

Euthanasia and assisted suicide in Dutch hospitals: the role of nurses

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Euthanasia and assisted suicide in Dutch hospitals: the role of nurses

Aim. To report a study on the role of nurses in euthanasia and physician-assisted suicide in hospitals, conducted as part of a wider study on the role of nurses in medical end-of-life decisions.

Background. Issues concerning legislation and regulation with respect to the role of nurses in euthanasia and physician-assisted suicide gave the Dutch Minister for Health reason to commission a study on the role of nurses in medical end-of-life decisions in hospitals, homecare and nursing homes.

Method. A questionnaire was sent in 2003 to 692 nurses employed in 73 hospital locations. The response suitable for analysis was from 532 (76.9%) nurses. Data were quantitatively analysed using SPSS version 11.5 for Windows.

Results. In almost half of the cases (45.1%), the nurse was the first with whom patients discussed their request for euthanasia or physician-assisted suicide. Consultations between physicians and nurses quite often took place (78.8%). In several cases (15.4%), nurses themselves administered the euthanatics with or without a

physician. It is not self-evident that hospitals have guidelines concerning euthanasia/physician-assisted suicide.

Conclusions. In the decision-making process, the consultation between the physician and the nurse needs improvement. In administering the euthanatics, physicians should take responsibility and should not leave these actions to nurses. Guidelines may play an important role to improve the collaboration between physicians and nurses and to prevent procedural, ethical and legal misunderstandings.

Relevance to clinical practice. Nurses in clinical practice are often closely involved in the last stage of a person's life. Consequently, they are often confronted with caring for patients requesting euthanasia or physician-assisted suicide. The results provide relevant information and may help nurses in defining their role in euthanasia and physician-assisted suicide, especially in case these practices should become legalised.

Key words: euthanasia, guidelines, hospitals, nurses, physician-assisted suicide, role

Introduction

To date, the debate concerning euthanasia in the Netherlands has mainly focused on the ethical and legal responsibilities of physicians. Their role is legally formalised in the law on euthanasia and physician-assisted suicide of April 2002 (De Haan 2002). The role of nurses has hardly been discussed in the public arena and has mainly been investigated in the context of research among physicians. It was only on the professional level that the agreements regarding the role of nurses were made by the establishment of joint guidelines of physicians and nurses (AVVV, NU'91 & KNMG 2006).

Apart from the need to clarify the role of nurses in euthanasia and physician-assisted suicide, several additional issues have arisen. One of these issues raised by professional associations of nurses, concerned the membership of nurses in the regional euthanasia review committees whose task is reviewing of reported cases of euthanasia and physician-assisted suicide based on the due care requirements of law.

However, the Health Minister decided that before any decision was taken about regulation of the role of nurses in euthanasia, their factual role in practice should be clarified. Consequently, the Minister commissioned a study on the role of nurses in medical end-of-life decisions in hospitals, homecare and nursing homes (Van Bruchem-van de Scheur *et al.* 2004). Meanwhile, an article has been published about the role of nurses in euthanasia and physician-assisted suicide in homecare (Van Bruchem-van de Scheur *et al.* 2007).

This article focuses on the role of nurses in euthanasia and physician-assisted suicide in Dutch hospitals, and presents the role of nurses during the request for euthanasia or physician-assisted suicide, the decision-making process and the administration of euthanatics. Subsequently, the article discusses

the role of existing guidelines in hospitals on euthanasia and physician-assisted suicide.

In the present study, euthanasia is defined as the administration of drugs by a person other than the patient with the explicit intention of ending the patient's life at his or her explicit request. Physician-assisted suicide is defined as the prescribing or supplying of drugs with the explicit intention of enabling the patient to end his or her own life. The concepts are different in the way they are carried out. In euthanasia, somebody administers the euthanatics. In physician-assisted suicide, the patient takes the lethal drugs as prescribed by the physician. Although there are moral and legal differences between both acts, in the present study, euthanasia and physician-assisted suicide are considered as one phenomenon. Respondents were not always present during the administering of the lethal drugs (143 times in 262 cases) and, consequently, did not know the ways in which these drugs were administered.

Literature review

Within the Netherlands, several surveys were conducted to determine the rate and main characteristics of euthanasia and physician-assisted suicide in medical practice (Onwuteaka-Philipsen *et al.* 2003, Van der Wal *et al.* 2003). As these studies focused on the role of physicians, they provided only marginal information about the role of nurses. Moreover, this information was indirect, as it was gathered not by asking nurses themselves. This latter point also applies for the study of Muller *et al.* (1997), this study concentrates on the role of nurses.

Apart from the large surveys among physicians, only a few qualitative studies have provided data from the perspective of

nurses themselves. However, these studies were conducted in single institutions (Pool 1996, The 1997, Van de Scheur & Van der Arend 1998). The study presented here is the first large-scale survey study exploring the role of nurses in euthanasia and physician-assisted suicide from their perspective.

In Belgium, the role of nurses has been explored in recent years both from the perspective of physicians (Deliens *et al.* 2000, Bilsen *et al.* 2004) and from the perspective of nurses (De Bal *et al.* 2006). In these studies, data were gathered at a time when euthanasia was illegal. Illegality of euthanasia during data-gathering is not exceptional, as becomes clear from the literature review of the De Beer *et al.* (2004). This review included 15 studies into the involvement of nurses in euthanasia, published between 1991 and 2002. In all selected articles, data were gathered at a time when euthanasia was illegal such as in Australia (Kuhse & Singer 1993), Japan (Tanida *et al.* 2002) and the USA (Asch 1996). Only in the included Dutch studies, euthanasia was not a punishable offence when the physician fulfilled the due care requirements.

The thread of several studies is that nurses, because of their daily involvement and specific expertise, are in a prime position to play a role in the various stages of the euthanasia process. According to De Beer *et al.* (2004) and De Bal *et al.* (2006), nurses are (often) the first caregivers to receive a request for euthanasia. In the decision-making process, they could have an important role in the analysis of the patients' request, for example to determine whether the request concealed an appeal for help (De Bal *et al.* 2006). However, several studies found that it is not obvious that nurses participated in the decision-making process (Muller *et al.* 1997, Deliens *et al.* 2000, Van der Wal *et al.* 2003, Bilsen *et al.* 2004, De Beer *et al.* 2004). Several studies reported that nurses cross the line by administering lethal drugs together with or without the physician (Muller *et al.* 1997, Van de Scheur & Van der Arend 1998, Bilsen *et al.* 2004, De Beer *et al.* 2004).

A comparison of the results in this article with the studies mentioned earlier is limited, because of differences in study design, definitions used and the absence of a sector-specific description of results in studies. Moreover, the illegal character of euthanasia during the data gathering could bias the comparison of results (see Discussion).

The study

Aim

The aim of the study was to investigate the role, perceptions, responsibilities and problems of nurses in medical end-of-life

decisions, to advise the Dutch government in legislation and policy-making concerning the role of nurses.

Design

The role of nurses in medical end-of-life decisions in Dutch hospitals, homecare organisations and nursing homes has been investigated using both qualitative and quantitative methods. During the qualitative part of this study, nurses were interviewed to explore their practices. The results were important for constructing the questionnaire for the quantitative part of the study.

Because the data presented here represent a sub-sample of the quantitative study, the methodology will be focused on this part of the study.

Recruitment of participants

All general and academic hospitals in the Netherlands were approached through telephone with the request to participate in the study. Of the 105 hospital locations, 73 (69.5%) agreed to participate. Reasons for non-participation varied: workload; other priorities, swamped with studies; reorganisation; sensitivity of the subject; no enthusiasm for the study among nurses.

Contact persons in the organisations recruited the respondents. Inclusion criteria were that respondents:

- had more than two years' experience as a registered nurse,
- had more than two years' bedside experience,
- were employed at least half-time and
- had experienced a request for euthanasia or physician-assisted suicide and/or its administration no longer than two years before.

The research group had the view that a randomly drawn sample would give a limited response to the study. For this reason, it was decided that the sample would consist of nurses experienced with euthanasia or physician-assisted suicide.

The contact persons recruited 692 nurses. The response suitable for analysis was from 532 (76.9%) nurses. This concerns the number of questionnaires of which any section was useful for analysis.

Data collection

Data were collected using a questionnaire. The results of the qualitative study, together with data from previous studies and insights from ethics and law, were the basis for constructing the questionnaire. To promote content validity, the questionnaire was presented to experts, with respect to both content and questionnaire construction and statistics. It

was then pilot-tested with 106 nurses who, in the qualitative study, had indicated their willingness to test the questionnaire. The response rate was 85%.

The research team discussed the outcomes of the questionnaire, adapted it where necessary and again tested it with three nurses. In the final version of the questionnaire, the first most extensive part concerned euthanasia and physician-assisted suicide. It started by describing the types of medical decisions at hand.

The part about euthanasia and physician-assisted suicide contained 153 questions. The time to be spent by respondents was estimated as one hour. The questionnaire mainly consisted of closed-ended questions to which an open answer category was added to avoid missing data. The need for this latter category was based on the complexity of the subject. The questionnaire has not been tested statistically. Simple descriptive statistics were used to present the role of nurses in euthanasia and physician-assisted suicide.

Respondents were asked to place their responses within the context of their most recent case of a request for euthanasia or physician-assisted suicide and/or its administration within the last two years. These cases took place in the years 2001–2003.

For respondents, the length of the questionnaire was reduced, because they were guided through the questionnaire, avoiding sections that were irrelevant because of their previous responses. This explains the variability in the number of nurses responding to items in the Results section. The phase 'requests for euthanasia or physician-assisted suicide', for example, begins with 381 cases and ends with 47 cases. Some choices are justified in the Results section.

Validity and reliability

Attention was paid to the interpretation of the different types of medical decisions by respondents to improve the validity of the results. Because of the retrospective character of the data, which could contribute to information bias, the cases reported by the respondents should have taken place within the last two years. In case respondents were confronted by more cases, they were asked to focus their answers on the most recent case. Promising anonymity and protecting from criminal prosecution may have contributed to honest answering by the respondents. Frequently, they provided very sensitive information.

Because of the large number of hospitals nationwide and the large number of nurses involved in the present study, the results may be regarded as representative of Dutch hospital nurses with experience in euthanasia and physician-assisted suicide.

Ethical considerations

The research ethics committee of the Academic Hospital Maastricht and Maastricht University approved the study.

As the subject was considered to be highly sensitive, participation was promoted by:

- the guarantee of anonymity to both organisations and respondents;
- both contact persons and respondents received a copy of a letter of the Minister of Justice in which participation was recommended and the explicit promise was made that respondents would be protected against criminal prosecution, should they disclose information of illegal practices.

This letter of the Minister of Justice contained, besides information about the study design and the research team, the following information. 'From the conclusions of this study, when necessary and desirable, recommendations may be made with respect to policy-making and/or legislation concerning the role of nurses. For this reason, I request your cooperation to this study. (...) Cooperation to the study is entirely voluntary. Refusing has absolutely no consequence for you. You may decide not to participate in the study at any moment and without giving a reason. The results of the study will not be reducible to individual persons. The information on a specific case, provided by you, will not be reported to the Public Prosecutor.'

Data analysis

The data were analysed using spss version 11.5 for Windows. However, as euthanasia practice can be a complex and sensitive situation, the study included several open answer categories and open questions. The answers were described and coded. They appeared to be helpful in obtaining additional data and interpreting the results.

Results

Description of participants

From the 532 questionnaires with one or more parts useful for analysis (see above), 404 cases in which patients requested euthanasia or physician-assisted suicide were analysed.

Participants ($n = 404$) ranged in age from 22 to 59 years (mean 38.1 years). Most (85.4%) were women. Participants (1 missing value) had a mean 14.0 years of experience as a registered nurse.

From 527 out of 532 questionnaires, the part about 'guidelines' could be analysed. Participants ($n = 527$) ranged

in age from 21–59 years (mean 38.2 years). Most (85.6%) were women. Participants (1 missing value) had a mean 13.9 years of experience as a registered nurse.

Requests for euthanasia or physician-assisted suicide

In 23.4% of 381 cases, physicians were the first person with whom patients discussed their request for euthanasia or physician-assisted suicide. In 45.1% of cases, patients spoke with the nurse first, and in 22.3% of cases, patients first raised their request when both the physician and the nurse were present, for example during the physician's rounds. In 9.2% of cases, the category 'other' or 'unknown' was applicable.

In this analysis, 23 of 404 cases were ignored, because the patient expressed the request to the physician in the outpatient clinic, before admission to the ward. The nurse, therefore, had no opportunity to be the first person with whom patients discussed their request for euthanasia or physician-assisted suicide.

When the patient spoke with respondents themselves ($n = 60$), the majority (78.3%) of those nurses informed the patient about the procedure around euthanasia/physician-assisted suicide.

The three most mentioned aspects were ($n = 47$):

- the legal due care requirements (70.2%),
- the policy/guidelines of the institution concerning euthanasia/physician-assisted suicide (51.1%),
- possibilities of palliative care (46.8%).

The decision-making process

Consultation between physicians and nurses during the decision-making process took place in 78.8% of 359 cases. In 14.2%, this was not the case and in 7.0% this was unknown.

In this analysis, 45 of 404 cases were ignored because of the following reasons:

- 1 Cases in which the decision-making and administering of lethal drugs did not take place within the same organisation. In such cases, it is conceivable that other factors have a role in the decision-making process, which could influence the role of nurses ($n = 17$).
- 2 A case in which the decision-making and administering of lethal drugs did not take place on the same ward ($n = 1$).
- 3 Cases in which the patient died during the decision-making process ($n = 7$).
- 4 Cases in which the decision had been taken before the patient was admitted to the ward.

Therefore, nurses could not have played a role in the decision-making process ($n = 20$).

The three most commonly cited reasons for a lack of consultation were ($n = 51$):

- it was what the patient wanted (35.3%),
- the patient's request was so obvious that consultation was unnecessary (31.4%),
- physicians considered euthanasia as a matter between themselves and the patient (31.4%).

When a distinction is made between accepted requests ($n = 264$) and not-accepted requests ($n = 95$), then nurses more often had a role in the accepted requests (81.4%) than in the not-accepted requests (71.6%).

In 29.5% of 224 cases, in which nurses had been involved in the decision-making process, they had taken the initiative by raising the issue with physicians. In 67.0% of cases, physicians had initiated the involvement of nurses in the decision-making process and in 3.5%, it was unknown.

Taking into account the distinction between accepted and not-accepted requests, physicians had taken the initiative more often (73.1%) than nurses (23.4%) in the accepted requests ($n = 171$). In the not-accepted requests ($n = 53$), nurses had taken the initiative more often (49.1%) than physicians (47.2%), although differences were small.

Administering the euthanatics

In 262 of 404 cases, in which a request was made, euthanasia or physician-assisted suicide was performed. However, the analysis is limited to 143 cases, because only in these cases respondents themselves were present while administering euthanatics.

In 80.4% of 143 cases, the nurse who was present during administering of euthanatics had a role in the decision-making process. In 18.9%, this was not the case and in 0.7% this was unknown.

In 83.2% of 143 cases physicians administered the euthanatics. In two cases (1.4%), patients took the euthanatics, as prescribed by the physician. In five cases (3.5%), nurses administered the euthanatics and in 17 cases (11.9%) nurses administered the euthanatics together with the physician.

In 9.8% of 143 cases, nurses had not been convinced that the physician complied with the due care requirements. The majority of these nurses indicated that they had insufficient knowledge of the due care requirements and/or that it was a matter of having faith in the physician.

Euthanasia guidelines in hospitals

From 527 of 532 questionnaires which contained one or more useful parts for analysis (see above), the part about 'guidelines' could be analysed. More than half (65.3%) of

527 nurses said that their hospital had its own written guidelines on dealing with requests for euthanasia and physician-assisted suicide. According to 3.2% of the nurses, their hospital had no guidelines, 28.1% of the nurses did not know whether their hospital had guidelines, 2.8% of the nurses indicated that guidelines were in the making, two nurses (0.4%) did not answer the question or gave an answer with an unclassifiable meaning and one nurse (0.2%) indicated that only the own ward had guidelines, but not the organisation.

When guidelines were available ($n = 345$), a large majority of nurses (81.7%) indicated that the guidelines were present on the ward. According to 8.7% of the nurses, the guidelines were not present on the ward, 9.0% of the nurses did not know whether the guidelines were present on the ward and some nurses (0.6%) did not answer the question or gave an answer with an unclassifiable meaning. More than half of the 345 nurses (57.1%) indicated that the guidelines describe their role, 9.9% of the nurses indicated that the guidelines did not describe their role, 32.2% of the nurses did not know whether the guidelines described their role and some nurses (0.9%) did not answer the question.

Discussion

Requests for euthanasia or physician-assisted suicide

In less than half of the cases (45.1%), patients spoke with a nurse first. However, it is conceivable that patients did not always deliberately choose to speak first with the physician or the nurse. The patient may suddenly be more inclined to talk about euthanasia/physician-assisted suicide, for example, after a bad news message or after a bad sleep.

When patients spoke with a nurse first, the nurse usually informed the patient about the formal euthanasia procedure, such as the due care requirements (70.2%) and/or the policy/guidelines of the institution (51.1%). This role is in accordance with the guidelines of the AVVV, NU'91 & KNMG (2006, p. 26), which state: 'it is the responsibility of the physician to inform the patient fully and in a way understandable for him or her during the different stages of the euthanasia procedure. Both the physician and the patient may ask the nurse for support. Repeated explanation by the physician or the nurse may strongly contribute to good information for the patient.... Preferably, the physician holds conversations in the presence of the nurse.'

When a patient has (cancer) pain or other major problems, it is conceivable that the nurse brings palliative care to the patient's attention. Taking into account the due care requirement that 'the physician should be convinced, together

with the patient, that there is no other reasonable solution', the offering of solutions other than euthanasia or physician-assisted suicide is important.

The decision-making process

The high percentage (78.8%) of consultations between physicians and nurses is in line with two recent studies among physicians. Van der Wal *et al.* (2003) and Bilsen *et al.* (2004) found that physicians consulted nurses in 78% of Dutch cases and in 83.3% of Belgian cases, respectively.

However, in comparing results, prudence is needed. Van der Wal *et al.* (2003) and Bilsen *et al.* (2004) analysed all cases, regardless of whether or not the nurse provided care during the decision-making process. The analysis in our study has been limited to cases of euthanasia and physician-assisted suicide in which the nurse provided care during the decision-making process and, therefore, could have played a role in this process. Furthermore, the percentages of Van der Wal *et al.* (2003) and Bilsen *et al.* (2004) arise in small study populations and the percentage of Bilsen *et al.* (2004) applies to both hospitals and nursing homes.

The high percentage of consultations may be related to the organisational structure of hospitals, where collaboration between physicians and nurses is usually formalised in several scheduled consultation moments. However, in several cases (14.2%), the consultation between physician and nurse was lacking. One of the reasons was that physicians considered euthanasia as their exclusive domain. Moreover, involvement of nurses in the decision-making is not a legal requirement in the Netherlands. However, physicians are encouraged to do so, for example, through a question on such activity in the model of the physician's report to the regional review committee. The physician is asked, 'Did you consult the nursing staff/the patient's carers about terminating the patient's life? If so, who did you consult and what view did they hold? If not, why not?' This is in contrast to Belgium where the legal regulation of euthanasia stipulates that the physician must discuss the patient's request for euthanasia with members of the nursing team who are directly involved in caring for the patient (Gastmans *et al.* 2004).

Although physicians are responsible for the decision whether or not to accept a patient's request, nurses could provide essential information to the physician, for example about the voluntariness and considered nature of the request. The finding that nurses more often have a role when the request is accepted (81.4%) than when it is not accepted (71.6%) could be explained as follows.

When physicians decide not to accept a request for euthanasia or physician-assisted suicide for reasons such as

conscientious objection or the institution's policy (euthanasia/physician-assisted suicide is not permitted), it is conceivable that such reasons are well-known on the ward and physicians will tend not to discuss such reasons first with the nurse.

When physicians decide (still) not to accept a request for euthanasia or physician-assisted suicide, it is important to inform nurses about the arguments for that decision. It is important that questions and doubts can be discussed between physician and nurse. However, it should be emphasised that, in case patients want to keep their discussion with the physician private, the physician has to respect this request.

If nurses were to wait for the physician to initiate a consultation, the percentage of nurses involved in the decision-making process would probably had been lower than the figures presented earlier. In 29.5% of cases, the nurse initiated discussion of the patient's request with the physician. A reason for such initiative could be their strong emotional bonds with the patient as was found in the qualitative part of the study. The contact with the physician might, then, be helpful in finding a balance between those emotions and the objective aspects of the case.

A striking outcome is that in the not-accepted requests, nurses took the initiative to contact physicians more often than in the accepted requests (49.1% and 23.4%, respectively). In the accepted requests the opposite happened, as in these cases, physicians more often took the initiative to contact nurses (73.1% against 47.2%). An explanation of these differences might be:

- in the accepted requests, physicians may gain a feeling of 'legal security' when the decision is supported by nurses.
- in the not-accepted requests, nurses often take the role of the patient's advocate, trying to represent the patient's interests. From this position, they will contact the physician.

Administering the euthanatics

It is not self-evident that when a nurse had a role in a case of euthanasia or physician-assisted suicide, she has been involved in the whole process from the beginning to the end of that case. In several cases (18.9%), the nurse who was present during administering of euthanatics had not had any role in the decision-making process. It is unknown how nurses experienced this. However, a conclusion could be that the involvement of nurses in several cases is 'fragmented'. An important reason might be the changing shifts of nurses.

Although the administration of euthanatics is an exclusive responsibility of physicians, in 15.4% of cases, nurses

themselves administered the euthanatics together with or without a physician. In our study, the demarcation line between administering activities and non-administering activities is defined as the moment at which the euthanatics flow into the patient.

The Dutch study of Muller *et al.* (1997) and the Belgian study of Bilsen *et al.* (2004) found that nurses administered the euthanatics in 21% and 58.8% of the cases, respectively. The comparison of these figures is problematic. In neither study, the demarcation line between administering activities and non-administering activities is defined. Furthermore, the figure of Bilsen *et al.* is based on the findings from both hospitals and nursing homes.

According to the Dutch euthanasia law and the above-mentioned exclusive responsibility of physicians, a nurse who administers euthanatics, or who assists in a suicide, risks both criminal prosecution and disciplinary measures. Physicians should take their responsibilities and should not leave these activities to nurses.

Some nurses (9.8%), who were present during the administering of euthanatics, were not convinced that the physician complied with the due care requirements of law. Explanations for this finding could be that nurses consider the compliance with the due care requirements as a medical responsibility only, and/or that they should exclusively focus on supporting the patients and/or their relatives. However, nurses should be aware of the fact that they always risk prosecution irrespective of the prosecution of the physician in such cases. Furthermore, although the physician is legally responsible for compliance with the due care requirements, it may be expected that nurses have knowledge of these requirements and check whether the physician complies with the requirements. This corresponds with the guidelines of the AVVV, NU'91 & KNMG (2006), which state that nurses who are involved in a care process around euthanasia should know about the law and legislation concerning euthanasia and about the due care requirements as stated in the law.

Institutional guidelines, to be consulted on the ward, could be helpful in promoting such knowledge and compliance (see the following section).

Euthanasia guidelines

It is not self-evident that hospitals have guidelines concerning euthanasia and/or physician-assisted suicide and, if they are present (65.3%), that they are 'within arm's reach' and describe the nurse's role. Therefore, in many cases nurses are not supported by such guidelines. This is not necessarily the result of a non-availability of guidelines. Nurses may make insufficient efforts to search for or read the guidelines. For

example, many nurses (28.1%) did not know whether or not their hospitals had developed guidelines and many (32.2%) of those who acknowledged the existence of guidelines were ignorant about their own role in the guidelines.

There are no figures from other studies to compare with. Nevertheless, Gastmans *et al.* (2006) provided additional information in a study among general directors of hospitals and nursing homes in Belgium, which showed that 79% of the hospitals had a written ethics policy on euthanasia and that 87% of these hospitals gave explicit attention to the role of nurses. It is important that the nurses be supported by guidelines, particularly when euthanasia and physician-assisted suicide are not frequently requested and, consequently, nurses may not have relevant knowledge at hand.

Moreover, institutional guidelines may play an important role in improving collaboration between physicians and nurses and in preventing procedural misunderstandings that could lead to ethical problems and legal offences. Therefore, those guidelines should include a description of the law and regulations and the roles of physicians, nurses and other care providers as well as rules for the communication between them.

During the development or renewing of institutional guidelines, the national joint guidelines of physicians and nurses can be helpful (AVVV, NU'91 & KNMG 2006). In these guidelines, tasks and responsibilities of both physicians and nurses are clarified and demarcated. In 2006, the fourth revised edition was published, which has been based also on the results of our study. According to Gastmans *et al.* (2004), who developed a clinical practice guideline, guidelines should build bridges between ethics, law and clinical practice in terms of integrated caring for patients who request euthanasia.

Additionally, it may be important for care providers to be provided with information in the multidisciplinary guidelines on issues such as:

- what step(s) the nurse can take if a physician does not fulfil the due care requirements;
- in which cases the institution will compensate for the costs of legal assistance in case of criminal prosecution;
- whether the employment contract will be broken in the event of a criminal prosecution.

Conclusions

Nurses perform a variety of tasks in the various stages of the euthanasia process. However, considerable fragmentation and disproportion exist in their role throughout those stages. During decision-making, the role of nurses could be expanded. Although nurses are consulted in the majority of

cases, in about 15% of cases, there is a lack of consultation between physician and nurses. In the administering of euthanatics, nurses are sometimes involved too strongly, as in 15.4% of the cases, nurses administered the euthanatics themselves. The latter finding is alarming and contrasts sharply with the legal rules and the professional responsibilities of nurses.

A sound policy could improve the collaboration between nurses and physicians and could strengthen the use of nurses' expertise without crossing legal and professional boundaries. Multidisciplinary institutional guidelines should play a more important role to achieve this.

An interesting follow-up study might be the analysis of such institutional guidelines, including the role ascribed to nurses.

While embedded in a Dutch cultural context, the data of this study may have international relevance, even in countries where euthanasia is not permitted by law. The findings of this study may help nurses in other countries to define their role in euthanasia and physician-assisted suicide, should they become legalised.

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The study sponsor approved the study design, but was not involved in the data collection, data analysis, data interpretation, writing of the report, and the decision to submit the paper for publication. The role of our contact person of the Ministry was restricted to the role of advisor without any involvement in the decision-making on the execution of the study.

Contributions

Study design: GGvB-vdS, AJGvdA, HHA-S, FCBvW, CS, RHJtM; data collection: GGvB-vdS; data analysis: GGvB-vdS, AJGvdA; manuscript preparation: GGvB-vdS, AJGvdA, HHA-S, FCBvW, CS, RHJtM.

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