

Nurses' attitudes to euthanasia: the influence of empirical studies and methodological concerns on nursing practice

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Abstract

This paper introduces the controversy surrounding active voluntary euthanasia and describes the legal position on euthanasia and assisted suicide in the UK. Findings from studies of the nurses' attitudes to euthanasia from the national and international literature are reviewed. There are acknowledged difficulties in carrying out research into attitudes to euthanasia and hence the review of findings from the published studies is followed by a methodological review. This methodological review examines the research design and data collection methods used in the published studies, problems with understanding definitions of euthanasia and the measurement of attitudes. The paper concludes with a discussion of how research in this area may influence nursing practice.

Keywords: euthanasia, nurses' attitudes.

Introduction

Euthanasia, derived from the Greek words *eu* and *thanatos*, means literally, 'a good death'. In the *Phaedo*, Plato recounts the 'good' death of Socrates who having been convicted of impiety and corruption of the young, chooses to die by taking hemlock rather than to escape his prison cell (Plato, 1975). In contemporary society, this literal interpretation of a good death has changed in that the term euthanasia is usually understood to mean mercy killing. 'Active euthanasia' is defined as a deliberate act bringing

about the death of another, while 'passive euthanasia' refers to allowing someone to die by withdrawing or withholding treatment. Other definitions of euthanasia depend upon consent such that euthanasia performed at the patient's request is described as voluntary, while euthanasia carried out without the request of the patient is involuntary. The term non-voluntary is used in situations where the person is incapable of giving consent.

While all forms of euthanasia remain controversial, involuntary euthanasia in recent history was associated with the Nazi death programmes during World War II and universally condemned. Central to the controversy is whether individuals should be allowed to end their lives if they choose to do so. In the UK, individuals have been able to lawfully take their lives since 1961 when section 1 of the Suicide Act

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decriminalized suicide (Pattinson, 2006). People who are terminally ill can, therefore, end their lives if they have the means and ability to do so. However, the debate is made more complex because few have the means or ability to commit suicide and therefore, would need to involve others (most notably health professionals) in what are currently unlawful acts. Proponents of euthanasia (such as members of the UK organization Dignity in Dying) campaign for changes to be made in the law to allow health professionals to administer medication to terminally ill patients with the explicit intention of killing them (active voluntary euthanasia) or to prescribe medication for the patient to take themselves [(physician-assisted suicide (PAS)].

Euthanasia is an important issue for all professionals in clinical practice as research, and technological advances allow patients to be resuscitated, given new treatments and kept alive using artificial means. In some instances, instead of asking 'can we treat the patient?' a more appropriate question may be 'should we treat the patient?' The morality of euthanasia and the merits or otherwise of changing the law are debated by healthcare professionals and also in the wider public arena. Nurses are the largest group of health workers in the UK whose role encompasses the care of people at the end of life in a variety of institutional and community-based settings. While this care includes fundamental caring activities such as the provision of hygiene, comfort and nutrition, the role of the nurse is changing to work across professional boundaries and skill share with doctors. Examples of these changes are clearly set out in the 10 key roles for nurses within the NHS Plan and include initiatives such as running clinics, ordering diagnostic investigations and prescribing medicines and treatment (Department of Health, 2000). This broadening of nursing responsibility means that the attitudes of nurses to euthanasia are of particular importance individually, because of their close involvement and experience in the care of the dying patient, and collectively, because of their influence upon healthcare policy and practice.

In English law deliberately taking another's life is murder and carries a mandatory life sentence. While taking one's own life is no longer a criminal offence,

helping another to do so is, and if found guilty the person may face imprisonment for up to 14 years (Pattinson, 2006). The consent of the patient, their health status, who carries out the act and what their intentions are all irrelevant, as in law euthanasia is seen as no different to any other deliberate killing. However, the courts do recognize the doctrine of double effect, i.e. a doctor is permitted to administer pain relief to a patient even if this shortens their life so long as the doctor's primary motive is to relieve suffering and not kill the patient (Grubb, 2001). Since 1936, several unsuccessful attempts have been made to introduce legislation in Parliament to allow voluntary euthanasia or repeal clauses in the Suicide Act culminating in the most recent attempt by Lord Joffe in 2005 (House of Lords, 2005). The ethical, legal and clinical implications of euthanasia and withholding treatment were also debated by a Select Committee of the House of Lords in 1993, but the committee report recommended that there be no change in the law to permit euthanasia or assisted suicide (House of Lords, 1994).

While active euthanasia remains unlawful in the UK, several high profile cases reported in the media have ensured interest in the subject continues. Such cases include that of Dr Cox, a consultant rheumatologist found guilty of attempted murder following administration of a lethal dose of potassium chloride to a patient (Regina v Cox, 1992) and that of Dianne Pretty, a woman with motor neurone disease who unsuccessfully sought leave from the courts for her husband to assist her suicide without fear of prosecution (House of Lords, 2001). More recently, terminally ill people from the UK have travelled to Switzerland to use the services of Dignitas, a euthanasia group that claims to offer a dignified death to terminally ill people. Dignitas claims to have helped about 85 British people end their lives since it began in 1998 and several of these cases have been reported in the media and doctors and the patient's relatives questioned by police over their role in the suicide, although none have been prosecuted (Minelli, 2007). In February 2003, an assisted suicide bill was introduced by Lord Joffe in the House of Lords. The bill was eventually blocked in May 2006 as peers backed an amendment to delay the bill by 6 months, but Lord

Joffe has plans to reintroduce it at a later date (Dyer, 2006). Euthanasia therefore remains a controversial and widely debated subject, and attempts continue to change legislation to allow it to be practised.

Frankena (1973) differentiates between normative ethics, metaethics and descriptive ethics as methods of ethical enquiry. Normative ethics in this context is concerned with questions and arguments about the morality of euthanasia such as whether it is morally right for nurses to engage in acts of euthanasia. There are numerous books and articles directly addressing questions on the morality of euthanasia, e.g. McCabe (2007), Begley (2008), Warnock & MacDonald (2008), Keown (2002), Dworkin Frey & Bok (1998), Singer (1993) and Rachels (1997). However, philosophical research into ethical questions rooted in practice may not be sufficient as DeGrazia & Beauchamp (2001, p. 42) identify, 'philosophy can provide reliable moral guidance only to the extent that its empirical assumptions are accurate'. Therefore, moral questions arising from practical contexts such as health care require empirical data. This is not to say that pure philosophical explorations of euthanasia are not valuable, but that a deeper and more rounded understanding of the subject can be gained by examining moral questions using different methods. Therefore, this paper will examine both the findings and methodological issues in empirical studies examining nurses' attitudes to euthanasia in an attempt to add to the debate and understanding of the subject.

Attitudes of the general public and doctors to euthanasia

Surveys of public opinion have periodically been published in newspapers, magazines and professional journals, and overall suggest that the general public is in favour of voluntary euthanasia but healthcare professionals view the practice negatively (Donnison & Bryson, 1996; McLean & Britton, 1996). A recent YouGov survey of 2000 people carried out on behalf of Dignity in Dying (the UK campaign organization for voluntary euthanasia) in May 2006 indicated that 76% of respondents thought that medically assisted dying should be available for those that want it (Dignity in Dying, 2006). However, the results were

less conclusive from a comparative study that used data from the European Values Study (EVS) to compare attitudes to euthanasia in 33 European countries. The EVS questionnaire consisted of 300 questions, but for this analysis only those variables associated with euthanasia were included. No common European attitude towards euthanasia was discovered. From a total of 1000 respondents from the UK, the mean score for acceptance of euthanasia was 4.99 (on a scale of 1–10) and subsequently the UK was classified in the group of countries that had certain reservations. However, the mean scores for other countries such as the Netherlands, Denmark, France and Belgium were higher and thus, classified as countries where the general public were relatively accepting of euthanasia (Cohen *et al.*, 2006).

Several international studies have been published examining the opinions of doctors to euthanasia, but there are difficulties in drawing conclusions from the data. Only two countries, the Netherlands and Belgium currently have legislation permitting doctors to perform euthanasia, although the state of Oregon in the USA allows PAS. A recent systematic review of 39 published studies of US physicians' attitudes to euthanasia and PAS showed a large variation in the acceptance of euthanasia that ranged from 23% to 63% (Dickinson *et al.*, 2005). However, within the review difficulties with question wording and definitions are noted and a lack of consistency in the measures used makes data comparison difficult across the studies.

Even in the Netherlands and Belgium where legislation exists permitting euthanasia there is not a great demand for the practice, and not all doctors are willing to carry it out. In the Netherlands the practice of euthanasia has been reviewed in 1990, 1995 and 2001 (Onwuteaka-Philipsen *et al.*, 2003). In 1990, 64% of a sample of 405 Dutch doctors agreed that people have a right to decide about their own life, but this had fallen to 56% (of 410 doctors) in 2001. Onwuteaka-Philipsen *et al.* concluded that despite being lawful, over 10 years doctors appear to be more restrictive about euthanasia and less accepting of the practice.

The British Medical Association (BMA) while issuing advice to doctors on withholding and with-

drawing treatment and the use of living wills, was firmly opposed to voluntary euthanasia until June 2005. At its Annual General Meeting (AGM) that year, members voted to withdraw their opposition to the legalization of assisted dying, and stated that the issue should be decided by parliament and society (Sommerville, 2005). However, the change was short lived as at the AGM in 2006, members voted to change the organization's stance back to one of opposition. While the BMA may be respected as representing medical opinion, doctors are not united in their views of euthanasia and other forms of assisted dying. For example, in a review of published polls of doctor's opinions, The House of Lords Select Committee on Assisted Dying found that support for legislation permitting assisted dying ranged from 30% to 60% (House of Lords, 2005).

Despite being unlawful, there is debate over whether doctors are willing to assist patients to die, but there is limited evidence to either support or refute this claim. A confidential survey of 300 general practitioners carried out by the Sunday Times newspaper on 15 November 1998 alleged that possibly thousands of patients die every year with the help of doctors and that 18% of doctors who replied to the questionnaire believed that they should prescribe lethal medication to assist suicide. Views were sought on withdrawing treatment and the administration of medication likely to shorten life, but views on administering lethal injections were not (Norton, 1998). As in this and other surveys, there are inherent problems with the way in which euthanasia was defined and this threatened the reliability of the results (this point is discussed in more detail below). A recent and more scientifically reliable national questionnaire survey of 857 medical practitioners in the UK revealed that of the 584 791 deaths in the UK in 2004, 0.16% (936) were by voluntary euthanasia. The survey also showed that only 2.6% of participants agreed that changing the law would benefit patients (Seale, 2006).

Nurses' attitudes to euthanasia

Fewer studies have examined the attitudes of nurses, and it may be argued that the practice of nursing with its emphasis on caring is incompatible with the prac-

tice of euthanasia. However, there is evidence from recent history that the nursing role has involved killing. Nurses were active participants in the organized killings of German citizens in the Nazi euthanasia programmes and intentionally killed more than 10 000 people. While there is a clear difference between the Nazi euthanasia programmes and a contemporary understanding of euthanasia, the nurses' explanations for participation are of interest. During the trial of 14 nurses in Munich in 1965, some reported that they had struggled with a guilty conscience, while others did not see anything wrong with their actions and believed they were ending the patient's suffering (Benedict & Kuhla, 1999). While this indicates that nurses have been willing to perform euthanasia on the grounds of alleviating suffering, Benedict *et al.* (2007) note that the 20 years that elapsed between the events and their trial may have allowed the nurses to arrive 'at a state of remembrance with which they could comfortably justify their involvement' (p. 792).

In the literature examining more modern practices, there does appear to be some evidence that nurses have participated in, or are willing to participate in acts of euthanasia. A survey of 1218 registered nurses in the Australian Capital Territory, reported that 70% of respondents would be willing to be involved in the provision of active euthanasia for an incurably ill patient if it were legal, and at the patient's request (Kitchener, 1998). An earlier Australian survey of 1942 nurses indicated that 65% of respondents would be willing to collaborate with doctors in the provision of active voluntary euthanasia if it were legal. A further 5% stated that they had complied with a patient's request to directly end their life without having been asked by a doctor to do so (Kuhse & Singer, 1993). A study of the role of US critical care nurses in acts of euthanasia indicated that 16% of respondents had engaged in the practice of euthanasia and moreover, an additional 4% reported that they had hastened a person's death by only pretending to provide life-sustaining treatment ordered by a physician (Asch, 1996).

Of these studies, those carried out by Asch (1996) and Kuhse & Singer (1993) have been criticized by nurses for their portrayal of nurses as participants in

acts of euthanasia. As well as criticism of the research methods and instruments, concern has been expressed regarding the media attention both studies have received, and the potentially damaging impact of this on the public image of nursing (Aranda & O'Conner, 1995; McInerney & Seibold, 1995; Dracup & Bryan-Brown, 1996; Scanlon, 1996; Mawdsley, 1997).

Even prior to legalization on 10 April 2001, doctors in the Netherlands were unlikely to be prosecuted if they followed the Dutch Medical Association Guidelines on administering euthanasia. Protection from prosecution did however, only apply to doctors, a position made clear by the Dutch High Court in 1995, when it found a nurse guilty of assisting with euthanasia (Spanjer, 1995). The role of Dutch nurses in active euthanasia and PAS has been investigated by collecting data from interviews and postal questionnaires from clinical specialists, general practitioners and nursing home physicians (Muller *et al.*, 1997). Although the majority of respondents in this survey thought that nurses should never be allowed to administer euthanasia, 21% of the sample of clinical specialists indicated that nurses administered the lethal drugs. In a discussion of what is described as a remarkable finding given the High Court judgement, Muller *et al.* state that in most cases the nurses administered morphine. They speculated that because the administration of morphine is one of the daily activities of nurses, then the clinical specialists may find it acceptable for nurses to administer this drug even if it results in the death of the patient, a conjecture based upon the principle of double effect.

Euthanasia was legalized in Belgium in 2002, but the legislation is similar to that in the Netherlands and only permits doctors to carry out acts of euthanasia (Gastmans *et al.*, 2006b). The administration of lethal drugs to patients by nurses is therefore not permitted under Belgian law. A review of 1925 Belgian physicians who had signed death certificates for patients in 1998 raised several questions about nurse involvement (Bilsen *et al.*, 2004). The results indicated that nurses administered lethal drugs in 58.8% of euthanasia cases in institutions and in 17.2% of deaths that occurred at home. While these results are striking, and as acknowledged by the authors, not easily explained, in almost all cases the administered drugs were

opiates. The administration of drugs, including opiates, is commonly delegated to nurses in institutional settings and therefore, in accordance with the doctrine of double effect, may have been administered with the intention of relieving pain rather than killing the patient. Hence, what may be reported in this study are instances of passive rather than active euthanasia.

There is only one published study examining the attitudes of UK nurses to euthanasia in which nurses responded to an invitation to complete a questionnaire published in the popular nursing journal, *Nursing Times*. The majority of respondents agreed that requests for euthanasia should be granted, with 14% responding that requests should always be granted, and 54% stating that sometimes they should be (Pyne & Booth, 1995). However, this survey was descriptive and only 149 nurses from the journals extensive readership responded. In 2003, the *Nursing Times* claimed that two-thirds of 2709 nurses they had surveyed believed that euthanasia should be legalized and that 31% of respondents thought that nurses should be allowed to assist in the suicide of patients. However, the questions used in the survey are not detailed in the article and apart from a brief description, the complete findings are unpublished (Hemmings, 2003).

The Royal College of Nursing (RCN) in its submission of evidence to the House of Lords on the Assisted Dying Bill stated its position to be firmly against euthanasia. The RCN considered the practice of euthanasia to be contrary to the public interest, nursing and medical ethics and patients' civil rights (House of Lords, 2004). However, while this remains the official position of the RCN, contrary views have been publicly expressed at debates during the RCN Congress meetings and by the chair of the RCN Ethics Forum (Boseley, 2003), indicating that similarly to the BMA, an official statement from a representative body does not necessarily mean that all nurses agree with it.

Problems with definitions of euthanasia in the published research

The problems associated with defining active and passive euthanasia both in meaning and use as well as

dispute regarding the very existence of the distinction affect the conclusions that can be drawn from research in this area. While deliberately administering a lethal substance (active euthanasia) to a patient is unlawful, withdrawing or withholding treatment (passive euthanasia) in some circumstances is both lawful and considered by health professionals to be good practice. End of life care is further complicated by other terms such as terminal sedation where a patient is sedated and nutrition and hydration withdrawn (Rietjens *et al.*, 2006).

British law has never sanctioned active euthanasia even administered on grounds of mercy as in the Dr Cox case discussed above. But the courts have recognized in some circumstances it may be legitimate to withhold treatment or administer large doses of opiates even if the incidental effect hastens the person's death (McHale *et al.*, 2006). This is known as the doctrine or principle of double effect which can be summarized as being 'always wrong intentionally to do a bad act for the sake of good consequences that will ensue, but that it may be permissible to do a good act in the knowledge that bad consequences will ensue' (Glover, 1977, p. 87). The importance of the distinction between active and passive euthanasia is clearly demonstrated in English legal cases where the defence has relied upon the doctrine of double effect. In an early case, Dr Adams, a general practitioner, was acquitted from a murder charge following administration of large doses of opiates to an elderly, incurably (rather than terminally), ill patient. In his summation to the jury, Judge Devlin stated that 'a doctor is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life' (Pattinson, 2006, p. 487). More recently, this principle was reaffirmed when permission was sought from the courts to discontinue artificially feeding Tony Bland, a young man in a permanent vegetative state as a result of injuries sustained during the Hillsborough football disaster (Airedale NHS Trust v Bland, 1993).

The legal, philosophical and healthcare literature includes debate on the problems of definitions. Begley in a philosophical examination of acts, omissions, intentions and motives in a nursing context argues that use of the principle of double effect 'encourages

hypocrisy rather than honesty' (Begley, 1998, p. 865), and philosophers such as Rachels (1997), Singer (1993) and Harris (1985) have argued that there is no moral difference between active euthanasia and passive euthanasia. However, even among bioethicists there appears to be confusion regarding use of the terms. A survey of members of the American Association of Bioethics examining semantic and moral debates about hastening death found significant variability in the way the terms active euthanasia, passive euthanasia and assisted suicide were used (Ubel & Asch, 1997). In a study of the attitudes towards active euthanasia of 150 nurses in seven countries, a marked difference in the responses of the Israeli nurses is noted (Davis *et al.*, 1993). The Israeli sample accounted for 50% of the total number of nurses who justified active euthanasia, but based on interview data, this result was explained by the respondents' confusion between active and passive euthanasia. In a replication of the studies carried out by Kuhse & Singer (1993), Aranda & O'Conner (1995) asked respondents to provide additional descriptive information about their experiences with euthanasia. Some clinical examples given by respondents for active euthanasia were actually examples of passive euthanasia as defined in the study.

Asch (1996) indicates that a weakness in his study was the failure to distinguish between euthanasia and assisted suicide in the questionnaire. The range of activities in this study which were labelled as euthanasia may, according to Asch, reveal the inadequacy of the term euthanasia and professional and legal policies based upon it. Wilkes & White (1995) report that palliative care nurses find themselves in ethical dilemmas because of conflict between the intent of palliative care and the failure to alleviate suffering. Conflicts in palliative care nursing such as issues about the value of life and the right to die, continuing and withdrawing treatment and providing comfort while not actively inducing death arose in Wilkes and White's study partly because of the nurses' lack of a clear definition of euthanasia. Whether active or passive euthanasia is being carried out is also of important to the findings in the study of Belgian nurses (Bilsen *et al.*, 2004). While it is claimed that a large number of nurses were involved in acts of

euthanasia, the use of opiates may suggest the administration of drugs with the primary intention of relieving pain and thus, provides further evidence of confusion about how euthanasia is defined.

Rogers (1996) points out that the lack of specificity of terms represents a continuing source of difficulty for research in this area, and Ho (1998) addresses this issue directly in a study analysing the subcategorical distinctions of euthanasia. In this study, four models were developed to reflect the subcategorical distinctions of active vs. passive and voluntary vs. involuntary euthanasia. Exploratory factor analysis identified two factors which represented the voluntary–involuntary subcategorical distinction. This two-factor structure of euthanasia was then cross-validated with a different sample and model comparisons indicated that the voluntary–involuntary euthanasia models offered the best fit to the data. The results of this study are surprising in that the decision to support or not support euthanasia was made by respondents primarily on the basis of whether or not consent had been given by the patient. Ho concludes, 'The present findings suggest that the active vs. passive distinction may not be as important a determinant of attitudes towards euthanasia as the literature has suggested' (Ho, 1998, p. 730).

However, the respondents in the study were members of the general public and graduate psychology students, and it may be argued that the attitudes of people unlikely to be directly involved in acts of passive or active euthanasia may differ from those of healthcare professionals. The attitudes of healthcare professionals to euthanasia are measured in the context of professional practice, encompassing beliefs about participating in acts of euthanasia as part of the professional role. The attitudes of members of the general public and students are more likely to be addressed in the context of themselves their family or friends as potential patients. Although the issue of consent is important for healthcare professionals and patients, concerns about the distinction between active and passive euthanasia are more likely to be of importance to those involved in decision making and participating in controversial actions directed at others. The attitudes of nurses have also been noted as being particularly useful in deciding how relevant

such distinctions are for two reasons: first, because they have the greatest amount of contact with dying people, and second, because the influence on caring in nursing ethics may cause nurses to question what may be seen as essentially medical decisions about withdrawing and withholding treatment (Dickenson, 2000).

Significant variables in research into attitudes to euthanasia

Age, gender and religion

Some variables are reported as being influential in determining attitudes to euthanasia. Kuhse & Singer (1993), Brown *et al.* (1971) and Kitchener (1998) report that age was a significant factor influencing decisions about euthanasia with nurses under 40 being more likely to be in favour of active voluntary euthanasia than older nurses. Nursing is a woman-dominated profession and this is reflected in the gender balance participants in the studies. Only the study by Kitchener (1998) examined the relationship between gender and attitudes to euthanasia which was non-significant.

As found consistently with surveys of public and medical practitioners, those without religious beliefs are more in favour of euthanasia (Shuman *et al.*, 1992; Richardson, 1994; Davis *et al.*, 1995; Kitchener, 1998). A systematic review of 15 published studies revealed that in studies that examined the relationship between the nurses' religious beliefs and their attitude to euthanasia the stronger a nurse's religious belief the more they opposed euthanasia (Verpoort *et al.*, 2004a). This finding is unsurprising as all major religions have strict moral rules about intentional killing.

Nationality

The enactment of legislation, cultural values and professional practice vary from country to country, and these differences may affect attitudes to euthanasia held by nurses of different nationalities. The fact that euthanasia remains unlawful in all jurisdictions except the Netherlands and Belgium influences

responses in many studies, either in terms of being cited as a reason for not agreeing with active euthanasia, or in terms of responding favourably to suggestions that the law be changed to allow the practice. The evidence to have emerged from the Netherlands in particular is used by both those who agree with euthanasia and by those who reject it, to support their arguments (Kuhse & Singer, 1993; Asch, 1996; Kitchener, 1998).

The studies by Kitchener (1998) and Kuhse & Singer (1993) describe the view of Australian nurses where the world's first voluntary euthanasia law was passed by the parliament of the Northern Territory in 1995. This allowed physicians to administer lethal substances to terminally ill patients who had made a formal request to end their lives. Nine months later, the Australian Senate overturned the Act during which time seven euthanasia deaths were reported (Kissane *et al.*, 1998). The presence of this legislation even though enacted for a short time may affect the attitudes of Australian nurses more than those working in countries where euthanasia has never been lawful.

Studies have also compared the attitudes of Australian and Japanese nurses (Tanida *et al.*, 2002), French nurses with the general public and other health professionals (Teisseyre *et al.*, 2005), French district nurses (Bendiane *et al.*, 2007), intensive care nurses in Turkey, (Kumas *et al.*, 2007), members of the Swiss Association for Palliative Care (Bittel *et al.*, 2001) and nurses in Finland (Kuuppelomäki, 2000). However, apart from the two polls carried out by the *Nursing Times* described above, there are no published studies specifically exploring the attitudes of British nurses to euthanasia. The findings of these two polls should be treated with caution in terms of how representative of the attitudes of British nurses they are as there are limitations in the design and response rate for the first, and no detail of the method is reported for the second study.

Nursing speciality

Differences in attitudes to euthanasia between nurses working in different clinical areas are not clearly demonstrated in the literature. While studies report some

evidence of nurses' willingness to participate in acts of euthanasia, the respondents in these studies are either from one clinical speciality such as critical care nurses (Asch, 1996), intensive care nurses (Kumas *et al.*, 2007), oncology nurses (Anderson & Caddell, 1993; Richardson, 1994; Pierce, 1999; Kuuppelomäki, 2000; Matzo & Schwarz, 2001), or palliative care nurses (Wilkes *et al.*, 1993; Verpoort *et al.*, 2004b). Other studies make comparisons between two clinical specialities such as oncology nurses and dementia care nurses (Davis *et al.*, 1995), or palliative care and oncology nurses (Aranda & O'Conner, 1995). Other studies report clinical specialism within the biographical details of respondents, but do not report this variable in the data analysis. From the limited evidence in the literature it appears that nurses who frequently care for dying patients (such as those in palliative care), do tend to be less supportive of euthanasia. Palliative care organizations are generally opposed to active voluntary euthanasia (Farsides, 1998), and Verpoort *et al.* (2004b) suggest that the speciality may therefore attract and retain nurses whose personal views on euthanasia match those of the organization.

Only one survey systematically examines the relevance of clinical experience within the study. A study of nurses from six clinical specialities in the Australian Capital Territory included a sample of 142 nurses from critical care, 130 from aged care and 27 from palliative care nurses (Kitchener, 1998). Participants were asked about their willingness to assist with active voluntary euthanasia for an incurably ill patient if it were legal and at the patient's request. Responses indicated that 78.9% of critical care nurses, 56.2% of aged care nurses and 33.3% of palliative care nurses expressed willingness to participate in active euthanasia. Multivariate analysis of predictors of willingness showed significant associations with area of speciality, and Kitchener (1998) concluded that nurses working in critical care or mental health are more willing to be involved in the provision of active euthanasia than those who work in aged or palliative care. These findings appear to concur with those in studies of nurses from single specialities, but the study reports the views of Australian nurses soon after active euthanasia was briefly permitted and the experience of this may have influenced the responses.

Methodological issues

Research into ethical questions has traditionally been that of philosophical investigation. However, the last 40 years has seen increasing interest in the application of ethics in practice-based disciplines such as information technology, business and marketing and most notably health care. The increase in ethical questions in health care has been driven by technological advances making a wide range of treatment options open to patients. Such improvements in care are, nonetheless, accompanied by serious questions about how beneficial or futile such a course of action may be, the cost of providing the treatment (particularly in a public-funded healthcare system), and the need for health professionals to carry out morally controversial procedures (such as abortion or euthanasia). Rather than engaging in theoretical discussions of ethical concepts, there is a need to understand the context and environment which gives rise to the ethical question (Holm, 1997), and cognisance of this has given rise to the development of empirical as well as philosophical methods of investigation. What has been termed the 'empirical turn' (Borry *et al.*, 2005, p. 1) has resulted in the application of a range of research methods particularly those used by psychologists and sociologists to investigate ethical problems (Sulmasy & Sugarman, 2001). Consequently, empirical studies of ethical problems are now more commonly found in the medical, nursing and bioethics literature (Hermsen & Have, 2002).

The published studies exploring nurses' attitudes to euthanasia use both qualitative and quantitative data collection methods. The use of qualitative methodologies with their emphasis on providing a holistic, natural world view of phenomena is popular in nursing research, and some studies, e.g. those carried out by Kuuppelomäki (2000), Pierce (1999), van de Scheur & van der Arend (1998), McInerney & Seibold (1995) and Wilkes *et al.* (1993), examined nurses' attitudes collecting data using semi-structured or unstructured interviews which can be time consuming and expensive. Hence, even for qualitative studies, the number of participants is low as 10 (McInerney & Seibold, 1995) and 13 (Kuuppelomäki, 2000).

Kuuppelomäki (2000) justifies the use of a qualitative methodology because it allows the participants to give reasons for their opinions in their own words, and the results will therefore yield a comprehensible and credible view of the world. McInerney & Seibold (1995) argue that the use of surveys fails to capture the complexity of the issue of euthanasia and describe such research as presenting a simplistic view of beliefs and attitudes. The authors make the rather ambitious claim that their study, based upon data obtained from interviewing 10 nurses, clearly demonstrates the inadequacy of quantitative survey methods in providing an accurate picture of nurses' beliefs about euthanasia. The purpose of qualitative research is to describe and explain the world and what it means to the people involved. While there is no need for such research to test theory or produce findings that can be generalized, Verpoort *et al.* (2004b) note that insufficient attention to ensuring the validity of the data threatens its trustworthiness.

The majority of quantitative studies measure attitudes towards euthanasia using questionnaires, e.g. Kitchener (1998), Pyne & Booth (1995), Winget *et al.* (1977) and Young & Ogden (1998). In all but three of the studies (Shuman *et al.*, 1992; Richardson, 1994; Aranda & O'Conner, 1995), the authors devised their own questionnaire. In none of the papers reviewed where a questionnaire had been specifically designed for the study was a rationale offered for the format of the questions, or a theoretical framework for the research identified. The study carried out by Aranda & O'Conner (1995) replicates the previous research carried out by Kuhse & Singer (1993) and Richardson (1994) used the questionnaire developed by Takeo *et al.* (1991). While two previously validated scales designed to measure attitudes to euthanasia could be found in the literature (Adams *et al.*, 1978; Tordella & Neutens, 1979), only one study of health professionals' attitudes was found that included either scale in the measures (Shuman *et al.*, 1992). This measure, the Euthanasia Ideology Scale, provides a total behavioural score measure from four items measured on a 5-point Likert scale (Adams *et al.*, 1978).

Data obtained from questionnaires may also be influenced by the way the questions are phrased and the importance of this is illustrated in a study consist-

ing of two surveys exploring this possibility (Hagelin *et al.*, 2004). In the first survey, a questionnaire completed by 684 Swedish undergraduates contained 37 questions, one of which asked participants if they were 'positive', 'negative' or 'don't know' towards euthanasia. An explanation of euthanasia was not given. In the second study, 639 students completed a different questionnaire consisting of four items, one of which defined euthanasia, described the criteria for carrying out euthanasia in the Netherlands and asked participants to select which of five options they favoured for legislation. The responses were compared and while a large proportion (43%) of participants answered 'don't know' in the first survey, in the second 90% of respondents selected one of the five options for legislation. While acknowledging that including a 'don't know' option is a contentious issue, Haglin *et al.* consider the 10% who did not answer the question in survey 2 to be analogous to those who responded 'don't know' in the first. They concluded that those who could not express an opinion in the first survey may have been able to in the second when given a selection of options. While both questions asked about euthanasia, one did not provide a definition and both offered quite different options. However, it would be plausible to report the findings of both surveys with participants expressing positive and negative attitudes to euthanasia. This illustrates the difficulties of interpreting results from different questionnaires and confirms that the survey instrument used might affect the outcome of questionnaires.

Ethical concepts are complex, and particular problems with question phrasing and response formats in surveys threaten the reliability of the results (Hagelin *et al.*, 2004). Verpoort *et al.* (2004a) note that participants appear to have difficulty in making a categorical decision about euthanasia and this may in part be explained by asking participants to respond to two-way forced choice questions. This can be overcome by the use of Likert scales which are considered to give a more graded response enabling capture of the nuance of attitudes to euthanasia which can not be achieved with a dichotomous answer (Cohen *et al.*, 2006). There is also a need to have a shared understanding of the concepts, but several studies have shown difficulties

with shared understandings of euthanasia, even when a definition is stated (Wilkes & White, 1995; Asch, 1996; Ubel & Asch, 1997; Bilsen *et al.*, 2004).

Quantitative studies and surveys claim to measure attitudes. The problems associated with using attitude measures to predict behaviour have been discussed in the psychological literature since the 1930s (LaPierre, 1934; Wicker, 1969), but Ajzen & Fishbein (1977) argue that if appropriate attitude measurement techniques are used, then attitudes can be accurately used to predict behaviour. In their paper, Ajzen & Fishbein (1977) developed two principles important in reliable attitude measurement, the principle of aggregation and the principle of compatibility. According to the principle of aggregation, attitudes can show substantial correlations with behaviour if the behavioural measure is aggregated across a number of specific behaviours. Single measures of behaviours are unreliable indicators of attitude, but an appropriate aggregation of responses to attitude-relevant questions will create a reliable measure of attitudes (Eagly & Chaiken, 1993). Strong attitude-behaviour correlations, therefore, are found when both attitudes and behaviour are measured using multiple items. For example, to ask nurses what they thought about active euthanasia by using a single item would not be an accurate predictor of behaviour, but constructing a questionnaire using multiple item measures of attitudes and behaviours will yield more accurate results.

Different elements of behaviour such as the action performed, the object to which the action is directed, the context in which the action takes place and the time at which it takes place can vary. Therefore, an accurate explanation of behaviour specifies not only what action is performed, but the target, action, context and time of the behaviour (Manstead, 1996). Using this principle of compatibility, a questionnaire constructed to examine nurses' attitudes to euthanasia should address not only the action (the act of euthanasia), but also the object (the patient for whom euthanasia is being considered), the context (the clinical area where the act of euthanasia will take place) and the time when the action will take place. Therefore, according to the principle of compatibility, stronger correlations between measures of attitude and behaviour are more likely to occur if they are com-

patible in action, object, context and time. However, as discussed above, in the studies examining nurses' attitudes to euthanasia there are few examples of studies using validated measures or replicating previous studies using the same measures. These problems together with the wide variations in reported data showing acceptance of euthanasia of doctors and nurses limit the conclusions that can be drawn from surveys into the subject (House of Lords, 2004; Berghs *et al.*, 2005).

A further design issue concerns the potential pressure of social correctness in that participants may feel inhibited answering questions on controversial issues and will seek to give acceptable answers. This is a particular issue for qualitative data collection methods when the researcher is speaking directly to participants in focus groups or individual interviews. More remote data collection methods such as questionnaires may reduce this effect particularly the use of scenarios reflecting real-life situations (Ryynanen *et al.*, 2002). To assure participants of confidentiality, questionnaires can also be completed anonymously; however, non-respondents cannot be followed up which may result in low response rates.

In a review of methodological issues in euthanasia research, Rosenfeld (2000) discusses how research in this area is 'plagued by methodological shortcomings and limitations' (p. 559), and how the development of specialized instruments may facilitate this research. However, the lack of use of reliable measures to examine nurses' attitudes to euthanasia is marked in the published research and the methodological and design differences limit the comparisons that can be made across the studies.

Implications for nursing practice

Nurses face ethical dilemmas in all areas of clinical practice, but this is a particular problem for nurses caring for the terminally ill. These nurses will care for the patient and their family in the time leading up to, during and after the death as well as participating in making decisions about the care and administration (or withdrawal) of treatment. An important feature of ethical problems in clinical practice is, therefore, the need for nurses to be able to address such problems

with clear understanding of not only the options available but also the moral, legal and professional implications of the available courses of action. For example, as shown in previous studies, nurses are asked by terminally ill people to help them die which raises a very obvious dilemma for the nurse (Kuhse & Singer, 1993; Matzo & Schwarz, 2001; van de Scheur *et al.*, 2008). In this situation, the nurse could refuse to help, but this could damage his/her relationship with the patient and compromise care delivery, a dilemma observed in countries where euthanasia is lawful (van de Scheur & van der Arend, 1998). Alternatively, the nurse could agree to help the patient but in doing so would not only be breaking the law (Pattinson, 2006) but also acting outwith expected professional standards and potentially subject to sanctions by the regulating body.

Research into this subject has shown that a greater number of nurses appear to agree with euthanasia than those who would be willing to assist in the process (Verpoort *et al.*, 2004a). These findings appear to indicate that just because a nurse holds a positive attitude towards euthanasia, this does not necessarily mean that s/he will be willing to administer it. If changes were made to UK legislation, this would not mean that all health professionals would (or even should) be required to administer euthanasia even if it was within the law. Any legislation would be almost certain to contain a conscience clause similar to that in the Abortion Act 1967, as is seen in the jurisdictions where euthanasia is currently lawful. In Belgium for example, nurses have a right to refuse to participate in the act of performing euthanasia (Gastmans *et al.*, 2006a).

If nurses were lawfully able to administer euthanasia, this would have implications for the organization and delivery of nursing care. As discussed above, the notion of nurses being involved in acts of killing has been viewed as potentially damaging to the public image of nursing (Aranda & O'Conner, 1995; McInerney & Seibold, 1995; Dracup & Bryan-Brown, 1996; Scanlon, 1996; Mawdsley, 1997). Furthermore, the caring role is fundamental to nursing practice and is enshrined in the professional code (Nursing and Midwifery Council, 2008). If nurses were to participate in euthanasia, there would need to be some

acknowledgement that killing (in some clearly defined circumstances) could be encompassed within the caring role. This would be highly controversial with some nurses willing to undertake this role and others not only refusing to do so, but strongly objecting to the actions of nurses willing to administer euthanasia.

Respecting patient autonomy is an important concept in the euthanasia debate. This is not a surprising finding as not only is autonomy identified as an important concept in healthcare ethics (Beauchamp & Childress, 2001; Gillon, 2003; Stirrat & Gill, 2005), but it also forms the basis for the law-governing consent and is a feature of the rights and responsibilities of patients within the NHS (Department of Health, 2000). The Nursing and Midwifery Council expects nurses to respect the autonomous decisions of patients (Nursing and Midwifery Council, 2008), and while autonomy cannot be thought of as an absolute principle, patients do have a legal and moral right to refuse treatment. Should there be a change in the law to allow active voluntary euthanasia, then patients would be able to request that it be administered, and if such a request met the required criteria in the legislation, then the health professional would be expected to act according to the patient's autonomous decision. However, as noted by Hartling (2006, p. 190), 'autonomy is not synonymous with autocracy, and it is not a violation of autonomy to refuse to kill the patient.'

An interesting finding of an Australian study is that among the doctors and nurses who participated in the study, opposition to euthanasia legislation did not necessarily equate to being opposed to euthanasia *per se* (Cartwright *et al.*, 2006). While acknowledging the possible influence that the temporary change in legislation permitting euthanasia in the Northern Territory, Cartwright *et al.* (2006) suggest that this finding may be explained by a resistance particularly from doctors to have the law intrude into their clinical and professional autonomous judgements. Therefore, patients may request euthanasia, but health professionals may refuse to comply with their wishes preferring treatment decisions to remain the responsibility of health professionals.

In its submission of evidence to the House of Lords on the Assisted Dying Bill, the UK nursing represen-

tative body, the RCN, stated the practice of euthanasia to be contrary to the public interest, nursing and medical ethics and patients' civil rights (House of Lords, 2004). However, it is difficult to discern why, if a nurse was in agreement with the practice, that respecting the lawful autonomous decision of a patient could be either against nursing ethics or indeed contrary to the public interest. Indeed, respecting such a decision could be viewed as upholding a patient's civil rights.

Conclusion

The attitudes of nurses to euthanasia are underrepresented in the literature in comparison with those of doctors. Of the research that has been published, there are few examples of studies using reliable, valid attitude measures or evidence of research-testing attitude theory. While some variables such as age and religiosity appear to influence nurses' attitudes, only one study (Kitchener, 1998) explored the significance of nursing speciality using multivariate analysis. This study reports the views of Australian nurses, which may have been influenced by the debate over the brief legalization of euthanasia in one Australian State, an issue less likely to influence the attitudes of nurses in other countries. With the exception of two polls carried out by the *Nursing Times*, the attitudes of British nurses to date have not been explored. Several published studies examine the attitudes of nurses in European countries as well as those from the USA and Japan. However, in addition to the influence of differing legal positions on euthanasia, important contextual social differences such as views on life and death, the influence of religion and the status of nursing impinge on direct comparison between nurses of different nationalities.

The published research shows limitations in the design and data collection methods for both quantitative and qualitative studies. While there is a need for reliable quantitative research to measure behaviour, important nuances may be missed when remote data collection methods (such as questionnaires) are the sole measures used. The strength of qualitative methods is their focus on understanding behaviour in exploring nurses' attitudes to euthanasia and it is

clearly important not only to explain, but also to understand the attitudes nurses hold. While empirical research alone cannot answer normative ethical questions such as 'what ought nurses to do', integration of empirical and normative claims can reveal a broader perspective of the study of morality (Molewijk *et al.*, 2004). As the largest group of caregivers in the UK and other countries, the attitudes nurses hold towards euthanasia, their views on proposed changes to the law and whether they would participate or administer euthanasia will impact upon clinical practice and ultimately patient care.

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