palliative care	?	<ul style="list-style-type: none"> Back-translated questionnaire, reviewed by author of original questionnaire
Young <i>et al.</i> , 1993 ¹⁰	<ul style="list-style-type: none"> Postal survey Nurses' Attitudes Regarding Physician-Assisted Dying questionnaire: 4 vignettes 	<ul style="list-style-type: none"> Frequencies and percentages Means Chi² test 	<ul style="list-style-type: none"> <i>n</i> = 2000 RR = 61% (1210/2000) Random Members of Oncology Nursing Society 	USA	Oncology	?	<ul style="list-style-type: none"> Content validity: panel Face validity: pilot study

CI, confidence interval; RR, response rate; ?, not mentioned

Table 2 Overview of the qualitative empirical studies

Study	Design	Data collection	Data analysis	Sample	Setting (country)	Setting (specialty)	Trustworthiness
Kuuppelomäki, 2000 ¹¹	<ul style="list-style-type: none"> • Explorative 	<ul style="list-style-type: none"> • Semistructured, focused interviews 	Content analysis	<ul style="list-style-type: none"> • $n = 71$ (32 patients ; 13 family members; 13 nurses; 13 physicians) 	Finland	Oncology (2 hospitals ; 4 health centres)	<ul style="list-style-type: none"> • Triangulation: yes • Member check: ? • Peer debriefing: ? • Other: pre-testing interview method, verbatim transcriptions of tape-recorded interviews, data collection and analysis by same researcher
Matzo and Schwarz, 2001 ¹²	<ul style="list-style-type: none"> • Explorative 	<ul style="list-style-type: none"> • Written comments on returned questionnaires from cross-sectional survey 	Content analysis	<ul style="list-style-type: none"> • $n = 110$ • Self-selected sample • Members of Oncology Nurses' Society 	USA	Oncology	<ul style="list-style-type: none"> • Triangulation: ? • Member check: ? • Peer debriefing: ?
McInerney and Seibold, 1995 ¹³	<ul style="list-style-type: none"> • Explorative 	<ul style="list-style-type: none"> • Semistructured interviews 	Grounded theory	<ul style="list-style-type: none"> • $n = 10$ • Network sample via nurses undertaking a conversion course 	Australia	Oncology, neonatal care, palliative care, critical care, coronary care, geriatric care, renal dialysis, midwifery	<ul style="list-style-type: none"> • Triangulation: ? • Member check: ? • Peer debriefing: ? • Other: verbatim transcription of tape-recorded interviews • Saturation: yes

Table 2 (Continued)

Study	Design	Data collection	Data analysis	Sample	Setting (country)	Setting (specialty)	Trustworthiness
The, 1997 ¹⁴	<ul style="list-style-type: none"> • Anthropological research 	<ul style="list-style-type: none"> • Interviews • Participant observation 	Ethnographic analysis	<ul style="list-style-type: none"> • <i>n</i> = ? 	The Netherlands	Respiratory diseases	<ul style="list-style-type: none"> • Triangulation: yes • Member check: yes • Peer debriefing: yes • Other: bracketing, verbatim transcriptions of tape-recorded interviews
Young and Ogden, 2000 ¹⁵	<ul style="list-style-type: none"> • Explorative 	<ul style="list-style-type: none"> • Responses to open-ended prompt at end of survey 	Content analysis Inductive approach	<ul style="list-style-type: none"> • <i>n</i> = 22 • Self-selected sample • Members of Association of Nurses in AIDS Care 	Canada	HIV/AIDS care	<ul style="list-style-type: none"> • Triangulation: ? • Member check: ? • Peer debriefing: ?

?, not mentioned

The right to die with dignity (as one aspect of quality of life) was mentioned in various articles as one argument justifying euthanasia. Kuuppelomäki¹¹ reported that a hopeless situation, in which a patient is no longer capable of continuing life in a humanly meaningful way, was the most important argument given by interviewees for justifying euthanasia. When further specifying the concept of a 'hopeless situation', reference was made to a state of dependency as well as the suffering and pain that cannot be alleviated. Many nurses found these patients' suffering to be morally irresponsible, and stated unequivocally that no one should die in pain.¹² The wish to free the patient of unbearable pain, thus contributing to a good death, leads to greater acceptance of euthanasia.¹³

In addition, many nurses stress the importance of patients' own will and their right to decide about their own life.^{11,12} Young and Ogden reported that respect for the autonomy of the individual can give rise to an ambivalent attitude towards euthanasia: some nurses say that they cannot accept euthanasia personally, but believe that individuals should be able to make their own decisions in this matter.¹⁵ The possibility of objecting for reasons of conscience means that nurses will not resist the legalization of euthanasia even though they will never assist in it personally.¹² Almost without exception, respondents expressed concern about legalization, but the few who said they support it do so out of dissatisfaction with the current state of affairs. As long as the shadow of repercussions hangs over it, the practice of euthanasia cannot be brought into the open. Fear of sanctions keeps the practice hidden and hinders nurses from seeking the advice and support of their colleagues.¹² This clandestine practice is an insecure situation for both the caregiver and the patient: for the caregiver owing to the criminal implications of euthanasia; for the patient because its illegal status implies that euthanasia often takes place in a less than humane manner.¹⁵ The two participants out of 10 who were pro-euthanasia in McNerney and Seibold's study believed that legalizing euthanasia would stop current and potential abuse.¹³

Arguments against

Just like the proponents of euthanasia, its detractors also argue in favour of a 'good death'. According to them, this good death should be attained by ensuring the maximum degree of comfort, care and adequate pain control.¹³ The primary care objective should not consist of ending life, but of alleviating discomfort.¹² The majority of respondents were willing to increase the pain medication to any level if a patient's comfort requires it, but did not want to participate in intentionally ending the patient's life.¹² The immediacy and certainty of death associated with euthanasia seems to be an obstacle to conscience. In addition, the fact that one has control over one's own death is alienating. The Dutch study¹⁴ demonstrated that euthanasia quickly acquires the features of a business transaction because many things need to be arranged, explained and signed. This impression is strengthened by the often threatening supervision of the judicial authorities.¹⁴

At the same time, there is growing confidence in the possibilities held out by palliative care. A belief voiced by the majority of nurses in Young and Ogden's study was that expert palliative care can make a patient's final days more bearable. This is quite important because the patient is usually trying to escape not from life but from pain and suffering.¹⁵ Several nurses identified the experience of pain and suffering as the reason why people want to die; they argued that, when those symptoms are controlled, most patients would want to live. It is noted that good pain management

still does not occur routinely, despite knowledge about palliative and hospice care. A number of respondents in the study by Matzo and Schwarz called for further education of health care professionals and additional research into palliative care interventions.¹²

A third group of arguments opposing euthanasia involve religious and moral objections. For instance, some participants stated that, based on their own religious values, a person does not possess the right to decide about the length of life or the time of their own death.^{11,12} This moment is predestined for every person. Death is a struggle, inherent in life, which must be fought to the very end.¹⁵ Life is in God's hands and hastening death is equivalent to murder. Interviewees mentioned killing and murder when they criticized the hastening of another person's death.¹¹

Final arguments have to do with the concern for potential abuse.¹¹⁻¹⁵ Two nurses were anxious that a euthanasia law would open up a Pandora's box and ultimately escalate to performing euthanasia without patients having requested it.¹³ Nurse participants also feared that financial considerations would play a part in end-of-life decision making, with euthanasia being regarded as a less expensive alternative to palliative care, thus resulting in the risk of economic pressure on the dying patient.¹²⁻¹⁵ Nurses who held this point of view considered that euthanasia makes ill people very vulnerable and does not rule out relatives' pressure to end patients' lives; in this context they questioned individuals' 'chance to make a confident informed decision'.¹³

Involvement in euthanasia

Nine studies reported the percentages of nurses willing to be involved in the euthanasia process if it was legal, although researchers did not clarify the nature of this involvement. These percentages vary from 14%^{4,9} and 23%⁸ to 65%.⁵ It is striking that the percentages of nurses willing to co-operate in euthanasia are lower than the percentages of nurses believing that euthanasia is ethically acceptable (23%,⁴ 31%⁸ and 78%⁵ respectively). There seems to be a tension between ethically reconciling oneself with the euthanasia practice and actively taking part in it.

Four studies observed nurses' willingness to remain with the patient during the act of euthanasia. According to Musgrave and Soudry,⁷ 64% of nurses are willing to do this. Musgrave *et al.*⁶ showed that this willingness is greater when the nurse has a long-standing relationship with the patient. According to The,¹⁴ this has to do with the fact that euthanasia is a process of growth and emotional development. The nurse must become accustomed to the idea that euthanasia is going to be carried out on a certain patient.¹⁴ Twenty-nine per cent of nurses who were unable to reconcile themselves to euthanasia were nevertheless willing to remain with their patient and support him or her while the lethal drug is given. This demonstrates the willingness to set aside one's personal conviction to meet professionally an expressed patient need.¹⁰

The percentage of nurses willing to administer legal drugs ranged from 14%,⁹ 16%⁶ and 17%¹⁰ to 36%.⁷ Explanations are scarce for the fact that few nurses actually want to administer the medication that will cause death. Musgrave *et al.*⁶ as well as Young *et al.*¹⁰ put nurses' unwillingness down to the fact that a philosophical agreement with euthanasia is very different from actively performing it. The illegality of euthanasia affected the decision of many Japanese nurses in Tanida *et al.*'s study.⁹ Another possibility is that nurses may feel that being the one to inject the drug could change the

nature of the nurse–patient relationship. This finding could be a reflection of how nurses view their role as patient advocates.¹⁰

From the articles studied it can be concluded that nurses hold various beliefs regarding euthanasia that range from being willing to accept euthanasia as a legitimate choice and supporting patients during the process, to believing that euthanasia is wrong and refusing to be involved in its performance.

Background factors

Nurse characteristics with a statistically significant influence on opinion formation were identified in the articles as: religious beliefs, nursing specialty and age.

Religious beliefs and attitude to euthanasia

Degree of religiosity. The six studies^{2,5–8,10} that examined the connection between nurses' religious beliefs and their attitude to euthanasia agreed unanimously that this relationship is statistically significant ($P < 0.05$): the stronger one's religious faith, the more one opposes euthanasia and its legalization.^{5–8} It is also apparent that the greater the role religion has in one's life, the less one is willing to remain with the patient during the act of euthanasia, and the less one is willing to assume responsibility for performing euthanasia.⁷ The study by Musgrave *et al.*⁶ also revealed that 54% of religiously inspired nurses who were opposed to euthanasia were nevertheless willing to remain with the patient during the actual act of euthanasia. Apparently, nurses are capable, to a certain extent, of setting aside their own religious faith in order to meet the needs of patients.

Religious affiliation. The relationship between religious traditions and attitudes towards euthanasia also follows a trend similar to that of degree of religiosity. A significant association has been observed between religious affiliation and nurses' attitudes: the more nurses observe religious traditions, the less likely they are to agree with euthanasia.⁶ Nurses who indicated that they were agnostic or atheist were stronger supporters of euthanasia than those who were Protestant or Catholic. Moreover, nurses who identified themselves as Catholic were less likely to agree with the acceptability of euthanasia than those who are Protestant.^{2,10} Attitudes were remarkably varied between Christian denominations. Anglicans were closer in attitude to atheists and agnostics than to Catholics, while other Protestant denominations and other religions (not specified) were closer in attitude to Catholics.²

Nursing specialty and attitude to euthanasia

Two studies^{2,6} examined the link between nursing specialty and attitude to euthanasia. The study by Musgrave *et al.*⁶ investigated whether a difference in attitude exists between oncology nurses and non-oncology nurses working in maternity and nursing departments. Non-oncology nurses were significantly ($P < 0.01$) more in favour of legalizing euthanasia than oncology nurses. The study by Kitchener² examined the differences in attitude regarding the legalization of euthanasia and willingness to assist in life-terminating action for nurses working in several specialties (home care, intensive care, geriatric care, palliative care, psychiatric care, oncology, etc.). There was a statistically significant ($P = 0.00001$) difference between the various nursing disciplines. The only subgroup not showing a majority support was that of the palliative care nurses (33%). The findings of Kitchener's study show that the more one

comes into contact with terminally ill patients, the less one is in favour of legalization ($P < 0.002$). These associations hold even when other nurse characteristics are statistically controlled.²

Age and attitude to euthanasia

Kuhse and Singer⁵ demonstrated that younger nurses tended to be more in favour of legalization and more willing to assist in euthanasia than their older colleagues. However, no statistical test has been performed to measure this difference statistically. Kitchener² confirmed these findings. Nurses younger than 40 years of age were more in favour of legalization and more willing to assist in euthanasia than older nurses. This relationship between age and attitude to euthanasia was strongly significant ($P = 0.00000$).

Nonsignificant relationships

No statistically significant relationship was shown between attitude to euthanasia and level of education (diploma), work experience and professional function.⁷ Richardson⁸ confirmed that nurses' educational preparation as well as length of practice as an oncology nurse had no influence on their attitudes. Kitchener² concluded that there is no statistically significant relationship between a nurse's gender and his or her attitude to euthanasia or willingness to assist in its performance.

Nurses' comments

Four studies^{5,8,12,13} gave the nurses the opportunity to make additional comments; 25%¹² to 56%⁵ of them took advantage of this. This indicates nurses' desire to express their views about this issue. They also explicitly stated that euthanasia should be talked about, and that they wish to express their stories, views and recommendations regarding this subject.¹²

Not only did participant nurses believe that we should talk more about euthanasia, they also thought that there is a need for more palliative care training.^{12,13} These nurses stated that pain and other symptomatic suffering are the main reasons for patients wanting their life to be terminated. They believed that, if these symptoms can be brought under control, then most patients would wish to continue living.¹²

Discussion and conclusion

Empirical research into the views of nurses with respect to euthanasia is relatively limited in number. Only 15 publications were selected for this study. An important obstacle to inclusion was the definition of euthanasia: in many studies, there was either no clear definition or the definition did not correspond with the one that had been predetermined. One of the reasons for misunderstanding concerning euthanasia is terminological. When scientists and/or professionals such as nurses from different countries discuss this subject they may think that they understand each other because they are using the same concepts, but they are often unaware of the fact that these concepts have different meanings in different countries and cultures. Yet, in order for a meaningful discussion to take place, uniformity is an absolute necessity. In the present

review there was no such ambiguity because the researchers clearly stated the definition of euthanasia.

Nurses' main arguments for believing euthanasia to be acceptable have to do with quality of life, respect for autonomy, and dissatisfaction with the current situation. Proponents of euthanasia believe that autonomous choice by patients about the circumstances of their death will promote more compassionate care that is sensitive to individual needs. They argue that competent, terminally ill individuals who are fully informed of the facts and cognizant of the consequences have the right to make decisions about their own death. Patient autonomy and beneficence are two ethical principles that play an integral part in the nurse-patient relationship. Patient autonomy acknowledges the right of individuals to decide for themselves, whereas beneficence dictates that nurses use strategies that will support the general well-being of patients. These two values guide the debate surrounding euthanasia.

Nurses find euthanasia to be a more acceptable alternative if the patient is suffering and in unrelievable pain. Suffering, often cited as a reason for requesting euthanasia, encompasses more than just physical symptoms and is an individualized phenomenon. Patients' suffering must be adequately addressed so that euthanasia is not considered as the only option for relief.

The most important arguments for believing euthanasia to be unacceptable have to do with the right to a good death, belief in palliative care, religious objections, and the risk of abuse. Opponents of euthanasia argue that health care professionals' special relationships with their patients entail particular responsibilities and obligations. Traditionally, these relationships have focused on healing, caring, promoting well-being and relieving suffering, striving to achieve the best possible quality of life for patients and their families. All these are paramount concepts of palliative care. Other opponents suggest that legalization of euthanasia will be the first step down a slippery slope that will have a deleterious effect on vulnerable segments of society, such as elderly and severely handicapped persons. Once the first step is taken down the slippery slope by allowing competent individuals to request euthanasia, no clearly defined stopping point will exist.

Research respondents find it difficult to take a categorical point of view on euthanasia. The reason why it is so difficult has to do with the complexity and strongly contextual nature of euthanasia and the unique process of dying.^{13,17} The development of a personal as well as a professional ethical stance has been shown to be a dynamic and reflective process taking place even within interviews. Although nurses' attitudes are often conceptualized as a dichotomy, they cannot be measured accurately by questions that have a two-way forced choice response format. We should gain insight into the issues involved in euthanasia within the context of the questions asked, into the situations encountered, and into the understanding each nurse has of the actions they take in response to a client's request to die. Qualitative studies have clearly been demonstrating that quantitative survey methods alone are inadequate to provide an accurate picture of health workers' opinions about euthanasia.

A noteworthy finding is that the percentage of nurses who think of euthanasia as ethical acceptable is higher than the percentage who are willing to assist in the process of euthanasia. Apparently, but not surprisingly, a tension exists between ethical reconciliation with the practice and actively taking part in it: moral agreement with euthanasia is different from actively performing it. This finding suggests that some conflict exists concerning the degree to which patients have a right to euthanasia.

Nurses may not feel that a patient's right to autonomy extends to a request for euthanasia. Another possibility is that nurses may feel that being the one to inject the drug could change the nature of the nurse-patient relationship. Nurses may also feel that administering drugs that cause death has a different connotation to simply being present while others perform the act. It is remarkable that many nurses who do not personally believe in euthanasia are willing to support patients who request it. These nurses indicate a willingness to set aside personal beliefs and emotions to meet an expressed patient need. This finding may be a reflection of how nurses view their professional role as patient advocates, emotionally labouring, silently witnessing and facilitating their patients' last journey. The respect for autonomy is evident in these nurses' responses.

None of the studies report on nurses' attitudes towards their involvement in the aftercare. Nevertheless, we think that nurses have an important task in supporting family members as well as colleagues after the patient has died.

Nurses' views on euthanasia are significantly ($P < 0.05$) related to religion, age and specialty. Data have been shown that the more one is religiously inspired, the more one opposes euthanasia. Further investigation is needed to determine if religious practices such as denomination and frequency of attendance are significant factors. The religious affiliation of the majority of participants (Catholic) needs to be acknowledged. Subsequent researchers would do well to choose a broader range of participants. The older nurses are, the less able they are to reconcile themselves to euthanasia. The age differences in attitude could be due to either greater experience of the older nurses or to the difference between younger and older generations. If this is so, nurses' attitudes will become more in favour of euthanasia as the older nurses retire and the younger ones take their place. The more often a nursing specialty is confronted with dying patients (e.g. palliative care), the more reserved nurses are with regard to euthanasia. There is no good explanation for this finding but the possibility is raised that palliative care nurses are self-selected for attitudes on end-of-life issues such that this specialty may attract and retain nurses with certain attitudes. It is precisely these nurses who will most often be confronted with euthanasia. It can be argued that participating nurses work directly with terminally ill patients, many of whom endure extreme pain and suffering. This undoubtedly influences nurses' perspectives towards end-of-life care and euthanasia.

Limitations of this review

This review has aimed to map nurses' attitudes to euthanasia described in scientific nursing and medical journals. Ignoring other literature domains, we are well aware of the fact that some arguments and concepts regarding euthanasia do not have the comprehensiveness and/or differentiation that can be discovered in philosophical-ethical literature.

Any study's findings must be regarded with a certain degree of caution. First, methodological and design differences make these studies difficult to compare. Samples were sometimes nonrandomly selected, small in size and composed of diverse nursing specialties. Most surveys were conducted with nurses who belong to some kind of professional association, which understandably raises concerns regarding selection bias. It is unknown whether these nurses are representative of the whole nurse population.

The qualitative studies paid little attention to trustworthiness of the data. Similarly, none of the questionnaires was sufficiently tested for validity or reliability. Further research for adding assurance of validity and reliability to questionnaires and trustworthiness to qualitative projects is recommended. In two studies the response rate was lower than 60% and unknown, respectively. With poor response rates and the increased chance of nonrespondent bias, it is difficult to generalize about nurses' opinions on euthanasia.

Thirdly, when comparing the study results, the time lag must be acknowledged. The possibility that the climate of opinion in nurses and other health care professionals as well as the general public became more favourable to euthanasia between 1990 and 2002, cannot be eliminated. More importantly, there are differences in the social context in terms of opinions concerning life and death, religion, the principle of autonomy etc., as well as differences in culture between the countries where the studies were located. For instance, Japanese nurses were working under tight supervision by doctors at the time of Tanida *et al.*'s survey. Australian nurses acted more independently than their Japanese colleagues, although they too had to follow doctors' orders within a historical doctor–nurse relationship.⁹

Fourthly, many investigators have asked nurses to respond to hypothetical vignettes about euthanasia and to speculate about factors that could affect their own practice in the future. Interpretation is difficult when researchers invite participants to respond to hypothetical cases and then ask them to speculate about how they would respond to similar cases in real life. Moreover, the quantitative research question of whether one is 'for or against' has been posed in absolute terms, leaving little room for a qualified response, yet contextual subtleties do play a part in determining a person's standpoint on euthanasia. Consequently, the percentages cited must be interpreted with the necessary caution. This also makes clear the need for input from nurses in the debate surrounding euthanasia. Caregivers who speak on the basis of their own experience can focus attention on context-dependent factors in the euthanasia debate.

Finally, because euthanasia was illegal at the time when the studies were carried out, nurses may have been reluctant to respond candidly to questionnaires or in interviews. Some respondents may have been confused or concerned about the acceptability of their own nursing actions or unfamiliar with the existing consensus about the appropriateness of certain end-of-life interventions.

Application

In the twenty-first century we speak of medical futility and hear concerns about balancing the rights of individual patients with the common good. In the light of the increasing acceptance of the concepts of 'rationed care' and 'quality of life', euthanasia is going to present difficult ethical dilemmas. Now that two western industrialized countries allow euthanasia, it is possible that others will follow. Nurses will be faced with the possibility of having to be involved with the performance of euthanasia. Thus they will need to be clear about their motives and their ethical justification for euthanasia, preferably before any legalization occurs. Nurses who are aware of their stance can actively respond to attempts to legalize euthanasia. Nurses' unique perspective can even assist in creating appropriate laws and guidelines.

The high response rate to a cursory request for comments as well as the comments' content indicate that nurses truly want to make known their ideas, concerns and

experiences regarding euthanasia and end-of-life nursing interventions. This somewhat contradicts the fact that they seldom do this in reality. The emotional content of much that has been written further suggests that nurses need a supportive forum to help them to manage, understand and process the complex nature of these issues. By representing the voices of nurses, professional nursing associations can bring the nursing profession into the debate.

Need for further study

It could be speculated that factors other than those discussed in this review may play a major role in the moralities and behaviours of nurses. Our current review cannot tell what is its nature; more empirical studies focusing on nurses' ethical beliefs will be needed to address this issue adequately. It can be argued that rather complicated multilateral relationships among different factors have played significant roles. Future qualitative research into euthanasia and related issues needs to acknowledge the contextual element of nurses' attitude formation and the development of a professional ethic.

Only 15 research articles were included in this literature review, thereby pointing to the critical need for ongoing research in the most complex area of end-of-life care. For instance, it would be interesting to compare nurses' attitudes with the attitudes of doctors, of relatives and of patients themselves.

This literature review forms a baseline for studying the changes in attitudes towards euthanasia over time. It will be interesting to see if attitudes change as it becomes legalized. Is a change in attitude influenced by health policy regulations or does a change in attitude towards euthanasia precipitate a change in health policy and legislation? In order to understand better the relationship between a country's policy on euthanasia and the influence it may have on professional attitudes, additional research needs to be performed.

Conclusion

There is a need to include the voices of nursing practitioners in the end-of-life discourse because they offer a contextual understanding of euthanasia and requests to die borne out of real experience with people facing life-and-death decisions. As patient advocates, experts and professionals who spend a great deal of time with dying patients, it is surprising that nurses have been on the sidelines in discussions surrounding end-of-life care.

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References

- ¹ Blondeau D ed. *Ethique et soins infirmiers. [Ethics and nursing care.]* Montréal: Les Presses de l'Université de Montréal, 1999.
- ² Kitchener BA. Nurse characteristics and attitudes to active voluntary euthanasia: a survey in the Australian Capital Territory. *J Adv Nurs* 1998; **28**: 70–76.
- ³ The Belgian Statute Book (Belgisch Staatsblad). *The Belgian Act on Euthanasia* of 28 May 2002.

- ⁴ Asai A, Ohnishi M, Nagata SK, Tanida N, Yamazaki Y. Doctors' and nurses' attitudes towards and experiences of voluntary euthanasia: survey of members of the Japanese Association of Palliative Medicine. *J Med Ethics* 2001; **27**: 324–30.
- ⁵ Kuhse H, Singer P. Voluntary euthanasia and the nurse: an Australian survey. *Int J Nurs Stud* 1993; **30**: 311–22.
- ⁶ Musgrave CF, Margalith I, Goldsmid L. Israeli oncology and nononcology nurses' attitudes toward physician-assisted dying: a comparison study. *Oncol Nurs Forum* 2001; **28**: 50–57.
- ⁷ Musgrave CF, Soudry I. An exploratory pilot nurse study of nurse-midwives' attitudes towards active euthanasia and abortion. *Int J Nurs Stud* 2000; **37**: 505–12.
- ⁸ Richardson DS. Oncology nurses' attitudes toward the legalization of voluntary active euthanasia. *Cancer Nurs* 1994; **17**: 348–54.
- ⁹ Tanida N, Asai A, Ohnishi M *et al*. Voluntary active euthanasia and the nurse: a comparison of Japanese and Australian nurses. *Nurs Ethics* 2002; **9**: 313–22.
- ¹⁰ Young A, Volker D, Rieger PT, Thorpe DM. Oncology nurses' attitudes regarding voluntary physician-assisted dying for competent terminally ill patients. *Oncol Nurs Forum* 1993; **20**: 445–51.
- ¹¹ Kuuppelomäki M. Attitude of cancer patients, their family members and health professionals toward active euthanasia. *Eur J Cancer Care* 2000; **9**: 16–21.
- ¹² Matzo LM, Schwarz KJ. In their own words: oncology nurses respond to patient requests for assisted suicide and euthanasia. *J Appl Nurs Research* 2001; **14**: 64–71.
- ¹³ McInerney F, Seibold C. Nurses' definitions of and attitudes towards euthanasia. *J Adv Nurs* 1995; **22**: 171–82.
- ¹⁴ The AM. 'Vanavond om 8 uur ... ' Verpleegkundige dilemma's bij euthanasie en andere beslissingen rond het levenseinde. [Tonight at 8 o'clock ... Nursing dilemmas in euthanasia and other decisions at the end of life.] Houten: Bohn Stafleu Van Loghum, 1997.
- ¹⁵ Young MG, Ogden RD. The role of nurses in AIDS care regarding voluntary euthanasia and assisted suicide: a call for further dialogue. *J Adv Nurs* 2000; **31**: 513–19.
- ¹⁶ Schwarz KJ. Assisted dying and nursing practice. *Image J Nurs Sch* 1999; **31**: 367–73.
- ¹⁷ Aranda S, Bence G, O'Conner M. Euthanasia: a perspective from Australia. *Int J Palliat Nurs* 1999; **5**: 298–304.

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