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Review

Attitudes and Behaviors of Palliative Care Nurses on Euthanasia

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Abstract

This review was planned to present an overview of the findings in the scientific literature on euthanasia, palliative care, and nurses' attitudes and behaviors. A literature search was done in "EBSCO," "PubMed" databases, and "Google Scholar" search engines. In the study, a search was made between January and March 2023 using the keywords "palliative care," "euthanasia," and "nurse attitudes." Articles published in English and accessible were included in the research. Palliative care practices differ according to the health system, socioeconomic status, cultural conditions, geographical location, and education levels of countries On the other hand, discussions on the integration of euthanasia into palliative care practices continue. While palliative care practices differentiate in countries where euthanasia has been legalized, scientific, legal, religious, and ethical discussions continue in countries where euthanasia is not legal. There are many different variables, such as age, gender, professional experience, and cultural and religious factors, that affect nurses' attitudes and behaviors on this issue. It can be suggested that the results of the research, which will evaluate the factors affecting the attitudes of nurses toward euthanasia, death and terminally ill patients, include social changes in order to provide a literature and database in this field.

Keywords: Euthanasia, nursing attitudes, palliative care

Introduction

It is known that the increase in the average life expectancy causes the individual's right to live and die to be questioned. Euthanasia began to become a topic of discussion when the right to sustain life with unbearable suffering or to die with dignity began to be considered (Can et al., 2020). Palliative care nurses, who provide holistic care by providing compassionate care to patients who stand on the line between life and death, and establish an empathetic relationship, frequently encounter patients' demands for euthanasia (Can et al., 2020; De Beer et al., 2004; Dierickx et al., 2018). This review was planned to provide an overview of the findings in the scientific literature on euthanasia, palliative care, and the attitudes and behaviors of nurses.

The Concept of Euthanasia

The term euthanasia, meaning a good death, has a Greek etymological origin and consists of the words "eu" meaning good, and "thanatos" meaning death. Francis Bacon expresses the concept of euthanasia, close to its current meaning, as a noble medical duty that includes alleviating the suffering of the terminally ill as part of healthcare. Since the beginning of the twentieth century, the definition of "good death" for euthanasia has changed, and it has been defined as the realization of death with the participation of health professionals and using health practices (Cabrera et al., 2021). The American Medical Association defines euthanasia as providing a painless death, terminating their treatment, or not making any effort for them to live, at the request of patients terminally ill, for whom medical science cannot relieve their pain and find a cure (Özkara, 2008). Active euthanasia is when the physician ends the patient's life by administering a lethal dose of another drug after deep sedation. Passive euthanasia can be defined as the physician accelerating death by not applying life-supporting treatment that will allow the patient to live for a while. In another type of euthanasia, assisted suicide, the physician prescribes a drug that will cause the patient's death, but the patient ends his life with this drug without the intervention of the medical staff. In active and passive euthanasia, health professionals usually perform the intervention that will lead to the death of the patient, while in assisted suicide, the patient himself is directly responsible for the action that led to his death (Özkara 2008). The terms euthanasia, voluntary-assisted dying, and physician-assisted dying can be used interchangeably in the literature, which includes the termination of a patient's life for compassionate reasons and at the express request of a person (Parpa et al., 2010).

Euthanasia and the Legal Dimension

When we look at euthanasia from the legal dimension, it is possible to say that euthanasia started to be accepted with the increase in the tendency not to consider suicide as a crime and the idea that the right to life is a right that one can voluntarily give up (Young et al., 2000). Euthanasia is discussed by legal

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science in the context of rights, freedoms, and the right to life. Euthanasia is being tried to gain a ground of legitimacy within the scope of the negative right to live/right to die as opposed to the right to live and the patient's right to determine his future. Euthanasia and physician-assisted suicide are legally possible in the Netherlands, Belgium, Luxembourg, Colombia, and Canada, while physician-assisted suicide is legal in only six American states (Oregon, Washington, Montana, Vermont, California, and Colorado). The legal regulations on euthanasia and assisted suicide show significant differences between European countries. Switzerland has more liberal laws regarding assisted suicide but does not allow euthanasia, although the Netherlands, Luxembourg, and Belgium allow euthanasia and assisted suicide under certain conditions. Other European countries strictly prohibit a death involving a second person (Dierickx et al., 2015). Belgium is the only country in the world where child euthanasia is legal, provided the child understands the consequences and actively requests this practice. German law allows assisted suicide under certain conditions, but there are ambiguities in the law (Dierickx et al., 2017). In Turkish Criminal Law, active euthanasia is not accepted as legitimate in any way, and it is thought that this practice will give rise to the crime of willful killing. On the other hand, some opinions argue that passive euthanasia is legally accepted within the framework of "the patient's right to refuse treatment" (Demirörs & Arslan Hızal, 2016). Therefore, euthanasia discussions in Turkey focus on whether passive euthanasia can be legally applied.

Euthanasia and Ethics

The views supporting euthanasia in euthanasia debates are determined as "respect for patient autonomy," "quality of life principle," "compassion," and "waste use of resources." Respect for the autonomy of the patient is discussed in the context of the principles of "usefulness," "non-harm," "autonomy," and "justice." According to this view, if a person is responsible for every act, he/she should have the right to decide on his/her own body and life. In the principle of quality of life, if a person is suffering and not enjoying life due to an incurable disease, euthanasia may be morally necessary if it has more painful consequences to live. The principle of compassion is dominated by the view that it is a moral obligation to end the life of a patient whose suffering cannot be cured. The principle of preventing the futile use of resources is that medical interventions for patients who cannot be treated will cause unnecessary loss of money, time, and effort. It is envisaged that these intensive labor and material resources will be used more effectively. The views that do not support euthanasia are based on the "sanctity and inviolability of life," "the hindrance of medical development," and "the unhealthy will to die" (Çelik, 2016). In religious discussions, it is emphasized that human life is sacred and superior to the life of other living things, based on the thesis of the sanctity of life. God is the source of the sanctity of human life, and it is out of the question to intervene in the domain of God's dominion and disobey his orders (Sümer, 2016).

Palliative Care and Euthanasia

The World Health Organization defines (2002) palliative care as an approach that aims to reduce or prevent suffering by early identification, evaluation, and treatment of physical, psychosocial, and spiritual problems of patients and their families who have problems accompanying life-threatening diseases and thus increasing their quality of life (Kabalak et al., 2013). In palliative care, death is considered a natural process, and access to palliative care is seen as a human right. Palliative care aims not to delay or accelerate death but to facilitate the transition from life to death and improve the quality of life (Lorenz, 2008). Although it covers end-of-life care, it is known that palliative care varies depending on the cultural structure and geographical characteristics of societies and how it is provided (Zaman et al., 2017).

Despite remarkable progress in palliative care, physicians and nurses still encounter critically ill patients dying of physical, psychological, and/or existential suffering and seeking medical attention (Dierickx et al., 2018). There are two different views regarding euthanasia and physician-assisted suicide. The first of these views is that euthanasia and physician-assisted suicide are incompatible with good palliative care. Reasons such as poor palliative care provision and insufficient success in relieving the pain and suffering of patients are shown behind the patients' request for euthanasia or assisted suicide. Therefore, before accepting a request for assisted suicide or euthanasia from patients who express a desire to die, it is considered essential to refer patients to palliative care to determine the factors that cause them to will to want to die. The European Palliative Care Association maintains the view that euthanasia and physician-assisted suicide should not be included in palliative care practices (Huemer et al. 2021). The preventive effect of palliative care on demand for euthanasia and assisted suicide is supported by the idea that palliative care and euthanasia have different purposes, conflict with the basic curative role of healthcare professionals, and the patient is left alone. Moreover, even if palliative care and euthanasia are compatible, it is generally argued that the availability of palliative care renders euthanasia and assisted suicide unnecessary. However, this is a view based on the idea that palliative care is always available and effective and that it is always preferable to euthanasia and assisted suicide (Riisfeldt, 2023). The preventive effect of palliative care on demand for euthanasia and assisted suicide has been discussed, but this thesis has never been confirmed. Dierickx et al. (2018) state in their study that a significant part of the people requesting euthanasia consists of patients receiving palliative care, and euthanasia requests of the majority of them were accepted. Studies on assisted death practices in Canada, the United States, and some European countries determined that 74%–88% of people prefer assisted death from patients receiving nursing homes or palliative care services (Emanuel et al., 2016). This means that receiving palliative care does not prevent patients who are really convinced to commit assisted suicide or euthanasia from requesting euthanasia (Dierickx et al., 2018).

The second view is that palliative care is a meaningful way to guide patients in their decision-making processes regarding euthanasia and assisted suicide and raise awareness of end-of-life care options (Huemer et al., 2021). According to this view, the suffering of patients can be reduced through palliative care. Therefore, it is thought that reducing the patient's pain, discomfort, and suffering and increasing the comfort and quality of life

will decrease the patient's death wish. It is thought that palliative care can act as a filter for patients who want to use their will to die due to psychological or severe temporary pain, discomfort, and suffering and therefore want euthanasia and assisted suicide so that they can think healthy and make the right decisions (Dierickx et al., 2018). Because due to the negative reflections of the situation on the quality of life for the person, he may think that one way of expressing pain is to hasten death, and he may see euthanasia or assisted suicide as an option to relieve his suffering, even if he does not want it (Rodríguez-Prat et al., 2016).

One of the reasons why patients decide to euthanasia is considered to be poor palliative care, and this causes nurses to evaluate themselves as unsuccessful. Farsides (1996) argues that euthanasia requests are not an indicator of the failure of health professionals' abilities to provide care but rather an expression of autonomy or an individual's right to make a "considered choice." However, Kopala and Kennedy (1998), while supporting a patient's autonomous decision to participate in euthanasia, emphasize that the autonomy of the healthcare provider involved in the care of that patient should also be respected and that consent should be obtained from healthcare providers. It is emphasized that autonomy is not absolute; individuals are included in a set of relationships, and the decision of euthanasia also significantly affects those around a person and cannot be a completely personal decision. In countries where euthanasia is legal, there is full conscientious objection where nurses may choose not to participate in euthanasia for reasons related to preserving moral integrity and choose to be exempted from all care. However, there are levels of participation in care that may or may not be directly related to the actual provision of euthanasia. For example, it is stated that they can work to provide ongoing care for people receiving euthanasia and psychosocial and bereavement support for the family (Canadian Nurses Association, 2017). King and Jordan-Welch (2003) argue that nurses should support their patient's autonomy when euthanasia requests help patients find meaning in life even when patients are suffering. It is also stated that it is important for nurses to investigate questions such as why the patient wants help when dying.

In countries where medical-assisted death is legal, people who receive palliative care face questions about how they can access it (Vandenberghe et al., 2013). With the enactment of laws regulating financing, education, accessibility, and insurance coverage in palliative care practices, and the realization of public health strategies, it is determined that public awareness of how people can access medical-assisted death has increased (Huemer et al., 2021). In Belgium, where euthanasia is legal, the first initiators of palliative care were advocating the view that euthanasia and palliative care can and should develop together. In the model known as the integrated end-of-life care model in Belgium, euthanasia is defined as an option located at the end of the palliative care pathway (Bernheim et al., 2014). The Belgian euthanasia law does not include a mandatory palliative care consultation but requires the physician to inform the patient about all available treatment options, including palliative care. Since the patient has the right to refuse all treatments, including palliative care treatment, the patient does not need to try palliative care. It is legally necessary to comply with the 1-month waiting period between the euthanasia request and the euthanasia (Dierckx et al., 2017).

In countries that accept euthanasia, palliative care nurses believe that they have an important role in the care process of a patient requesting euthanasia. The role of palliative care nurses regarding euthanasia is primarily to assist the patient, the patient's family and the physician by supporting them (De Beer et al., 2004). The participation of nurses in euthanasia begins with the patient's request for euthanasia and ends with the support of the patient's relatives and health workers after the possible life-ending action. In the study of De Beer et al. (2004), in which he examined the attitudes of nurses toward patients' request for euthanasia, nurses emphasize the importance of using palliative care techniques, being open-minded, considering the situation of the patient in the decision-making process and showing understanding.

Systematic reviews of the relationship between palliative care and death identify professionals' attitudes and experiences toward euthanasia or assisted suicide, desire to die or hasten death, and how palliative care practitioners may respond to it, and information about euthanasia or assisted suicide practices in different jurisdictions (Gerson et al., 2020). In some studies, it has been reported that frequent contact with dying patients, together with their increasing knowledge and experience in palliative care, strengthens the critical attitudes of nurses toward euthanasia and causes them to support euthanasia less (Hol H., 2022). It is believed that this condition is caused by the fact that assisted dying is an action that unnaturally accelerates death and contradicts the principles of the palliative care philosophy (Terkamo-Moisio et al. 2017). However, Freeman et al. (2020) reported that 75% of 249 palliative care nurses supported individuals' right to decide on their death. In a study conducted in Germany by Zenz et al. (2015), 4% of nurses working in palliative care services stated that they would like to apply for active euthanasia if requested by patients with a terminal illness.

Nurses' Attitudes and Behaviors Regarding Euthanasia

Despite the important role of nurses in end-of-life care, their attitudes toward euthanasia are an ongoing controversial issue both in the current literature and in many countries, and little is known about nurses' attitudes toward euthanasia (De Bal et al., 2006; Inghelbrecht et al., 2010; Terkamo-Moisio et al. 2017).

Cayetano-Penman et al.'s scoping study (2021) revealed two key concepts in nurses' attitudes toward euthanasia. It is reported that while some nurses support euthanasia by looking positively, some nurses do not support euthanasia by showing a negative attitude. It is stated that nurses who support euthanasia are associated with the main factors such as the patient's uncontrollable extreme pain, unbearable suffering or other disturbing experiences, the legality of euthanasia, and the patient's right to die. Religion, moral/ethical dilemmas, the role of the gender of the healthcare worker, and poor palliative care are reported in the study to be the factors determining nurses' negative and unsupportive attitudes to euthanasia. Cabrera et al. (2021) state that the factors affecting nurses' attitudes toward euthanasia practices are the patient's uncontrollable extreme pain, avoidance

of unbearable suffering or distressing experiences, whether euthanasia is legal or not, and the patient's right to die. Opposing views to these practices are religion, moral and ethical dilemmas, the gender role of health professionals, and the view that palliative care is inadequate. In the study of Terkamo-Moisio et al. (2017), it is revealed that the principle of respect for the patient's autonomy is effective and important in the attitudes of nurses toward euthanasia. The value of self-determination, the ability to choose the moment and manner of one's death, is emphasized.

Asadi et al. (2016) find that most nurses have negative views about euthanasia. Hol et al. (2022) determine that nurses' attitudes toward euthanasia are influenced by their age, education, and work in different units. In addition, it is stated in the literature that nurses with more work experience are less willing to participate in decision-making processes related to euthanasia. It is stated that among experienced nurses, especially those with postgraduate education in the field of palliative care, nurses should not participate in actions that accelerate the death of a patient but instead advocate the view that patients should alleviate their suffering as long as they live (Terkamo-Moisio et al., 2017). From the point of view of nurses' attitudes to euthanasia in terms of gender, it is determined in the field literature that men support euthanasia more than women (Terkamo-Moisio, 2017; Vijayalakshmi et al., 2018).

Religion is identified as one of the most critical factors causing nurses' negative attitudes toward euthanasia (Cabrera et al., 2021; Cayetano-Penman et al., 2021). Although the distribution of religious beliefs differs between countries, decrees generally emphasize the sanctity of life in all monotheistic religions. Ryynänen et al. (2002) found that all forms of euthanasia are accepted more often among nurses with a higher level of religious beliefs than other nurses. Öztürk (2021), in his study conducted with healthcare professionals in Turkey, shows that more than half of the participants believe it is vital for a patient to have the right to decide for their own life. In the study by Naseh et al. (2015), in which they evaluated the attitudes of Muslim nurses, it was determined that 57.4% of the nurses had a negative attitude toward euthanasia. In the study of Emami Zeydi et al. (2022), conducted in Iran, it is stated that patients with advanced stages of the disease exhibit a negative attitude toward euthanasia, and it is stated that this attitude has decreased compared to studies conducted in Iran in the past. Among Christian countries, there are countries where euthanasia is accepted and legalized (Dierickx et al., 2017).

Euthanasia has found its place in the health systems of some developed and developing countries and is used legally by medical personnel (Shekoufeh et al., 2022). In countries where euthanasia is legal, emotional burden and fear of psychological consequences are identified as the main reason for euthanasia opposition by some health professionals. Because it is thought that participation in euthanasia may conflict with professional role perception, personality traits, and responsibilities (Cabrera et al., 2021). Bellens et al. (2020), in a qualitative study investigating how nurses working in home care experience their participation in the care of patients requesting euthanasia 15 years after the legalization of euthanasia, report that nurses define euthanasia as something unnatural and planned, which raises many questions and doubts. Nurses express a deep sense of professional satisfaction that they can contribute to a dignified end of life and make a difference. However, the study notes that nurses experience negative emotions and frustration when they cannot provide good euthanasia care.

Crusat-Abelló et al. (2021), in a literature review study, stated that most nurses have a positive attitude toward the legalization of euthanasia, and it is stated that nurses should receive special training on this issue. This is consistent with the increasingly positive attitude of nursing professionals toward euthanasia in previous studies, but all studies report nurses' lack of knowledge about the specific theme of euthanasia.

Conclusion and Recommendations

Palliative care practices differ according to the health system, socio-economic status, cultural conditions, geographical location, and education levels of countries. It is essential to consider the patient, patient relatives, healthcare professionals, social values, judgments, and sensitivities in discussions of death, which is an individual and private experience. Considering the dynamic structure of society, social changes are inevitable, and it can be seen that the perspectives of social change over time. Nursing carries out its professional practices by maintaining professional and ethical values according to social changes. In research on euthanasia, it is crucial to reveal the findings of social changes and the reflections of this situation on the nursing profession. For this reason, it can be recommended to increase the results of the research that will evaluate the factors affecting the attitudes of nurses toward euthanasia, death, and terminally ill patients in order to provide literature and a database in this field.

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